NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Bryan William Carroll, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity and any information that would disclose the identity of the patients whose names are disclosed 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: Carroll, B. W. (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. BRYAN WILLIAM CARROLL

PANEL MEMBERS:

S. DAVIS
DR J. WATTS
D. DOHERTY
DR. T. MORIARITY
DR. M. DAVIE

Hearing Date:	**October 15, 2012**
Decision Date:	**October 15, 2012**
Release of Written Reasons:	**December 6, 2012**

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 October 15, 2012. 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. Bryan William Carroll committed an act of professional misconduct:

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

2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or 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.

RESPONSE TO THE ALLEGATIONS

Dr. Carroll admitted the allegations in the Notice of Hearing: (1) that he contravened a term, condition or limitation on his certificate of registration; and (2) that he has engaged in conduct or 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.

FACTS AND EVIDENCE

The following facts were set out in an Agreed Statement of Facts and Admission which was filed as an exhibit and presented to the Committee:

Background

1. Dr. Bryan William Carroll ("Dr. Carroll") has been a member of the College since 1969. He practises gynaecology in Ontario under a restricted certificate of registration.

Previous College Matter

2. In 2008, Dr. Carroll was the subject of a discipline proceeding which proceeded by way of agreed statement of fact and admission. A copy of the decision of the Discipline Committee dated December 12, 2008 is attached at Tab A [to the Agreed Statement of Facts and Admission].

3. In that proceeding, the Discipline Committee ordered, among other things, that Dr. Carroll undergo a Comprehensive Practice Assessment by an assessor approved by the College (the "CPA") and that Dr. Carroll abide by any and all recommendations made as a result of the CPA.

4. In accordance with the Discipline Committee's Order, Dr. Carroll underwent a CPA. The CPA was conducted by Dr. X. A copy of Dr. X's report, received by the College on November 9, 2009, is attached at Tab B [to the Agreed Statement of Facts and Admission].

5. Dr. X concluded that Dr. Carroll's care provided in the out-patient setting met or exceeded reasonable standards of practice. However, he observed that Dr. Carroll had not previously been following currently accepted guidelines with respect to colposcopy and uroflow studies. Dr. X recommended that Dr. Carroll comply with the currently accepted guidelines with respect to the indication for these two investigations.

6. As a result of the CPA, and the Discipline Committee's Order to abide by the recommendations arising from the CPA, Dr. Carroll entered into an undertaking dated January 8, 2010 (the "January 2010 Undertaking"), attached at Tab C [to the Agreed Statement of Facts and Admission]. Dr. Carroll's January 2010 Undertaking requires that effective immediately, he will abide by the currently accepted consensus on the threshold for ordering colposcopy and uroflow studies.

The Current Investigation

7. In 2010, the College received reports from Dr. Carroll's supervisor, Dr. Y, stating that Dr. Carroll continued to perform colposcopy without indication. On the basis of Dr. Y's reports, the College commenced an investigation to determine whether Dr. Carroll had breached his January 2010 Undertaking.

8. The College retained Dr. Z to provide an independent opinion as to whether Dr. Carroll met the standard for performing colposcopy and uroflow studies since January 2010. A copy of Dr. Z's report, received September 13, 2011, is attached at Tab D [to the Agreed Statement of Facts and Admission].

9. Of the 15 patient charts reviewed, Dr. Z identified 7 patients since January 2010 for which Dr. Carroll had performed repeated colposcopy and/or uroflow studies where these procedures were not indicated or were unnecessary.

Admission

10. Dr. Carroll admits the facts in paragraphs 1 to 9 above and admits that by failing to abide by the currently accepted consensus on the threshold for ordering colposcopy and uroflow studies, he has committed an act of professional misconduct, in that:

(a) he contravened a term, condition or limitation on the certificate of registration contrary to paragraph 1(1)1 of O. Reg. 856/93 made under the *Medicine Act, 1991*; and,

(b) he engaged in conduct or an act or omission relevant to the practise of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional contrary to section 1(1)33 of O. Reg. 856/93 made under the *Medicine Act, 1991* .

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Carroll's

admission and found that he committed an act of professional misconduct, in that he contravened a term, condition or limitation on his certificate of registration, and in that he has engaged in conduct or 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.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The following facts were set out in an Agreed Statement of Facts Regarding Penalty, which was filed as an Exhibit and presented to the Committee:

Positive Reports from Dr. Carroll's Clinical Supervisor

1. Pursuant to the Order of the Discipline Committee dated December 12, 2008, Dr. Carroll was subject to clinical supervision. He retained Dr. Y to act as his Clinical Supervisor.

2. Throughout 2010, the College received reports from Dr. Y. In reports received February 2010, August 2010 and September 2010 (attached at Tab A [to the Agreed Statement of Facts Regarding Penalty]), Dr. Y stated that Dr. Carroll continued to perform colposcopy without indication. With the exception of colposcopy, however, Dr. Y reported that he did not see any evidence of patient care or prescribing that does not meet the appropriate standard of care for an obstetrician/gynaecologist practising in Ontario.

3. In his report received December 13, 2010, Dr. Y indicated that he continued to review the guidelines for colposcopy with Dr. Carroll (Tab B [to the Agreed Statement of Facts Regarding Penalty]).

4. On February 24, 2011, April 15, 2011 and April 27, 2011, Dr. Y provided positive reports indicating that in the charts he reviewed, Dr. Carroll performed few colposcopies,

all of which were indicated. He continued to report that he saw no evidence of patient care or prescribing that did not meet the appropriate standard of care for an obstetrician/gynaecologist practising in Ontario. The reports of Dr. Y dated February 24, 2011, April 15, 2011 and April 27, 2011 are attached at Tab C [to the Agreed Statement of Facts Regarding Penalty].

Dr. Carroll's Admission

5. In the course of the College investigation which gave rise to these proceedings, Dr. Carroll accepted the opinion of Dr. Z and conceded that he had failed to adhere to the guidelines in determining the threshold for the performance of colposcopy and uroflow studies.

6. Prior to the referral of this matter to the Discipline Committee, on April 12, 2012, Dr. Carroll entered into an undertaking agreeing that, effective immediately, he will cease to engage in colposcopy and uroflow studies altogether. A copy of this undertaking (the "April 2012 Undertaking") is attached at Tab D [to the Agreed Statement of Facts Regarding Penalty]

7. Following the referral to discipline, Dr. Carroll agreed to proceed by way of agreement, obviating disclosure and proceeding directly to the hearing of the matter.

Further Reassessment of Practice

8. Pursuant to the Order of the Discipline Committee dated December 12, 2008, Dr. Carroll is subject to a further reassessment of his practice.

In general, a penalty must first and foremost protect the public. Other penalty principles include maintenance of public confidence in self-regulation of the profession, specific and general deterrence and rehabilitation of the physician.

The Committee has the discretion to accept or reject a joint submission on penalty. The Committee acknowledges, however, that the case law provides that a tribunal should accept a joint submission unless the penalty proposed is so disproportionate to the

findings that acceptance of the proposed penalty would be contrary to the public interest and bring the administration of justice into disrepute.

The proposed penalty of a two month suspension and reprimand should send a clear message to both the public and the profession that it is a serious matter when a physician does not abide by an undertaking with this College. A failure to comply with an undertaking raises concerns regarding a member's governability and challenges the self-regulation process. It is always very concerning to the Committee when a physician disregards his or her regulatory body. In order for the public to have confidence in self-regulation, a physician must scrupulously abide by his or her undertaking with the College. Dr. Carroll's breach of his undertaking was tantamount to breaching an order of the Discipline Committee, and such conduct cannot be tolerated.

The Committee did consider the mitigating factors in this case, including the timely cooperation and admission made by Dr. Carroll, which led to a speedy resolution, obviating the need for a contested hearing. Also, Dr. Carroll accepted the expert opinion of Dr. Z, and agreed to cease performing colposcopies and uroflow studies altogether and to arrange referral to other physicians in the future for these studies. This will ensure the public will be protected. The proposed penalty provides that Dr. Carroll's practice will continue under supervision and he is to undergo another practice assessment in accordance with the previous order. This will provide further protection for the public. The Committee is also aware there have been no other clinical concerns regarding Dr, Carroll's practice. Recent supervisor reports have noted marked improvement.

For these reasons, the Committee finds the jointly proposed penalty to be fair and reasonable in the circumstances, and adequately addresses the guiding principles of penalty.

ORDER

Therefore, having stated the findings in paragraph 1 of its written order of October 15, 2012, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Carroll appear before the panel to be reprimanded.

3. the Registrar suspend Dr. Carroll's certificate of registration for a period of two (2) months, to commence October 15th, 2012.

4. Dr. Carroll pay costs to the College in the amount of $3,650.00 within thirty (30) days from the date of this Order.

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