NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Jeffrey Marlowe Brown, 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 Dr. Brown's family member referred to orally and in the exhibits filed at the hearing., in particular, the nature of the family member's relationship to Dr. Brown, 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… 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. Brown,**
2019 ONCPSD 23

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. JEFFREY MARLOWE BROWN

PANEL MEMBERS:

MR. JOHN LANGS
DR. PAMELA CHART
MS. CHRISTINE TEBBUTT
DR. ELIZABETH SAMSON
DR. SUSANNA YANIVKER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MR. KIRK MAIJALA

COUNSEL FOR DR. BROWN:

MR. JAAN LILLES

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. JENNIFER MCALEER

PUBLICATION BAN

Hearing Date: **May 10, 2019**
Decision Date: **May 10, 2019**
Written Decision Date: **June 24, 2019**

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 May 10, 2019. At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Brown committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Jeffrey Marlowe Brown committed an act of professional misconduct:

i. 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.

ii. 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 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. Brown is incompetent, as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Brown admitted that he failed to maintain the standard of practice of the profession, and 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.

The allegation of incompetence was withdrawn by the College.

PART I - THE FACTS

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

Dr. Brown is a 58-year-old physician who practices in Thornhill, Ontario. Dr. Brown practices primarily in the areas of weight loss medicine and complementary/alternative medicine at a weight loss clinic in Thornhill. Dr. Brown graduated from the University of Toronto in 1987 and received his certificate of independent practice from the College in 1988.

Overview of the Case

1. The College commenced an investigation into Dr. Brown's practice in 2014, followed by investigations into two public complaints received in 2014 and 2017.

2. As part of its investigation, the College obtained independent opinions from Dr. Michael Lyon, a physician who practices in the area of medical weight management, Dr. Jennifer Pearlman, a physician who practices in the area of women's health and wellness, including complementary/alternative medicine and bio-identical hormone replacement therapy, and Dr. Pauline Pariser, a primary care physician. Dr. Pearlman reviewed 25 of Dr. Brown's patient charts, while Dr. Lyon reviewed 24 patient charts and observed 6 of Dr. Brown's patient encounters. Dr. Pariser reviewed Dr. Brown's patient records for his family members. In its investigation of the one of the public complaints, the College also obtained an independent opinion from Dr. Yoni Freedhoff, a physician who practices in office-based weight management.

3. Dr. Brown obtained opinions from Dr. Esther Konigsberg, a physician who practices complementary/alternative medicine and bio-identical hormone replacement therapy, and Dr. Deborah Martin, a physician who practices in metabolic medicine.

PART II – FAILURE TO MAINTAIN THE STANDARD OF PRACTICE OF THE PROFESSION

Record-Keeping

4. The charts reviewed were obtained by the College from Dr. Brown's practice in 2014 and included care in some cases provided as far back as ten years of patients that entered and exited the weight loss program, restarting the weight loss program often many times over the years. Dr. Brown's practice was to re-assess patients at each restart and create a new chart, including a new patient history profile and CPP.

5. The expert reviews of Dr. Brown's medical records revealed a number of deficiencies in Dr. Brown's charting, including:

(a) Organization: Dr. Brown's charts were disorganized, with test results and patient history profiles inserted throughout the chart and sometimes duplicated, and with no way to identify who made a particular chart entry other than Dr. Brown;

(b) Legibility: Dr. Brown's chart entries were frequently illegible;

(c) Completeness: In a number of charts, Dr. Brown did not document physical examinations, or record in the chart key relevant information about weight loss patients such as height, body mass index (BMI), or relevant diagnoses such as diabetes or metabolic syndrome;

(d) Consent: Dr. Brown did not clearly document informed patient consent to receive Complementary/Alternative Medicine in accordance with College Policy #3-11, *Complementary/Alternative Medicine*;

(e) CPPs: Dr. Brown did not have complete Cumulative Patient Profiles in a number of charts;

(f) Prescribing: Dr. Brown failed to clearly state prescription and supplement additions in a number of patient charts;

(g) Testing: Dr. Brown did not always record tests that he ordered or lab work received in the patient charts; and

(h) Rationale for testing or prescribing: Dr. Brown failed to document his rationale for ordering tests or for prescribing medications despite normal test results in a number of charts.

6. Since the commencement of the investigation, Dr. Brown voluntarily enrolled in and successfully completed the University of Toronto Medical Record Keeping course on November 16, 2016.

Complementary/Alternative Medicine

7. Dr. Brown's provision of Complementary/Alternative Medicine was deficient in that:

(a) Dr. Brown did not always reach a conventional diagnosis; and

(b) In one instance, in his prescribing of transdermal estrogen therapy.

Treatment of Family Members

8. Dr. Pariser opined that Dr. Brown failed to maintain the standard of practice of the profession by providing treatment to his family member in circumstances that were not episodic or emergent, contrary to College Policy #7-06, *Physician Treatment of Self, Family Members or Others Close to Them*, including completing a requisition for her for saliva hormone testing and allergy blood testing. Dr. Pariser opined that Dr. Brown's conduct did not expose his family member to risk of harm.

PART III – DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

Conduct Towards College Investigators

9. On March 12, 2015, College Investigators attended at Dr. Brown's office in order to notify him of an investigation into a patient complaint and to obtain relevant information and records, including a patient chart and supplement sample. Dr. Brown became upset with the investigators, and began to speak loudly and angrily. Dr. Brown interrupted the investigators and made disparaging comments about the investigators and disputed their authority to obtain the charts and the supplements. Dr. Brown subsequently provided the requested materials and apologized to the investigator for his conduct.

PART IV – ADMISSION

10. Dr. Brown admits the facts specified above and admits that, based on these facts, he engaged in professional misconduct, in that:

(a) He has failed to maintain the standard of practice of the profession, under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"); and

(b) 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, under paragraph of O. Reg. 856/93.

FINDINGS

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee found that Dr. Brown committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession, and 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 parties jointly proposed that Dr. Brown attend before the panel to be reprimanded; that his license be suspended for a period of two months; that he complete professional education in communications and ethics; that he be subject to a period of clinical supervision; and pay the College costs in the amount of $6,000.00.

The Committee is aware that a joint submission on penalty should be accepted unless doing so would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony Cook*, 2016 SCC 43).

In assessing the proposed penalty, the Committee was mindful of the accepted penalty principles. The Committee's overarching consideration was whether the proposed penalty would serve to protect the public. Deterrence, both of the member specifically and the entire profession more generally, was also a key consideration in assessing the penalty proposed. Further, the Committee was cognizant that the penalty should promote public confidence in the College's ability to regulate the profession in the public interest. The penalty should also be proportional to the misconduct, and where possible, provide for the rehabilitation of the member.

Aggravating Factors

Failure to Maintain the Standard of Practice

A review of Dr. Brown's medical records revealed serious deficiencies. These deficiencies included a lack of basic organization and illegible content. Even more concerning to the Committee was that the charts reviewed were incomplete, omitting key information such as Cumulative Patient Profiles, patient diagnoses, and Dr. Brown's rationale for testing and

treatment. Further, Dr. Brown did not clearly document patients' informed consent to receive complementary/alternative medicine in accordance with College Policy #3-11, *Complementary/Alternative Medicine*.

Dr. Brown's deficits in record keeping are concerning and reflect inattention to required information. Dr. Brown has been in practice a number of years and should be aware of the importance of accurate and complete medical records. Record keeping is a basic professional responsibility, and necessary for proper patient management and referral. The content of patient records must demonstrate clarity of thought and rationale for a proposed treatment.

Dr. Brown's practice deficiencies also extend to his provision of complementary/alternative medicine in that he did not always reach a conventional diagnosis as required by College policy.

Further, Dr. Brown contravened College Policy #7-06, *Physician Treatment of Self, Family Members or Others Close to Them* by treating his family members on occasions that were neither episodic nor emergent.

The Committee is very concerned about Dr. Brown's failure to adhere to College policies. College policies are developed to assist the profession in providing quality health care, and to ensure the interests of patients are protected. Members of the profession are expected to comply with College policies.

Disgraceful, Dishonourable or Unprofessional Conduct

Dr. Brown has a duty to cooperate with the College, his regulatory body. Dr. Brown's confrontational behavior towards College investigators was out of line. His questioning of investigators' authority frustrated their ability to effectively carry out their role. In the view of the Committee, this behavior is unacceptable.

The Committee does note that Dr. Brown subsequently apologized and promptly produced the requested material.

Mitigating Factors

The Committee accepts the following as mitigating factors:

- This was the first time Dr. Brown has been before the Discipline Committee;
- Dr. Brown admitted the misconduct, which shortened the hearing and eliminated the need to call witnesses;
- Dr. Brown's admission demonstrates that he has gained insight and has taken responsibility for his actions; and
- Dr. Brown apologized to College investigators and provided the requested materials by the end of the visit.

Prior Cases

In support of the joint penalty proposed, College counsel and counsel for Dr. Brown submitted the following Discipline Committee cases. The Committee accepts that while not bound by these previous decisions, in keeping with general principles of fairness, like cases should be treated alike.

In *CPSO v. Billing*, 2017 ONCPSD 30, numerous deficiencies were found in Dr. Billing's record keeping, as well as failures to maintain the standard of practice with respect to infection control. The Committee ordered a 2 month suspension, a 12 month period of clinical supervision, a re-assessment three months after the end of the clinical supervision, ongoing monitoring and a reprimand. Dr. Billing was also ordered to pay costs to the College. Dr. Billing entered a plea of no contest and the Committee accepted the joint submission on penalty.

In *CPSO v. Aziz*, 2014 ONCPSD 33, the Committee found that Dr. Aziz failed to maintain the standard of practice, and engaged in disgraceful, dishonourable or unprofessional conduct by failing to co-operate with the College. In addition, Dr. Aziz was in breach of an undertaking made with the College's investigation. The penalty imposed included a 3-month suspension, a period of clinical supervision, and a reprimand. This was an agreed statement of facts case and the Committee accepted the joint proposal on penalty.

In *CPSO v. Moore*, 2013 ONCPSD 19, the finding of disgraceful, dishonourable or unprofessional conduct was based on boundary violations and Dr. Moore's treatment of his family members. The Committee ordered a reprimand and terms, conditions and limitations on Dr. Moore's certificate of registration, which included remedial education. Dr. Moore was also ordered to pay costs to the College. This was an agreed statement of facts case and the Committee accepted the joint proposal on penalty.

Having considered the above cases, the Committee concluded that the jointly proposed penalty fell within the range of penalties established by previous decisions of this Committee.

Summary

For these above reasons, the Committee accepted the parties' joint submission on penalty as an appropriate penalty in the circumstances of this case.

A two month suspension serves to denounce the misconduct and acts as both a specific and general deterrent. The requirement that Dr. Brown complete a course with emphasis on professional responsibility and ethics is rehabilitative. The reprimand allows the Committee the opportunity to speak directly to Dr. Brown regarding his actions. It serves as a specific deterrent for Dr. Brown and a general deterrent to the profession that this type of misconduct is not tolerated. The clinical supervision and reassessment imposed should reassure the public that Dr. Brown will practice in accordance with professional standards going forward.

Seen as a whole, the penalty ordered will achieve public protection and is appropriate given the circumstances.

ORDER

The Committee stated its finding in paragraph 1 of its written order of May 10, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Brown attend before the panel to be reprimanded.

3. The Registrar suspend Dr. Brown's certificate of registration for a period of two (2) months effective June 10, 2019.

4. The Registrar impose the following terms, conditions and limitations on Dr. Brown's certificate of registration:

a. Dr. Brown shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "B" to this Order;

b. Dr. Brown shall, within six (6) months of the end of the period of the suspension, complete professional education in communications and ethics acceptable to the College;

Clinical Supervision

c. Within sixty (60) days of the date of this Order, Dr. Brown shall obtain a clinical supervisor acceptable to the College, who will supervise Dr. Brown for a period of twelve (12) months, and who will sign an undertaking in the form attached hereto as Schedule "A" (the "Clinical Supervisor");

d. The Clinical Supervisor will meet with Dr. Brown initially to discuss practice improvement recommendations;

e. The Clinical Supervision shall be at a moderate level for three (3) months, commencing on the date following the expiry of the suspension of Dr. Brown's certificate of registration. During moderate level supervision, the Clinical Supervisor will meet with Dr. Brown monthly, review a minimum of twenty (20) of Dr. Brown's patient charts and observe Dr. Brown's patient encounters for one (1) day at each meeting, and discuss Dr. Brown's patient care and documentation,

identify any concerns regarding the care and documentation make recommendations for improvement, and provide a report to the College each month;

f. After three (3) months, with approval of the College and on the recommendation of the Clinical Supervisor, the Clinical Supervision shall be at a low level for the remainder of the period of Clinical Supervision. During low level supervision, the Clinical Supervisor will review a minimum of twenty (20) of Dr. Brown's patient charts per month, and discuss with Dr. Brown his patient care and documentation, identify any concerns regarding the care and documentation, make recommendations for improvement and report to the College every three (3) months;

g. Within six (6) months after the completion of the Clinical Supervision, Dr. Brown will submit to a reassessment of his practice (the "Reassessment") by an assessor or assessors selected by the College (the "Assessor(s)"). The Reassessment may include a chart review, direct observation of Dr. Brown's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The results of the Reassessment will be reported to the College and may form the basis of further action by the College;

h. Dr. Brown shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor(s) with respect to practice improvements and education;

i. Dr. Brown shall consent to the disclosure by the Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Brown's compliance with this Order. This shall include, without limitation, providing the Clinical Supervisor with any reports of any assessments of Dr. Brown's practice in the College's possession;

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

k. If Dr. Brown is unable to obtain a Clinical Supervisor in accordance with paragraphs 4(b) or 4(g) of this Order, he shall cease practising medicine until such time as he has done so, and the fact that he has will constitute a term, condition or limitation on his certificate of registration until that time;

l. Dr. Brown shall co-operate with unannounced inspections and shall consent to the monitoring of his OHIP billings of his Practice by a College representative(s), for the purpose of monitoring and enforcing his compliance with the terms of this Order;

m. Dr. Brown shall inform the College of each and every location that he practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location; and

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

5. Dr. Brown pay the College costs in the amount of $6000, within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Brown 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 May 10th, 2019
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. JEFFREY MARLOWE BROWN

Dr. Brown,

The public places great trust in the medical profession and you must be worthy of that trust. Part of this trust is the expectation that those holding a Certificate of Registration with the College will maintain the standard of practice of the profession.

The deficits in your medical records were not simply limited to legibility but extend far beyond. It was particularly troubling to this Committee to see deficits in consent, accuracy and treatment rationale.

Your disregard for College policy in complementary medicine and in the treatment of family members is also troubling. College policies are written to guide the behaviour of the profession in areas where conflict or concern occurs. The consequences of not following College policies are significant.

The Committee wishes to emphasize to you the important role of the College in regulating the profession. To have been verbally abusive and unhelpful to the College investigators in carrying out their role is unacceptable. An apology was certainly needed.

We are encouraged by the remedial steps you have taken, and we trust you have gained some insight into your role as a responsible physician by virtue of this process.

Please be seated.