NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Thomas Joseph Barnard, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity or any information that could disclose the identity of the 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… 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. Barnard, 2019 ONCPSD 43

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. THOMAS JOSEPH BARNARD

PANEL MEMBERS:

MR. P. PIELSTICKER
DR. Y. VERBEETEN
DR. P. BERGER
MR. J. P. MALETTE, QC
DR. B. LENT

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. LINDSAY CADER

COUNSEL FOR DR. BARNARD:

MR. MATTHEW K. DALE

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. JENNIFER McALEER

PUBLICATION BAN

Hearing Date: **July 23, 2019**
Decision Date: **July 23, 2019**
Release of Reasons Date: **September 17, 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 July 23, 2019. At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Barnard 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. Barnard committed an act of professional misconduct:

1. under clause 51(1)(a) of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the "Code"), in that he has been found guilty of an offence that is relevant to his suitability to practise; and

2. 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 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. Barnard did not attend the hearing. Counsel on his behalf indicated that Dr. Barnard admitted the allegations in the Notice of Hearing, that: he has been found guilty of an offence that is relevant to his suitability to practise; and 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 FACTS

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

Background

1. Dr. Thomas Joseph Barnard ("Dr. Barnard") is a 70 year old family physician practising in Windsor.

2. Dr. Barnard received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("College") in July 1980. He was certified by the College of Family Physicians of Canada as a specialist in Family Medicine in July 1982, and as a specialist in Family Medicine (Emergency Medicine) in November 1984.

3. On January 20, 2017, Dr. Barnard signed a voluntary Undertaking with the College. The Undertaking was part of the resolution of a discipline proceeding, which involved allegations regarding, among other things, Dr. Barnard's clinical care and prescribing practices. Pursuant to this Undertaking, Dr. Barnard agreed to cease practising family medicine and to limit his practice to the provision of cosmetic, aesthetic, and nutritional and lifestyle services. Dr. Barnard provided these services at a medical spa that he owned, the Fresh Medical Spa, located at 2430 Dougall Avenue, in Windsor, Ontario ("Fresh Medical Spa").

Disgraceful, Dishonourable or Unprofessional Conduct Re: Breach of Discipline Committee Order

4. Pursuant to the Undertaking referenced above, as of March 17, 2017, Dr. Barnard's practice was restricted to aesthetic and cosmetic services and nutritional counselling. The Undertaking specified eleven services that he was permitted to provide. These included "injections of Botox for the reduction of wrinkles and superficial deformities"; and "injection of dermal fillers to replace lost volume and to correct deformities and scarring".

5. By Order of the Discipline Committee, dated February 13, 2017, Dr. Barnard was suspended from practising medicine for a period of four months, commencing on March 17, 2017. On account of his suspension, Dr. Barnard arranged for a nurse to attend Fresh Medical Spa to provide cosmetic injections during this period. He also contacted a physician colleague to act as a medical supervisor and oversee the nurse. The colleague agreed, in principle, to act as

the medical supervisor to the nurse during Dr. Barnard's suspension. Dr. Barnard's initial telephone call was the only contact anyone at Fresh Medical Spa had with the proposed medical supervisor regarding supervision.

6. In late March 2017, the College learned that a nurse was scheduled to attend Fresh Medical Spa on April 5, 2017 for the purpose of performing cosmetic injections. On April 5, 2017, two Compliance Case Managers from the College attended Fresh Medical Spa unannounced. The nurse was present and had performed 10 injections over approximately two hours. Staff members of Fresh Medical Spa informed the Compliance Case Managers that the nurse was being overseen by the proposed medical supervisor, and that she was to contact him directly with any questions or concerns regarding the injections.

7. On the same day, the Compliance Case Managers interviewed the proposed medical supervisor. He confirmed that he had not been contacted to arrange for consultations with patients or to review the procedures recommended by the nurse before they were performed. He was entirely unaware that the nurse was attending Fresh Medical Spa and performing injections on that day. Consequently, the nurse performed injections without the oversight of a medical supervisor.

8. The College retained a cosmetic dermatologist, Dr. Nowell Solish, to review the issues around supervision and delegation during Dr. Barnard's suspension. Dr. Solish reviewed eleven charts of patients who attended at Fresh Medical Spa on April 5, 2017, as well as transcripts of interviews with the nurse and the proposed medical supervisor. He found no evidence that any patients were seen or reviewed by any physician in charge, and no evidence that any treatments or doses had been properly delegated to the nurse.

9. In his report, Dr. Solish opined that, due to his suspension, Dr. Barnard could not be the physician in charge to either perform or delegate the injections. As such, a new physician-patient relationship with a physician other than Dr. Barnard was required for the purpose of assessing and delegating the injections. He further opined that "although Dr. Barnard requested that [the proposed medical supervisor] cover him during his suspension that no proper plan was in place.

It appears that [the proposed medical supervisor] was not aware patients were being treated under his care and what his responsibilities were. It also appears that [the nurse] was not aware of these circumstances." A copy of Dr. Solish's report, dated November 28, 2017, is attached at Tab 1 to the Agreed Statement of Facts and Admissions.

10. Along with his report, Dr. Solish provided an addendum, dated November 28, 2017, which is attached at Tab 2 to the Agreed Statement of Facts and Admissions. In the addendum, Dr. Solish describes concerning practices by Dr. Barnard that he noted during his chart review, namely, injecting Botox that was brought in by a patient from home, injecting Botox after its date of expiration and storing partial filler for future use instead of using it fully on a single patient or discarding.

Convicted of an Offence Relevant to his Suitability to Practise

11. In 2009, the Ministry of Health and Long-Term Care ("MOHLTC") notified the Ontario Provincial Police ("OPP") regarding Dr. Barnard's billing practices. According to the MOHLTC, Dr. Barnard had been billing a very significant number of time-based services (i.e., psychotherapy and counselling), which require direct patient contact for a prescribed period of time, pursuant to the Ontario Health Insurance Plan's ("OHIP") Schedule of Benefits. As a result, the OPP monitored Dr. Barnard's billing activity for a three-day period: November 17 – 19, 2009. That monitoring revealed that Dr. Barnard billed the following amounts:

i. November 17, 2009: Dr. Barnard billed for 42.7 hours of time-based services. He was paid $5,690.55 for that day;
ii. November 18, 2009: Dr. Barnard billed for 36.97 hours of time-based services. He was paid $4,974.90 for that day; and,
iii. November 19, 2009: Dr. Barnard billed for 32.23 hours of time-based services. He was paid $4,309.20 for that day.

12. Dr. Barnard also billed for other, non-time-based services on those days.

13. As a result of the above information, the OPP conducted an investigation of all Dr. Barnard's billing for a period of 33 months. The OPP investigation determined that between April 1, 2007 and December 29, 2009, Dr. Barnard claimed 15 – 19 hours of time-based services per day on 57 days. He claimed more than 19 hours of time-based services per day on 323 days. His total billings for the 380 days where he billed in excess of 15 hours between April 1, 2007 and December 29, 2009 were approximately $1.3 million.

14. As a result of the investigation, on May 27, 2010, Dr. Barnard was arrested by the OPP and charged with two counts of fraud over $5,000 under section 380(1) of the *Criminal Code of Canada*. He was released on a Promise to Appear and an Undertaking.

15. The OPP investigation, however, continued and revealed that between December 31, 2009 and September 9, 2010, Dr. Barnard submitted the following claims for time-based billing services:

i. On 6 days during this period, Dr. Barnard billed between 15 – 19 hours of time-based services per day. He billed $13,360 for those 6 days.
ii. On 28 days during this period, Dr. Barnard billed between 19 – 24 hours of time-based services per day. He billed $80,156 for those 28 days.
iii. On 138 days during this period, Dr. Barnard billed more than 24 hours of time-based services per day. He billed $595,034 for those 138 days.

16. Even after being charged on May 27, 2010, Dr. Barnard continued his improper billing practices. He was subsequently charged with two additional counts of fraud over $5,000 on November 30, 2010.

17. The College learned of the criminal fraud charges through articles that appeared in the Windsor Star newspaper, and from the OPP. The MOHLTC also contacted the College to advise of their ongoing concerns regarding Dr. Barnard's billing of time-based K-Prefix codes and assessment fee codes which occurred after the first set of charges were laid. Dr. Barnard did not notify the College of these criminal charges, as he was required to do.

18. On May 31, 2017, all criminal fraud charges were withdrawn and Dr. Barnard pleaded guilty to one count of knowingly obtaining or attempting to obtain payments for an insured service that he was not entitled to obtain, contrary to section 43(1) of the *Ontario Health Insurance Act*. A certified copy of the transcript from the Proceedings at Trial held in the Ontario Court of Justice in Windsor before Justice of the Peace A. Renaud on May 31, 2017 is attached at Tab 3 to the Agreed Statement of Facts and Admissions.

19. Prior to the Ontario Court of Justice Proceedings on May 31, 2017, Dr. Barnard had signed an Undertaking with the College which prohibited him from billing OHIP and from providing any insured services to patients. Justice of the Peace A. Renaud was advised of this Undertaking during the joint submissions on sentencing. The Court imposed a global restitution fee of $600,000, of which Dr. Barnard had already paid $350,000, as well as a fine totalling $10,000. Dr. Barnard paid the remaining $250,000 of restitution and the fine by June 9, 2017.

Disgraceful, Dishonourable or Unprofessional Conduct Re: Medical Post Comment

20. On February 13, 2017, a hearing regarding Dr. Barnard was held before the Discipline Committee of the College. At the hearing, Dr. Barnard admitted that he failed to maintain the standard of practice of the profession in his care and treatment of 55 patients. He also pleaded no contest, and the Discipline Committee made the finding, that he engaged in disgraceful, dishonourable and unprofessional conduct with respect to two patients.

21. The following day, the Windsor Star published a news story regarding Dr. Barnard's hearing at the College. The story referenced some of the evidence presented by the College at the hearing, including evidence related to a patient who had been prescribed narcotics by Dr. Barnard and who died of an overdose.

22. The Windsor Star article was circulated by the Medical Post via an e-newsletter on February 15, 2017. Shortly after it was circulated, a reader posted a comment on the news story that referenced Dr. Barnard's "legacy of overprescribing". Dr. Barnard posted a comment online

in response to the reader's comment. A copy of Dr. Barnard's comment, as posted on February 15, 2017, is attached at Tab 4 to the Agreed Statement of Facts and Admissions.

23. Dr. Barnard's comment could be viewed by all healthcare providers across Canada who subscribed to the Medical Post at the time.

24. On February 16, 2017, the College learned of the comment posted by Dr. Barnard and immediately advised him that it viewed the post as containing highly confidential and personal information of a former patient and that this was a breach of patient privacy. Dr. Barnard was directed by the College to remove all references to confidential information that came to his attention in the course of providing care to patients, present or past.

25. On February 21, 2017, Dr. Barnard's comment was edited to remove all information regarding the patient. The comment was nevertheless viewable in the original version for six days.

PART II - ADMISSIONS

26. Dr. Barnard admits the facts at paragraphs 1 to 25, above, and admits that based on these facts:

i. he has committed an act of professional misconduct pursuant to clause 51(1)(a) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "Code"), as he has been found guilty of an offence that is relevant to his suitability to practice; and,

ii. he has committed an act of professional misconduct pursuant to 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 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.

FINDINGS

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admissions. Having regard to these facts, the Committee accepted Dr. Barnard's admission and found that he committed an act of professional misconduct in that he has been found guilty of an offence that is relevant to his suitability to practice; and 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.

AGREED STATEMENT OF FACTS REGARDING PENALTY

The following facts were set out in an Agreed Statement of Facts Regarding Penalty:

Prior Discipline History

2017 Discipline Hearing

1. On February 13, 2017, the Discipline Committee found that Dr. Barnard had failed to maintain the standard of practice of the profession in relation to his patient care and prescribing practices with respect to 55 patients. The Discipline Committee also found that Dr. Barnard engaged in disgraceful, dishonourable and unprofessional conduct in the manner in which he terminated two patients from his practice; cancelled one patient's specialist consultation; and failed to notify that patient of the cancellation. The Decision and Reasons for Decision of the Discipline Committee of the College released on March 28, 2017 is attached at Tab 1 to the Agreed Statement of Facts Regarding Penalty.

2. The Discipline Committee issued a reprimand, suspended Dr. Barnard from practice for a period of four months, and placed significant restrictions on his scope of practice and prescribing practices, among other things. The penalty reflected the Undertaking that Dr. Barnard had entered into on January 20, 2017, prior to the discipline hearing, by which he had agreed, among

other things, that, effective March 17, 2017, he would no longer practise family medicine and would no longer bill the Ontario Health Insurance Plan.

2006 Discipline Hearing

3. On January 9, 2007, the Discipline Committee of the College released its Decision and Reasons for Decision in respect of a discipline proceeding regarding Dr. Barnard that was held on November 28, 2006. A Supplementary Decision and Reasons for Decision was released on July 3, 2007.

4. At the 2006 discipline proceeding, Dr. Barnard was found to have 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, in relation to the manner in which he implemented block fees for uninsured services in his family practice.

5. The Discipline Committee issued a suspension for a period of one month and ordered Dr. Barnard to pay costs to the College. In addition, Dr. Barnard was required to comply with numerous conditions in relation to administrating block fees, and to cooperate with inspections of his practice for a period of nine months following the suspension. The Decision and Reasons for Decision of the Discipline Committee released on January 9, 2007 and the Supplementary Decision and Reasons for Decision released on July 3, 2007 are attached at Tab 2 to the Agreed Statement of Facts Regarding Penalty.

Prior Public Complaints History

6. The College received and investigated several complaints regarding Dr. Barnard in the period between 2001 to 2017, described below:

- Public Complaint (2017): This complaint related to Dr. Barnard's advertising practices. The Inquiries, Complaints and Reports Committee ("ICRC") issued advice to Dr. Barnard to ensure that he complies with the advertising regulations.

- Public Complaint (2016): This patient complained about Dr. Barnard's care and conduct with respect to the patient's newly diagnosed lymphoma. The ICRC ordered Dr. Barnard to attend at the College for a verbal caution.

- Public Complaint (2016): This patient complained about Dr. Barnard's communications. The ICRC advised Dr. Barnard regarding patient communication and the termination of the physician-patient relationship.

- Public Complaint (2008): These patients complained about Dr. Barnard's termination of them as patients, his reported disclosure of confidential information and his failure to properly administer his office in that he failed to return the patients' block fees when he dismissed them from his practice. The Complaints Committee cautioned Dr. Barnard about the importance of following the College's guidelines when ending the physician-patient relationship.

- Public Complaint (2001): This complaint concerned the clinical care provided to a child. Prior to the Complaints Committee's disposition, the complainants stated that they had reached a financial settlement with the Centre that Dr. Barnard had been associated with and they no longer wished to pursue their complaint. The Complaints Committee referred this matter to the Quality Assurance Committee.

- Public Complaint (2001): This complaint also concerned the clinical care provided to a young child. The complainant, the patient's mother, withdrew her complaint prior to the Complaints Committee's disposition. The Complaints Committee referred this matter to the Quality Assurance Committee.

7. The College also conducted a Registrar's investigation into Dr. Barnard's compliance with an Undertaking he signed with the College:

    - Registrar's Investigation (2016): This investigation examined whether Dr. Barnard had breached his interim Undertaking with the College not to prescribe narcotics or controlled substances while the College completed investigations into his practice, including his prescribing practices. Dr. Barnard signed the Undertaking on November 9, 2014. On February 15, 2015, the Ministry of Health and Long-Term Care's Narcotic Monitoring System provided the College with data indicating that 1,527 prescriptions for narcotics and controlled substances had been issued in Dr. Barnard's name between November 9, 2014 and January 20, 2015. The ICRC advised Dr. Barnard that a physician who has relinquished prescribing privileges must be aware of the drug he is prescribing and be careful not to prescribe in breach of his Undertaking.

Undertaking to the College

8. Dr. Barnard entered into an Undertaking with the College on June 18, 2019, resigning his certificate of registration and agreeing never to apply or re-apply for registration as a physician in Ontario. The Undertaking is attached at Tab 3 to the Agreed Statement of Facts Regarding Penalty.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Barnard made a joint submission as to an appropriate penalty and costs order, which consisted of a public reprimand and the payment of costs to the College in the amount of $6,000.00 within thirty days of the Order.

College counsel submitted that the proposed penalty is fair and reasonable given the nature of the misconduct, and the fact that Dr. Barnard had entered into an undertaking with the College, effective June 30, 2019, resigning his certificate of registration and agreeing never to apply or re-apply for registration as a physician in Ontario.

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

In considering the joint submission on penalty, the Committee took into account the general principles underlying penalty orders. Paramount among these is the need to protect the public. The penalty imposed should also maintain the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest. The penalty should also serve as a specific deterrent to the member, a general deterrent to the broader profession, and where applicable or appropriate, provide for the rehabilitation of the member. The Committee also recognized that the penalty must be proportionate to the conduct at issue.

Aggravating Factors

(i) Nature of the Misconduct

The Committee regarded Dr. Barnard's improper OHIP billing, which resulted in his plea of guilty to knowingly obtaining or attempting to obtain payment for insured services that he was not entitled to obtain under the *Health Insurance Act*, to be egregious and offensive to the values of the profession. Dr. Barnard's billing practices demonstrated a complete lack of integrity and absolute disregard for the importance of accountability within a publicly-funded health care system. This is a betrayal of the public trust. The Committee was dismayed that even after being charged criminally with two counts of fraud over $5000 under section 380(1) of the *Criminal Code of Canada*, Dr. Barnard continued to bill OHIP in the same manner, resulting in two more charges of fraud over $5000, six months after the initial charges. The repeated nature of the

misconduct brings the reputation of the profession as a whole into disrepute and is an aggravating factor.

Further, the Committee was shocked to hear that following Dr. Barnard's 2017 Discipline hearing, he wilfully shared confidential personal information about a patient on the internet, in an effort to explain his own behaviour. In doing so, Dr. Barnard committed an unacceptable breach of his former patient's trust and reasonable expectation that the personal health information she provided in a clinical context would remain confidential. The fact that Dr. Barnard put his own interests ahead of those of his patient is an aggravating factor.

(ii) Prior College History

Dr. Barnard's conduct and/or care have been reviewed by the College on several occasions. During the period between 2001 and 2017, the College received and investigated four public complaints regarding Dr. Barnard's clinical care and two public complaints regarding his office practices. In 2014, Dr. Barnard's prescribing practices were subject to a Registrar's Investigation. In resolution of the latter, Dr. Barnard signed an undertaking not to prescribe narcotics or other controlled substances. However, within the first three months after signing the undertaking, Dr. Barnard wrote more than 1,500 prescriptions for these very medications. Although none of these matters was referred to the Discipline Committee, one would have thought that Dr. Barnard would have learned from these experiences and paid closer attention to his professional obligations. This does not appear to have been the case. It is especially troubling that the Registrar's Investigation was focussed on compliance with a prior undertaking, yet failure to comply with an undertaking is part of the misconduct at issue in the current case.

In 2017, Dr. Barnard was found to have failed to maintain the standard of practice of the profession in relation to 55 patients. Dr. Barnard signed another undertaking with the College, this time to cease practising family medicine and to restrict his activities to cosmetic, esthetic and nutritional services. Within a few weeks of this undertaking coming into force, Dr. Barnard disregarded his signed undertaking and arranged for a nurse to perform injections without the required supervision, which is part of the misconduct for which he is now being disciplined.

Further, in 2006, Dr. Barnard was found by the Discipline Committee to have 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, in relation to the manner in which he implemented block fees for uninsured services in his family practice. It is again troubling that part of the conduct at issue in the current case also involves OHIP billing and that on May 31, 2017, Dr. Barnard was found guilty of knowingly obtaining or attempting to obtain payments for an insured service that he was not entitled to obtain contrary to section 43(1) of the Ontario *Health Insurance Act*. Again, one would have reasonably expected that given the 2006 discipline proceeding, Dr. Barnard would not engage in further misconduct related to OHIP billings.

The Committee was extremely troubled by Dr. Barnard's repeated disregard of his professional obligations, despite the College's intervention on several prior occasions. The fact that this is the third time that Dr. Barnard has been before the Discipline Committee is an aggravating factor.

Mitigating Factors

The Committee accepts that by admitting to the misconduct described in the Agreed Statement of Facts and Admissions, Dr. Barnard saved the College the time and expense associated with a contested hearing, thereby avoiding the need for witnesses and/or experts to testify before the Committee.

Prior Cases

Counsel for the College provided the Committee with two prior cases to assist in its determination of an appropriate penalty: *CPSO v. Sweet* 2017 ONCPSD 40 (CanLII) and *CPSO v. Cameron* 2018 ONCPSD 25 (CanLII). The Committee recognizes that it is not bound by prior decisions of this Committee and that no two cases are identical. The Committee also recognizes, however, that cases that are similar in nature may assist the Committee in establishing a reasonable range of penalty.

In *CPSO v. Sweet*, Dr. Sweet, an experienced family doctor, was found to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching an undertaking not to prescribe controlled substances. He was also found to have failed to maintain the standard of practice of the profession in his care of numerous patients. The Committee commented on Dr. Sweet's ungovernability and his disregard for standards in his continued prescribing of opiates and other controlled substances in contravention of the undertaking. Dr. Sweet had previously appeared before the Discipline Committee in 2002, 2004, 2008 and 2012 regarding his prescribing practices and for not posting required signage in the waiting area of his clinic regarding his prescribing restrictions. Further, despite completing the Medical Record-Keeping course in 2006 and again in 2009, a 2012 reassessment found that his documentation was still inadequate. Prior to the discipline hearing, Dr. Sweet had signed an undertaking to resign his membership with the College and never to re-apply for membership in Ontario or in any other jurisdiction. In light of this undertaking, the Committee accepted the joint penalty proposal of the parties and ordered that Dr. Sweet attend before the panel to be reprimanded. The Committee ordered that Dr. Sweet pay costs in the amount of $5,500.00 within thirty days of the order. The Committee stated that it would have revoked Dr. Sweet's certificate of registration but for the undertaking.

In *CPSO v. Cameron*, Dr. Cameron, an experienced general physician, was found to have failed to maintain the standard of practice of the profession with respect to his prescribing of narcotics. The Committee accepted the parties' joint submission and ordered that Dr. Cameron attend before the panel to be reprimanded. The Committee also required that Dr. Cameron pay costs in the amount of $10,180.00 within sixty days of the order. Dr. Cameron had been the subject of two prior findings of professional misconduct by the Discipline Committee. In 2011, his failure to attend to a child with a life-threatening anaphylactic reaction was found to constitute disgraceful, dishonourable or unprofessional conduct. In 2013, the Discipline Committee found that he engaged in disgraceful, dishonourable or unprofessional conduct by unwanted, inappropriate and sexual remarks to two registered practical nurses and unwanted touching of one of them. The Committee in Dr. Cameron's case found the two prior findings of disgraceful, dishonourable and unprofessional conduct to be aggravating factors on penalty. Prior to the hearing, Dr. Cameron had entered into an undertaking with the College to resign and never to

apply or re-apply for membership. The Committee accepted that given Dr. Cameron`s resignation, he would "never be in a position to cause or potentially cause harm to members of the public by his prescribing of controlled substances".

The Committee finds that Dr. Barnard's case is similar in nature to the *Cameron* and *Sweet* cases given the multiple findings of misconduct and repeated occurrences. These cases assist the Committee in concluding that the penalty proposed by the parties falls within a reasonable range of penalty in similar cases. The undertaking will ensure better public protection than revocation of Dr. Barnard`s certificate of registration, as the governing legislation would allow Dr. Barnard to apply for reinstatement one year after revocation, whereas the undertaking provides that he will never again re-apply for a certificate of registration in Ontario.

CONCLUSION

Given the breadth of Dr. Barnard's misconduct and his repeated failure to comply with professional expectations, and a Discipline Committee order, it was eminently clear to the Committee that Dr. Barnard must be removed from medical practice. The Committee considered the full range of penalties that could be imposed, including revocation that carries with it forceful denunciation of the misconduct and the maximum fine allowable of $35,000. But for the undertaking to resign and never to re-apply, the Committee would have found revocation and the maximum fine to be appropriate sanctions for the misconduct in this case. However, the Committee recognizes that a physician whose certificate of registration is revoked for misconduct other than sexual abuse can apply for reinstatement in one year. An undertaking to resign and never to re-apply ensures that the physician would never be able to hold a certificate of registration to practise medicine in Ontario ever again. Accordingly, Dr. Barnard's undertaking ensures that the public and the health care system are forever protected from Dr. Barnard's misconduct and ungovernability. This is more than can be achieved by an order of revocation. Therefore, the Committee accepted the proposed penalty of a reprimand, in light of Dr. Barnard`s undertaking to resign and never to re-apply effective June 30, 2019. To be clear, in the absence of a joint submission and based on the facts available to us, the Committee would have ordered a reprimand, revocation and a significant fine. The Committee found that this was

an appropriate case in which to order Dr. Barnard to pay hearing costs to the College.

The Committee trusts that the public will see that it strongly denounces Dr. Barnard's misconduct. The Committee accepted the proposed penalty on the basis that he had signed the undertaking. Through the public reprimand, the Committee intended to express to Dr. Barnard and signal to the profession its view that such behaviour is unconscionable and will not be tolerated. Specific deterrence and rehabilitation of the member are not relevant in this case; Dr. Barnard will never again hold a certificate of registration to practise medicine in Ontario. We trust that this penalty upholds the integrity of the profession and maintains public confidence in the College's ability to regulate in the public interest.

ORDER

The Committee stated its findings in paragraph 1 of its written order of July 23, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

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

3. Dr. Barnard pay costs to the College in the amount of $6,000.00, within thirty (30) days of the date of this Order.

Counsel for Dr. Barnard provided Dr. Barnard's signed waiver of his right to an appeal under subsection 70(1) of the Code. The Committee administered the public reprimand at the conclusion of the hearing, in his absence.

TEXT of PUBLIC REPRIMAND

July 23, 2019

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

Dr. Thomas Joseph Barnard

So the doctor is not present, so we will be delivering the reprimand to an empty chair.

Dr. Barnard, you are truly ungovernable. You are motivated by greed above all. You knowingly and significantly overbilled OHIP for an extended period of time, burdening an already financially-strained health system.

And then when you were charged for overbillings, you continued with further overbilling resulting in further charges. Because of these overbillings, you were brought to the Discipline Committee and terms, conditions and limitations were placed on your practice. You proceeded to ignore the Discipline Committee's Order and put patients at risk by continuing your practice without appropriate supervision. Again, greed overrode your professional obligations.

And finally when you were questioned about your narcotics prescribing as a result of a patient's death, you publically posted confidential medical information about your patient in an attempt to divert attention to your medical practice procedures. Patient health information is confidential and you ignored your legal and professional obligations in this regard, simply to further your own cause. This is abhorrent behaviour.

Your behaviour is reprehensible. You have disgraced yourself, dishonoured your profession and colleagues, and dismayed the public by your actions. We are relieved on behalf of the public and the profession you will not practice medicine in Ontario again.