

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. John Edward Esmond, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the witnesses or any information that could disclose the identity of the witnesses 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: **Ontario (College of Physicians and Surgeons of Ontario) v.
Esmond, 2016 ONCPSD 4**

**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. JOHN EDWARD ESMOND

PANEL MEMBERS:

**DR. P. POLDRE (CHAIR)
D. GIAMPIETRI
DR. F. SLIWIN
S. BERI
DR. W. KING**

Hearing Date:	December 18, 2015
Decision Date:	December 18, 2015
Release of Written Reasons:	February 18, 2016

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 December 18, 2015. 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. Esmond 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. Esmond is incompetent as defined by subsection 52(1) of the Code.

At the commencement of the hearing, counsel for the College advised that the College would not be seeking a finding on the allegation of incompetence in the Notice of Hearing.

RESPONSE TO THE ALLEGATIONS

Dr. Esmond admitted the first and second allegations in the Notice of Hearing, that he failed to maintain the standard of practice of the profession and that he 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 FACTS

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

PART I – FACTS

Background

1. Dr. John Edward Esmond (“Dr. Esmond”) is a family physician who practises family medicine in Mississauga, Ontario. He graduated from the School of Medicine at the University of Toronto in 1994 and obtained a certificate of Independent Practice in 1996.

Clinical care issues – prescribing

2. On July 31, 2013, the College received a letter from the Office of the Chief Coroner notifying the College of the death of a patient of Dr. Esmond, who died at home with end-stage cancer. The Coroner raised concerns with respect to the care provided by Dr. Esmond, including the dose of morphine prescribed by Dr. Esmond prior to the patient’s death. This information led the College to initiate an investigation into Dr. Esmond’s practice.

3. The College retained a Medical Inspector, Dr. Z as part of its investigation. Dr. Z reviewed the charts of 36 patients from Dr. Esmond’s practice, conducted an interview with Dr. Esmond, and observed seven patient encounters at Dr. Esmond’s office. Copies of Dr. Z’s reports, dated April 21, 2014 and May 3, 2014, are attached at Tab 1 to the Agreed Statement of Facts and Admission.

4. As found by Dr. Z, Dr. Esmond failed to meet the standard of practice in the care provided to 16 of the 36 patients whose charts were reviewed and one of the seven patient encounters observed in Dr. Esmond’s office. Further, Dr. Esmond’s care exposed patients

to risk of harm by “placing [them] in a situation of reliance on major analgesics for an undefined and indeterminate length of time.” Dr. Z noted:

What is concerning is the repeating pattern in many of the charts reviewed. In each of those charts reviewed, in which the conclusion is reached that the physician fell below the accepted standard of care, a very troublesome pattern emerges. From the first encounter there is recognition by the physician that the patient has chronic pain. Yet there is little to indicate any thorough investigation of the source of the pain is ever undertaken. Even when there is acknowledgement by the physician that the patient has marked underlying psychosocial disorders, the management always defaults to utilization of narcotic analgesics. A case can be made that with many of these patients it is unlikely that significant identifiable organic sources of the pain would be discovered.

[...]

The pattern here also indicates a rush to major analgesics, seemingly bypassing any thought of management with non-pharmacologic modalities or less powerful analgesics [...] There is no indication of any systematic method of walking up the analgesic ladder with the almost immediate reliance on Percocet, long acting strong opioids, Duragesic patches and Suboxone. [...]

5. On May 20, 2014, after receiving Dr. Z’ report, Dr. Esmond voluntarily entered into an undertaking relinquishing his privileges to prescribe narcotics, benzodiazepines and all other monitored drugs and controlled substances. Dr. Esmond also undertook to refer all patients on opioid therapy to other physicians for assessment and care. On February 12, 2015, following the referral of this matter to the Discipline Committee, Dr. Esmond signed an interim undertaking imposing substantially similar restrictions on his certificate of registration pending the hearing before the Discipline Committee. A copy of Dr. Esmond’s February 12, 2015 undertaking is attached at Tab 2 to the Agreed Statement of Facts and Admission.

Treating his family member, contrary to College policy

6. Dr. Esmond treated a family member between 2007 and 2014, acting as the family member's primary care provider between 2007 and 2011 and following the family member for a number of serious medical conditions.

7. In the course of treating his family member, Dr. Esmond made diagnoses, ordered investigations, made referrals to specialists, wrote prescriptions, including prescriptions for psychotropic medication, billed the Ontario Health Insurance Program ("OHIP"), and completed insurance forms. Some of Dr. Esmond's treatment of his family member was not documented in his records or billed to OHIP. By treating his family member in this manner over the course of many years, Dr. Esmond acted in direct contravention of the College Policy on Treating Self and Family Members, a copy of which is attached at Tab 3 to the Agreed Statement of Facts and Admission.

Treating and being treated by another physician whom he supervised

8. A second investigation into Dr. Esmond's practice was commenced after the College received a third-party complaint alleging that Dr. Esmond had entered into a relationship with a physician whom he was supervising ("Dr. A").

9. Dr. A is a foreign-trained family physician. Dr. Esmond acted as College-approved supervisor for Dr. A while her application for a certificate of registration to practise independently in Ontario was pending before the College. As her supervisor, Dr. Esmond agreed to ensure that Dr. A's patient care met the standard of practice. Dr. Esmond also agreed to submit reports every 4-6 months and to notify the College immediately if he had any concerns about Dr. A's knowledge, skill, judgement or attitude. The period of supervision began in February 2009 and ended on March 30, 2011. Dr. Esmond and Dr. A subsequently became friends and then commenced an intimate relationship in 2012. In 2013, Dr. Esmond and Dr. A married.

10. While acting as her supervisor, Dr. Esmond sought and received medical treatment from Dr. A on approximately 40 occasions for various conditions, including a burn to his hand and chronic back pain. In addition, Dr. A referred Dr. Esmond to a

chiropractor, urologist, psychiatrist, nephrologist and a Physical Medicine specialist as well as prescribed various medications to him, completed a disability form for him, ordered a CT scan of his lumbar spine and ordered an MRI scan of his thoracic spine. Dr. Esmond continued to seek intermittent treatment from Dr. A following the conclusion of the period of supervision, including for a urinary tract infection and anxiety. In addition, after the conclusion of the period of supervision, Dr. A completed an insurance assessment for Dr. Esmond which was submitted to Dr. Esmond's insurance company in support of Dr. Esmond's application for disability benefits.

11. Dr. Esmond also treated Dr. A during the period of supervision, including by providing allergy shots on four occasions and assessing Dr. A for conjunctivitis. Dr. Esmond continued to provide incidental treatment to Dr. A on occasion following the conclusion of the period of supervision, including ordering an ultrasound for Dr. A and referring Dr. A to a gynaecologist.

PART II – ADMISSION

12. Dr. Esmond admits the facts specified above and admits that, based on these facts, he engaged in professional misconduct by having failed to maintain the standard of practice of the profession in his care of patients with chronic pain, including his narcotics prescribing practices, and failing to maintain appropriate records of patient encounters.

13. Dr. Esmond also admits that, based on the facts specified above, he engaged in disgraceful, dishonourable or unprofessional conduct, including by providing frequent care to a family member over the course of many years and treating and being treated by a physician whom he was entrusted by the College to supervise and with whom he later developed a personal and intimate relationship.

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. Esmond's

admission and found that he committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and that he 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.

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 whose terms included: a four-month suspension, terms, conditions and limitations on Dr. Esmond's certificate of registration, a requirement that Dr. Esmond complete courses in Professional Boundaries and Ethics as well as Medical Record Keeping, a public reprimand and costs to the College for a single hearing day at the tariff rate of \$4,460.00.

The Committee found that the joint penalty submission adequately addresses the penalty principles of public protection, specific and general deterrence, the expression of the condemnation of the profession for the admitted behaviour, maintenance of public confidence in professional self-regulation and appropriate rehabilitation of the member.

Counsel for the College submitted that the allegations agreed to and admitted by Dr. Esmond are serious. The Committee wholeheartedly agrees.

The practice deficiencies found in the course of the inspection of Dr. Esmond's practice, relating to narcotic prescribing and record keeping, cry out for public protection and the imposition of a practice limitation prohibiting the prescription of narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances and all other controlled drugs (particularized in the Draft Order) is fully justified. The Committee noted that Dr. Esmond voluntarily relinquished these prescribing rights on receipt of the expert report. The requirement to post a sign, in English and in Spanish, in a clearly visible location in his office, informing patients of this prohibition is a further measure of public protection.

The requirement to complete a course in medical record keeping will serve to correct the substandard practice deficiencies identified by the medical inspector.

Few, if any, physicians can be unaware of the College policy prohibiting more than incidental or emergency treatment of family members or others with whom the physician has a close personal relationship. The provision of optimal care requires the objectivity inherent in an "arm's length" doctor/patient relationship. That Dr. Esmond violated this policy repeatedly and over a prolonged period of time is beyond question.

Equally serious in the eyes of the Committee was the provision to, and receipt of, care from another physician over whom Dr. Esmond agreed to take a supervisory role, in violation of a mentor/mentee relationship, sacred since the time of Hippocrates.

The imposition of a significant suspension and the public reprimand clearly demonstrates the abhorrence of the profession for this behaviour.

Counsel for Dr. Esmond submitted that he had cooperated fully with the College investigation and that in agreeing to the allegations he had taken responsibility for his actions and saved the College the time and expense of a contested hearing. The Committee accepted this submission and agreed with the awarding to the College of the cost for a single hearing day at the tariff rate of \$4,460.00 (albeit a portion of the true costs incurred).

The Committee therefore made the following order:

ORDER

Therefore, having stated the findings in paragraph 1 of its written order of December 18, 2015, the Committee ordered and directed on the matter of penalty and costs that:

1. the Registrar suspend Dr. Esmond's certificate of registration for a period of four (4) months commencing immediately.
2. the Registrar impose the following terms, conditions and limitations on Dr. Esmond's certificate of registration:

(a) Dr. Esmond shall not issue new prescriptions or renew existing prescriptions for any of the following substances:

- (i) **Narcotic Drugs** (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
- (ii) **Narcotic Preparations** (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
- (iii) **Controlled Drugs** (from Schedule G of the Regulations under the *Food and Drugs Act*, S.C., 1985, c. F-27);
- (iv) **Benzodiazepines and Other Targeted Substances** (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
(A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached [to the Order] as Schedule “A”; and the current regulatory lists are attached [to the Order] as Schedule “B”)
- (v) **All other Monitored Drugs** (as defined under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22 as noted in Schedule “C” to the Order).

(b) Dr. Esmond shall post a sign that is clearly visible upon entering his office(s) in the form set out at Schedule “D” to the Order. For further clarity, this sign shall state as follows:

IMPORTANT NOTICE

Dr. Esmond must not prescribe any of the following:

- Narcotic Drugs
- Narcotic Preparations
- Controlled Drugs
- Benzodiazepines and Other Targeted Substances
- All other Monitored Drugs

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpsso.on.ca

A sign reflecting this restriction will also be posted in Spanish.

(c) Dr. Esmond shall cooperate with unannounced inspections of his practice and patient charts and such other steps as the College may take for the

purpose of monitoring and enforcing his compliance with the terms of this Order and will make his Ontario Health Insurance Plan billings and Narcotics Monitoring System data accessible to the College for this purpose.

- (d) Dr. Esmond must successfully complete, at his own expense, the first available Professional Boundaries and Ethics (“ProBE”) Canada course and University of Toronto Medical Record Keeping course, or, if these courses are unavailable, other courses acceptable to the College in ethics, boundaries, and medical record keeping, within four (4) months of the date of this Order.
- 4. Dr. Esmond appear before the panel to be reprimanded.
 - 5. Dr. Esmond pay to the College costs in the amount of \$4,460 within 30 days of the date of this Order.

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