NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Barnard, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients 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, 2017 ONCPSD 14**

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:

DR. J. WATTS
MR. S. BERI
DR. J. KIRSH
MR. A. RONALD
DR. P. CASOLA

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS L. CADER

COUNSEL FOR DR. BARNARD:

MR. M. DALE

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

Hearing Date:	February 13, 2017
Decision Date:	March 28, 2017
Release of Reasons Date:	March 28, 2017

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 February 13, 2017**.** At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Barnard committed an act of professional misconduct setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

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

RESPONSE TO THE ALLEGATIONS

Dr. Barnard admitted to the first allegation in the Notice of Hearing, that he failed to maintain the standard of practice of the profession. Dr. Barnard entered a plea of no contest to the second allegation in the Notice of Hearing, 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. Counsel for the College withdrew the allegation of incompetence.

THE FACTS

Agreed Facts regarding Failing to Maintain the Standard of Practice

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.

PART I - FACTS

1. Dr. Thomas Joseph Barnard ("Dr. Barnard") is 67 year old family physician practising in Windsor. Dr. Barnard received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College') in July 1980. He was certified by the College of Family Physicians of Canada as a specialist in Family Medicine on July 1, 1982 and as a specialist in Family Medicine (Emergency Medicine) on November 1, 1984.

2. Dr. Barnard operates a family medicine practice called the Barnard Wellness Centre, at which he is the sole primary care physician, and also operates the Fresh Medical Spa, which is located at the same address as his family medicine practice.

Section 75(1)(a) Investigation into care of a single patient

3. On October 18, 2012, the College received a letter from the Chief Coroner for Ontario, enclosing reports from a Coroner's investigation of the death of a person who was a regular patient of Dr. Barnard's between May 2000 and April 2012.

4. The Coroner's report indicated that the cause of death was a multi-drug toxicity, which included controlled substances that had been prescribed to the patient by Dr. Barnard.

5. The patient suffered from long-term chronic pain. Over the 12 years in which he treated the patient, Dr. Barnard had prescribed a number of narcotics and other drugs including Cesamet, Benzodiazepines, Seroquel, Domperidone, Cymbalta and Quinolones.

6. The College retained Dr. Alison Arnot, a family physician, to review the standard of care with respect to the above-noted patient. In her report dated July 8, 2013, Dr. Arnot found that the care provided by Dr. Barnard demonstrated a lack of skill and did not meet the standard of practice for the following reasons:

    a) His information gathering was perfunctory;

    b) His histories were not sufficiently detailed;

    c) The physical examinations were cursory at best and appeared to be generated from a template. Often they were not relevant to the presenting complaint;

    d) There was no information about family history in his notes. It was gathered from the consultant reports;

    e) The patient's surgical history was not recorded except in the consultant's notes;

    f) He did not routinely ask about allergies;

    g) His assessments were not based on the history and physical findings; he often reiterated the patient's complaint rather than making a true diagnosis;

    h) The rationale for his treatment plans was difficult to understand;

    i) The Cumulative Patient Profile (“CPP”) at the front of the chart was difficult to read;

    j) The results of the patient's tests were not organized for easy retrieval;

    k) He did not keep an up to date list of the medications that were prescribed and every consultant who looked after the patient had an incomplete or inaccurate list of her actual medications.

7. Dr. Arnot opined that Dr. Barnard lacked knowledge about the risks of polypharmacy and the risks of treating chronic pain with opioid analgesics. She further opined that he demonstrated a lack of judgment by continuing to prescribe drug combinations with known risks of harm, by continuing to prescribe narcotics when it was obvious that the patient was

unable to control her use and the medication was doing more ‘to her’ than ‘for her’, and by continuing to provide the patient with large numbers of narcotics when he knew the patient was unable to prevent theft by her husband. Dr. Arnot’s report, dated July 8, 2013, is attached to this Agreed Statement of Facts and Admissions at Tab 1 to the Agreed Statement of Facts and Admissions.

8. On November 9, 2014, Dr. Barnard signed an undertaking to the College restricting him from prescribing any Narcotics, Controlled Drugs, Benzodiazepines/Other Targeted Substances and all other Monitored Drugs and Narcotics Preparations, with the exception of Tylenol with codeine #3 in limited amounts.

9. Dr. Barnard failed to maintain the standard of practice of the profession in his care and treatment of the patient as described above.

Section 75(1)(a) Investigation into prescribing practices

10. As a result of the above investigation, the Inquiries, Complaints and Reports (ICR) Committee approved the appointment of investigators under section 75(1)(a) of the Health Professions Procedural Code in order to conduct a broader investigation into Dr. Barnard’s prescribing practices.

11. The College retained Dr. Scott Higham, a family physician, to provide an opinion with respect to Dr. Barnard’s standard of care in his prescribing to 25 patients.

12. Dr. Higham concluded that Dr. Barnard’s care of 12 patients did not meet the standard of practice and that he demonstrated various degrees of a lack of knowledge, skill or judgment. He opined that in 7 charts the care provided posed a potential risk of exposing patients to harm or injury and, of these 7, the risk of harm was particularly high with respect to 4 patients. By way of summary, Dr. Higham opined as follows:

> *There was a tendency to prescribe large amounts of narcotic medications as well as stimulant medication, benzodiazepines, and testosterone preparations. Often all of these medications were prescribed for the same patient. I was concerned in a few charts where there were large amounts of injectable morphine prescribed for a long period of time. In late 2014, Dr Barnard voluntarily gave up his priveleges* (sic) *to prescribe narcotics and controlled substances. This drastically reduced the potential harm his patients were exposed to. Most of these patients were referred to Dr. Farago, a chronic pain specialist, at that time. In almost all cases when the patients were seen by Dr. Farago, the narcotic treatment was reduced or changed.*

Dr. Higham's report, dated June 28, 2015, is attached at Tab 2 to the Agreed Statement of Facts and Admissions.

13. The four cases in which Dr. Higham concluded the risk of exposing the patient to harm or injury was particularly high were those in which:

- A patient was receiving frequent morphine injections as well as other narcotics while she was pregnant;
- A patient who had severe migraine headaches was receiving frequent morphine injections as well as nasal butorphanol, the amounts of which were well in excess of recommended guidelines for non-cancer pain;
- A patient was receiving very frequent morphine injections for chronic pelvic pain, much in excess of recommended guidelines; and
- A patient's chart contained indications from anonymous phone calls that he was selling his medication and a letter from the Children's Aid Society expressing concern of large amounts of narcotic medication in a household with small children.

14. Dr. Barnard responded to Dr. Higham's report. After reviewing Dr. Barnard's response, Dr. Higham changed his opinion with respect to Dr. Barnard's care of one patient, concluding that he met the standard of care and did not display a lack of knowledge, skill or judgment with respect to this patient. Other than that patient, Dr. Higham maintained the opinions that

he reached in his report of June 28, 2015. Dr. Higham's response to Dr. Barnard's letter, dated July 27, 2015, is attached at Tab 3 to the Agreed Statement of Facts and Admissions.

15. Dr. Barnard failed to maintain the standard of practice of the profession in his care of 11 patients as described above.

Section 75(1)(a) Investigation regarding broader patient care

16. On September 18, 2012, the College received information regarding Dr. Barnard from the Ministry of Health and Long-Term Care (MOHLTC) as a result of a review of his medical records for services completed in 2009. In the course of this review, MOHLTC medical advisors identified clinical concerns with respect to Dr. Barnard's patient care.

17. The College retained Dr. Catherine Faulds, a family physician, to provide an opinion regarding the standard of care provided by Dr. Barnard to 37 patients. Dr. Faulds reviewed 53 charts for the 37 patients (36 charts from the Barnard Wellness Centre and 16 charts from the Fresh Medical Spa, only 1 of whom was not also a patient at the Barnard Wellness Centre), as well as other supporting materials, and interviewed Dr. Barnard. Dr. Faulds concluded that the standard of care was not met in any of the cases reviewed and that Dr. Barnard displayed a lack of knowledge and judgment in each case. She also opined that Dr. Barnard's clinical practice and conduct exposed all but one of the patients whose care was reviewed to a risk of harm.

18. Dr. Faulds based her conclusions, in part, on the following concerns:

    a) Dr. Barnard's administration of human chorionic gonadotropin ("HCG," known colloquially as "human growth hormone") for weight loss in the management of obesity despite it being discredited and rejected by the medical community;
    b) numerous, significant examples of disjointed and episodic care with poor recordkeeping and judgment that impairs the provision of an adequate diagnosis and case management;

c) certain use of "off label" prescribing and potentially harmful prescribing (including prescribing HCG as described above; potentially harmful prescribing of narcotics for non-cancer pain; prescribing benzodiazepines with narcotics; Methotrexate and Plaquenil without indication; prescribing hormone replacement therapy without appropriate documentation and assessment; prescribing high doses of vitamin D; prescribing iron and high doses of vitamin B without indication);

d) failure to meet the standard in his documentation of consent for "off label" or potentially harmful prescribing, and other failures of documentation;

e) lack of documentation of appropriate follow-up on test results;

f) failing to document history, physical examination, diagnosis, and informed consent when prescribing complementary and alternative medicines, and prescribing some such medicines which he knew had no medical evidence for use, such as HCG; and

g) the use of excessive laboratory testing in the absence of clear documentation of medical need.

Dr. Faulds' report, dated May 15, 2015, is attached at Tab 4 to the Agreed Statement of Facts and Admissions.

19. In December 2015, the College requested updated patient records from Dr. Barnard for 10 patients whose care had been reviewed by Dr. Faulds. The 13 updated charts (10 charts from the Barnard Wellness Centre and 3 charts from the Fresh Medical Spa) were provided to Dr. Faulds for her opinion regarding the standard of care provided by Dr. Barnard since the time of her last review. Based on her review, Dr. Faulds found that Dr. Barnard's care did not meet the standard of practice in any of the charts reviewed and that his care continued to display a lack of knowledge, skill and judgment:

Despite some minor improvements in the documentation of prescribing narcotics and other medications by including dates and amounts, the themes described in my original report continued. These include off label prescriptions (several are

extreme examples such as Invocana and Arimidex), excessive poly-pharmacy, excessive laboratory testing, chaotic charting without clear CPP and flow sheets, poor case management of chronic disease, prescribing patterns of narcotics that falls below the CPSO standards and severe documentation deficiencies with EMR stamps that are the same for almost all chart entries. These deficiencies, while showed some minimal improvement continue to fall well below an acceptable standard that would meet CPSO policy.

Dr. Faulds' addendum, dated December 20, 2015, is attached at Tab 5 to the Agreed Statement of Facts and Admissions.

20. Dr. Barnard failed to maintain the standard of practice of the profession in his care of 37 patients as described above.

Investigation Regarding Patient A

21. Patient A became Dr. Barnard's patient in the Barnard Wellness Centre in May 2012. The patient's past medical history included bipolar disorder. He received an operation in August 2012, with the referral arranged by his former family doctor (not Dr. Barnard). Patient A had a history of testosterone levels having been documented as low by other physicians as recently as 2011, but it was very high based on the initial bloodwork ordered by Dr. Barnard in May 2012. Dr. Barnard's first encounter note indicated that Patient A had been buying testosterone at the gym.

22. Dr. Barnard treated Patient A, including continually prescribing testosterone injections from July 2012 until April 2013 when Dr. Barnard severed the doctor-patient relationship. At this time, Patient A wrote a letter of complaint to the College.

23. The College retained Dr. John Aquino, a family physician with a focus in men's health, including testosterone deficiency, to review Dr. Barnard's care in regard to Patient A.

24. Dr. Aquino described Dr. Barnard's records as "brief and sparse," lacking detail for the historical elements of the encounters and the rationale for treatment decisions. He found that Dr. Barnard did not meet the standard of practice of the profession in that he:

    a) displayed poor documentation and recordkeeping of his thought process and/or discussions with Patient A;
    b) failed to adequately counsel Patient A in the hazards of continued steroid use;
    c) failed to try to have Patient A adhere to a more traditional protocol for testosterone replacement, with lower initial dosing and further titration based on serum testosterone levels and/or symptom management, and escalated the dosage of testosterone without monitoring hematocrit; and
    d) demonstrated poor judgment in embarking on an unorthodox treatment plan of high dosing with little monitoring that, while for the most part it worked along with the desires and with the consent of the patient, was not in the best long term interests of the patient.

    Dr. Aquino's report, dated October 6, 2014, is attached at Tab 6 to the Agreed Statement of Facts and Admissions.

25. Dr. Barnard failed to maintain the standard of practice of the profession in his care of Patient A.

Investigation Regarding Patients B and C

26. Patient B became Dr. Barnard's patient in March 2012 and continued until April 2013. Patient C became Dr. Barnard's patient in February 2013 and continued until April 2013. Dr. Barnard terminated both patients from his practice.

27. Dr. Barnard treated Patient B for chronic pain. He prescribed Lyrica, Cymbalta, Botox injections, vitamin injections and testosterone injections beginning in May 2012. Dr. Barnard did not record Patient B's serum testosterone levels before prescribing testosterone injections.

28. Dr. Barnard did not record evidence of having received the informed consent of Patient B or Patient C before prescribing medication.

29. The College retained Dr. Alison Arnot to review the care provided by Dr. Barnard to Patients B and C. Dr. Arnot opined that the care provided to both patients fell below the standard of the profession based on a lack of skill, knowledge and judgement and that Dr. Barnard's care exposed them to harm. Specifically, she concluded that Dr. Barnard:

    a) demonstrated a lack of skill in the quality and quantity of his information gathering, in his record keeping and in his performance of proper physical assessments;
    b) demonstrated a lack of knowledge when he increased Patient C's dose of thyroxine and added Cytomel without evidence of thyroid deficiency;
    c) demonstrated a lack of knowledge when he prescribed Flagyl to Patient C without indication;
    d) demonstrated a lack of knowledge in failing to identify the significance of Patient C's rising erythrocyte sedimentation rate ("ESR") (which with other symptoms was suggestive of an autoimmune disorder); and
    e) demonstrated poor judgment in failing to comply with College guidelines for record keeping, prescribing drugs and the use of alternative therapies.

    Dr. Arnot's report, dated January 25, 2014, is attached at Tab 7 to the Agreed Statement of Facts and Admissions.

30. The College retained Dr. Ralph Masi, a family physician with some knowledge of and interest in complementary and alternative medicine, to provide an opinion regarding Dr. Barnard's care of Patients B and C, having regard to the College's Complementary / Alternative Medicine Policy. With regard to Patient B, Dr. Masi opined that Dr. Barnard's use of testosterone and vitamin injections was unconventional and not supported by any scientific evidence of which Dr. Masi was aware. Dr. Masi noted that Dr. Barnard had failed to clearly indicate the diagnosis although he treated chronic pain syndrome with an

associated neuropathy. Dr. Masi also noted that Dr. Barnard did not document valid informed consent for his unconventional therapeutic interventions.

31. With respect to Patient C, Dr. Masi found:

    a) Dr. Barnard's care of Patient C's inflammatory disorders falls within the realm of complementary medicine;
    b) Dr. Barnard failed to provide an appropriate clinical assessment with regard to Patient C. He recorded no clear working diagnosis or treatment plan;
    c) Dr. Barnard failed to document a conventional diagnosis;
    d) he did not record any evidence of informed consent having been obtained for the unconventional therapeutic interventions;
    e) he failed to address the patient's elevated ESR;
    f) despite the poor assessment and review of Patient C, his care did not demonstrate a lack of knowledge or skills. However, Dr. Barnard showed poor judgment by failing to document more appropriate patient counselling regarding the unconventional therapies being utilized.

    Dr. Masi's report, dated October 6, 2014 is attached at Tab 8 to the Agreed Statement of Facts and Admissions.

32. Dr. Barnard failed to maintain the standard of practice of the profession in his care of Patients B and C.

Investigations Regarding Patients D, E and F

33. Patients D, E and F, who were a mother and her two children, became Dr. Barnard's patients in the Fall/Winter of 2010/2011, and continued as his patients until November 2013.

34. The College retained Dr. Ewa Ciechanska, a family physician, to review the standard of care provided by Dr. Barnard to Patients D, E and F. In her report, dated March 10, 2016, Dr, Ciechanska concluded that Dr. Barnard did not meet the standard of practice of the

profession in relation to Patients D, E and F and that he demonstrated a lack of knowledge and skill. Examples of Dr. Barnard's lack of knowledge and skill include:

a) a lack of knowledge of appropriate testing and investigations for specific symptoms. Among other things, Dr. Barnard repeatedly ordered a broad spectrum of tests on Patients D, E and F without indication, including broad annual testing for Patient D, and ordered specific tests that were not inappropriate based on the patient's age or lack of suitability as a screening tool;
b) a lack of knowledge in treating asthma in children with respect to Patients E and F, where those patients received oral medications without any clear indication for their use and without corresponding use of inhaled medications;
c) a lack of knowledge in the use of antibiotics, including prescribing incorrect doses and prescribing in cases where antibiotics are not indicated;
d) a lack of knowledge in prescribing with respect to dosage of Topamax;
e) a lack of knowledge of the treatment of anxiety for Patient D, and giving inappropriate treatment for the same; and
f) a lack of skill in the documentation of visits, including incomplete or absent charting of history, physical examinations and assessments that seemed to be in an identical template for nearly every visit, missing vital signs, and a lack of any differential diagnosis and treatment plan in any of the entries.

Dr. Ciechanska opined that Dr. Barnard did not expose Patients D, E and F to harm. Her report, dated March 10, 2016, is attached at Tab 9to the Agreed Statement of Facts and Admissions.

35. Dr. Barnard failed to maintain the standard of practice of the profession in his care of Patients D, E. and F.

PART II - ADMISSION

36. Dr. Barnard admits the facts in paragraphs 1 to 35 above and admits that, based on these facts he failed to maintain the standard of practice of the profession contrary to paragraph 1(1)2 of Ontario Regulation 856/93.

Uncontested Facts regarding Disgraceful, Dishonourable or Unprofessional Conduct

The following facts were set out in a Statement of Uncontested Facts, which was filed as an exhibit and presented to the Committee.

1. Patient B became Dr. Barnard's patient in March 2012 and his wife, Patient C, became Dr. Barnard's patient in February 2013.

2. During a double appointment in April 2013, attended by both Patient B and C, Dr. Barnard became upset when asked to complete a Functional Abilities Form for Patient B. He told Patient B to "come back when you have your head screwed on right".

3. Patient B and C left the office. A few days later, they received a letter from Dr. Barnard sent by courier terminating both patients from his practice. The letter and termination were unexpected.

4. Prior to the termination, Dr. Barnard had requested a consultation with an otolaryngologist, Dr. Abdallah, for Patient C. Shortly after the last appointment, and before receiving the termination letter, Patient C received a call from Dr. Barnard's office indicating the date and time for the specialist consultation.

5. On the scheduled date in July, Patient B and Patient C attended at Dr. Abdallah's office for the consultation. However, when they arrived they were told that although Patient C had been booked for an appointment, it had been cancelled. Dr. Abdallah's staff showed Patient C a copy of the faxed cancellation from Dr. Barnard's office, sent in May 2013.

6. Dr. Barnard did not advise Patient C at any time that he had cancelled her consultation with Dr. Abdallah.

7. Dr. Barnard engaged in disgraceful, dishonourable and unprofessional conduct in the manner in which he terminated Patients B and C from his practice, in cancelling Patient C's specialist consultation and in failing to notify her of the cancellation.

FINDINGS

With respect to Dr. Barnard's plea of no contest to the allegation of disgraceful, dishonourable or unprofessional conduct, Rule 3.02(1) of the Discipline Committee's Rules of Procedure states that:

> 3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:
>
> (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
> (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
> (c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admissions and the Statement of Uncontested Facts. Having regard to these facts and Dr. Barnard's admission, the Committee found that he committed an act of professional misconduct in that: he failed to maintain the standard of practice of the profession; 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.

FACTS ON PENALTY

The following facts were set out in an Agreed Statement of Facts regarding Penalty, which was filed as an exhibit.

Undertaking to the College

1. Dr. Thomas Joseph Barnard ("Dr. Barnard") entered into an undertaking to the College on January 20, 2017, by which he has agreed, among other things, that, effective March 17, 2017, he shall no longer practice family medicine and shall no longer bill the Ontario Health Insurance Plan. The undertaking is attached at Tab 1 to the Agreed Statement of Facts regarding Penalty.

Past Discipline History

2. Attached at Tab 2 to the Agreed Statement of Facts regarding Penalty is the decision and reasons for decision of the Discipline Committee of the College released on January 9, 2007 in respect of a prior discipline proceeding held on November 28, 2006 involving Dr. Barnard, as well as a supplementary decision and reasons for decision released on July 3, 2007.

3. In his past 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. As a result, Dr. Barnard was required to comply with certain conditions in relation to his administration of block fees and to cooperate with inspections of his practice for a period of time, was suspended for a period of one month, and was required to pay costs to the College.

Interim Orders

4. The Inquiries, Complaints and Reports Committee of the College made an interim order in this matter on February 16, 2016, attached at Tab 3 to the Agreed Statement of Facts regarding Penalty. Since that time, Dr. Barnard's family medicine practice and his practice at Fresh Medical Spa have been subject to clinical supervision, pending this hearing. Dr. Barnard has also been prohibited from prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines, Other Targeted Substances or All Other Monitored Drugs on an interim basis. Dr. Barnard has also had limits on the number of patients with whom he could have professional encounters. The February 2016 interim order set the limit at 50 patients per day and a rate of a maximum of 5 patients per hour.

5. The Inquiries, Complaints and Reports Committee made a new interim order in this matter on July 21, 2016 which has remained in effect pending this hearing and which is attached at Tab 4to the Agreed Statement of Facts regarding Penalty. While maintaining clinical supervision and prescribing restrictions, the new interim order required Dr. Barnard to see no more than 48 patients per day at a maximum rate of 6 per hour.

Interim Clinical Supervision

6. The supervisory reports of Dr. Kristen Kupeyan received regarding Dr. Barnard's Fresh Medical Spa practice are attached at Tab 5to the Agreed Statement of Facts regarding Penalty. Dr. Kupeyan described Dr. Barnard and his staff as cooperative with supervision and receptive to her recommendations. Among other things, she recommended improvements to documentation and to delegation to staff.

7. The supervisory reports of Dr. David Fisher and Dr. Roberto Gonzalez-Almeyda received regarding Dr. Barnard's family medicine practice are attached at Tab 6to the Agreed Statement of Facts regarding Penalty. Both Dr. Fisher and Dr. Gonzalez-Almeyda noted that Dr. Barnard worked to implement their recommendations regarding appropriate documentation. Dr. Gonzalez-Almeyda has made both practice recommendations and recommendations regarding individual patients' care, which were accepted by Dr. Barnard. Dr. Gonzalez-Almeyda noted that there had been improvement through supervision, including "major improvement with regard to excessive lab testing" such that by October 2016 such excessive testing was no longer an issue.

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 Committee is mindful of the guiding principles of the courts in imposing penalty. The law is very clear regarding the test to apply in accepting a joint proposal from the parties: the proposed penalty should only be rejected if it would bring the administration of justice into disrepute or it is otherwise contrary to the public interest. The Committee accepts the jointly proposed penalty and costs as appropriate in this particular case.

Beginning in 2012 continuing to 2016, Dr. Barnard's practice has been reviewed by seven of his peers, including physicians specializing in family medicine (Dr. Alison Arnot, Dr. Scott Higham, Dr. Catherine Foulds, Dr. Ewa Ciechanska), a family physician specializing in men's health (Dr. John Aquino) and a family physician with a knowledge and focus in complementary and alternative medicine (Dr. Ralph Masi). All of these physicians opined that Dr. Barnard's practice failed to maintain the standard of practice of the profession.

The practice reviews by these physicians were strikingly similar in their conclusions and highlighted multiple deficiencies, including: lack of skill; lack of knowledge; poor record keeping; diagnostic and treatment rationale that were difficult to understand; use of polypharmacy including large amounts of controlled substances; harmful off-label prescribing of medications; and, excessive laboratory testing. The Committee was struck by the paucity of change to Dr. Barnard's practice despite these multiple reviews. The Committee was also informed that Dr. Barnard has been before the Discipline Committee on a prior occasion. This information further increased the Committee's concern about the ability or willingness of Dr. Barnard to implement changes in his practice. However, the Committee did take some comfort from reports of his current clinical supervisors indicating that he had implemented recommendations for change and this has been manifested by apparent improvements to his practice.

The issue of excessive and inappropriate prescribing of controlled substances was of particular concern given that it was directly correlated to the death of a patient (patient A). Dr. Barnard's prescribing of controlled substances was reckless in terms of amounts, monitoring, documentation, and the use of polypharmacy. Dr. Barnard's prescribing of controlled substances went far beyond the realm of acceptable standards of care. Dr. Barnard's approach to care lacked basic common sense, which continued despite multiple reviews by his peers pointing to this fact. Through the College's intervention, his inappropriate prescribing ceased through a prescribing restriction on his license.

This Panel cannot recall another situation in which a physician would have had seven practice reviews over a period of four years. This speaks to the level of concern that the College had with respect to Dr. Barnard's practice. His practice, be it general medical practice or his complementary medical practice, violated the physicians oath of "do no harm". Whether he practised within a framework of accepted family medical practice or within a complementary medicine framework, patient care was compromised.

Counsel for the College and counsel for Dr. Barnard jointly proposed as an appropriate penalty a four month suspension, a reprimand and significant restrictions on Dr. Barnard's scope of

practice and prescribing. They also jointly proposed that Dr. Barnard be required to pay the costs pursuant to the tariff for one day of hearing.

The four-month practice suspension and reprimand are in keeping with the seriousness of the findings and denounce the misconduct. The Committee concluded that that a four month suspension and reprimand were necessary to make it clear to Dr. Barnard that his misconduct is very serious and that repeated misconduct of this nature would not be tolerated.

The Committee accepted the proposed practice restrictions as appropriate in the interests of public protection. Dr. Barnard will no longer be practising as a family physician, nor prescribing controlled substances, the areas of his care found to be most glaringly lacking. It is encouraging to note that the recent interim clinical supervision reports provided by Dr. Kristin Kupeyan, Dr. David Fisher, and Dr. Roberto González Almeyda have noted that Dr. Barnard has made improvements in his medical practice, was cooperative with supervision and receptive to recommendations.

Mitigating factors in determining penalty included the fact that Dr. Barnard was cooperative with the College in its investigations, had already signed an undertaking limiting his practice and agreed to a set of uncontested facts concerning his standard of care. His agreement to enter into an undertaking to end his family practice and not provide any OHIP insured services therefore restricting his practice to cosmetic, aesthetic and nutritional counseling protects the public from harm. Furthermore, Dr. Barnard's practice will be monitored and a limitation has been agreed upon as to the number of patients he may see on a given day. Dr. Barnard has admitted that his care failed to maintain the standard of practice of the profession.

In submissions in support of the proposed penalty, College counsel presented a Brief of Authorities citing prior similar cases. Although no two cases are identical, it was noted that a number of the penalties in the prior similar cases included monitoring, restrictions to prescribing, and suspension. The Committee concluded that the proposed penalty met the requirement of protecting the public and guiding the profession. It is in line with prior penalties for similar misconduct.

ORDER

The Committee stated its findings in paragraphs 1 and 2 of its written order of February 13, 2017. In that order, and in light of Dr. Barnard's undertaking of January 20, 2017, that, effective March 17, 2017, he shall no longer practice family medicine and shall no longer bill the Ontario Health Insurance Plan, the Committee ordered and directed on the matter of penalty and costs that:

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

4. The Registrar suspend Dr. Barnard's certificate of registration for a period of four (4) months commencing on March 17, 2017 at 12:01 a.m.

5. The Registrar impose the following terms, conditions and limitations on Dr.Barnard'scertificate of registration:

    a. Dr. Barnard shall not prescribe or recommend human chorionic gonadotropin ("HCG") for the purpose of weight loss to any individual;

    b. Dr. Barnard shall have clinical interactions with no more than a total of forty-eight (48) patients per day, at a rate of no more than six (6) patients per hour within each hour;

    c. Dr. Barnard shall execute the Prescribing Resignation Letter to Health Canada, which is attached hereto as Schedule "A" (the "Resignation Letter") to the Order, and shall consent to the College sending the Resignation Letter to Health Canada on his behalf;

    d. Dr. Barnard 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 Part G of the Food and Drug 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 hereto as Schedule "B" to the Order; and the current regulatory lists are attached hereto as Schedule "C" to the Order)

v. **All other Monitored Drugs** (as defined under the *Narcotics Safety* and *Awareness Act, 2010*, S.O. 2010, c. 22 as noted in Schedule "D" to the Order);

and as amended from time to time.

e. Dr. Barnard shall, by July 17, 2017, retain a clinical supervisor or supervisors (the "Clinical Supervisor") acceptable to the College, who will sign an undertaking in the form attached hereto as Schedule "E" to the Order. For a period of four (4) months thereafter, Dr. Barnard may practise only under the supervision of the Clinical Supervisor. Clinical supervision of Dr. Barnard's practice shall contain the following elements:

i. Dr. Barnard shall facilitate review by the Clinical Supervisor of twenty (20) patient charts per month or, should Dr. Barnard treat fewer than twenty (20) patients in any month, the charts of all patients with whom he had clinical interactions in that month, and shall permit the Clinical Supervisor to directly observe him in practice for one half-day per month, with the Clinical Supervisor providing a report every two (2) months to the College.

ii. Dr. Barnard shall meet with the Clinical Supervisor at least once per month or more frequently if requested by the Clinical Supervisor, to: discuss the

results of the Clinical Supervisor's review of patient charts and direct observation of Dr. Barnard's practice; discuss Dr. Barnard's care, treatment plans, and follow-up; identify any issues or concerns regarding Dr. Barnard 's care, treatment plans, or follow-up, discuss and receive recommendations for improvement and professional development.

iii. Dr. Barnard shall fully cooperate with, and shall abide by any recommendations of, his Clinical Supervisor, including but not limited to any recommended practice improvements and ongoing professional development.

iv. If a Clinical Supervisor who has given an undertaking in the form attached at Schedule "E" to this Order is unwilling or unable to continue to fulfill its terms, Dr. Barnard 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.

v. If Dr. Barnard is unable to obtain a Clinical Supervisor in accordance with paragraph 5(v) or paragraph 5(v)(d) of this Order, he shall cease practising medicine immediately until such time as he has done so, and the fact that he has ceased practising medicine will constitute a term, condition or limitation on his certificate of registration until that time.

f. Approximately six (6) months after the completion of Clinical Supervision, Dr. Barnard shall undergo a reassessment of his practice by a College-appointed assessor (the "Assessor"). The assessment may include a review of Dr. Barnard's patient charts, direct observation, interviews with staff and/or patients, one or more interviews with Dr. Barnard, and/or a formalized evaluation. The results of the assessment shall be reported to the College after which Dr. Barnard shall abide by any recommendations made by the Assessor by which the College has requested Dr. Barnard to abide.

g. Dr. Barnard shall consent to such sharing of information among the Assessor, the Clinical Supervisor, and the College as any of them deem necessary or desirable in order to fulfill their respective obligations and in order to monitor Dr. Barnard's compliance with this Order and with any terms, conditions or limitations on his certificate of registration.

h. Dr. Barnard shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities, such as a medical director, at any location where he practises ("Chief(s) of Staff") with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

i. Dr. Barnard shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within five (5) days of this Order and shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

j. Dr. Barnard shall maintain an up-to-date daily log of every patient with whom he has a clinical interaction, which shall include the patient's name, the date, and the hour within which the clinical interaction occurred ("Patient Log"). Dr. Barnard shall maintain the original Patient Log and shall send a copy to the College at the end of every calendar month.

k. Dr. Barnard shall cooperate with unannounced inspections of his Practice Location(s) and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

l. Dr. Barnard shall post a sign in the waiting room(s) of all his Practice Locations, in a clearly visible and secure location, in the form set out at Schedule "F" to the Order, and a certified translation of the same in any language in which he provides services, with Dr. Barnard providing such certified translation to the College within thirty (30) days of this Order or, should he later begin providing services in another language, prior to doing so. For further clarity, this sign shall state as follows:

IMPORTANT NOTICE

Dr. Barnard must not prescribe:

- Narcotic Drugs

- Narcotic Preparations

- Controlled Drugs

- Benzodiazepines or Other Targeted Substances

- All Other Monitored Drugs.

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

m. Dr. Barnard shall consent to the College making enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22, as amended ("NMS"), and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order and any terms, conditions or limitations on Dr. Barnard's certificate of registration.

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

6. Dr. Barnard pay to the College costs in the amount of $5,000.00, within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Barnard 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 February 13, 2017
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
Dr. Thomas Joseph Barnard

Dr. Barnard,

This Committee regularly and unfortunately sees physicians who are deficient in their provision of patient care. Only rarely do we see a doctor whose deficiency has been associated with the death of a patient. This Committee rarely, if ever, sees before it a physician whose practice has been reviewed by no fewer than six of his peers, who unanimously stated that your practice fell below the standard demanded by the profession and expected by the public. One of these reviewers even described your practice as not meeting the standard of a competent physician.

While we appreciate the problems of treating patients with chronic pain, there can be no excuse whatsoever for a doctor in this province to be unaware of the risks and dangers of excessive inappropriate and uncontrolled narcotic prescription.

The order of this Committee justifiably ensures that you are removed from the practice of those areas of medicine that provide honourable physicians with their professional reward, but these same areas were the ones in which you put your patients at most risk of harm. Dr. Barnard you put your patients including children in harms' way. You abused healthcare funding and harmed your patients by your practices of over investigation. You brought shame and dishonour on yourself and your profession. We never want to see you before this Discipline Committee again.