NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Brand, this is notice that the Discipline Committee ordered that there shall be a ban on the publication or broadcast of the names of patients or information that can identify them under subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

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. Brand, 2016 ONCPSD 44

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. CHRISTOPHER PAUL BRAND

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
MS. D. DOHERTY
DR. J. RAPIN
MR. J. LANGS
DR. P. ZITER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. R. AINSWORTH

COUNSEL FOR DR. BRAND:

MR. A. MATHESON
MR. M. FLISFEDER

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

PUBLICATION BAN

Hearing Date: October 18, 2016
Decision Date: October 18, 2016
Release of Written Reasons: December 14, 2016

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on October 18, 2016. At the conclusion of the hearing, the Committee delivered a written order stating its finding that Dr. Christopher Paul Brand 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. Brand committed an act of professional misconduct:

1. 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; and

2. under paragraph 1(1)34 of O. Reg. 856/93, in that he has engaged in conduct unbecoming a physician.

RESPONSE TO THE ALLEGATIONS

Dr. Brand admitted the first allegation in the Notice of Hearing, that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional. The College withdrew the second allegation in the Notice of Hearing.

THE FACTS

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

1. The College of Physicians and Surgeons of Ontario (the "College") and Dr. Christopher Paul Brand, ("Dr. Brand") agree to the following facts:

BACKGROUND

2. Dr. Brand is a 65 year old physician who currently practices family medicine in Brechin, Ontario.

3. Dr. Brand received his certificate of registration authorizing independent practice in Ontario in 1979.

4. At the time of the incident described below, Dr. Brand was the medical director of the Leacock Care Centre, (the "Centre"), a Long-Term Care Home licensed by the Ministry of Health and Long-Term Care ("MOHLTC"), and had worked at the Centre for about 15 years.

NOVEMBER 2014 INCIDENT

5. One of the residents of the Centre, Patient A., was a man in his 70s with severe developmental delays since childhood and many serious behavioural challenges. Patient A is mostly non-verbal and has been in care for many years.

6. Patient A often engaged in aggressive behaviour. This behaviour was described as being akin to "temper tantrums". During his "tantrums", he was observed to throw and bang on objects, throw himself on the floor, scream, yell and cry, and hit or kick out around him.

7. On a date in November 2014, staff had been attempting to cut Patient A's beard and Patient A refused. Staff asked Dr. Brand to assist as he had trimmed Patient A's beard before. When Dr. Brand approached, Patient A. dropped to the floor and began kicking. Dr. Brand grabbed Patient A's legs or feet and pulled him on the floor, up the hall to a conference room which had previously been set aside as Patient A's bedroom. Neither Dr. Brand nor Patient A. suffered any injuries in this incident.

8. At the time of the incident, residents were attending for breakfast and other activities in the area.

9. The incident was observed by at least three staff members, including a nurse, as well as a compliance officer from the MOHLTC who happened to be in the building.

10. The nurse who observed the incident asked Dr. Brand to stop dragging the resident by his feet. At that point, Dr. Brand had reached the door of the conference room. Dr. Brand was heard stating to Patient A, "you don't want to get your hair cut", as he pulled him towards the conference room. Shortly after, Patient A exited the conference room, followed by Dr. Brand, who was holding hair clippers and an extension cord. Dr. Brand was heard to say, "guess the resident doesn't want his hair cut then".

11. Shortly after the incident took place, the Administrator of the Centre informed Dr. Brand that this would not be tolerated. Dr. Brand replied by indicating it was Patient A they were talking about and that he had been Patient A's doctor for many years.

12. Very soon after, however, Dr. Brand acknowledged to the Administrator of the Centre that he should not have dragged Patient A and that it was an error in judgment. He stated that, after Patient A fell to the floor, Patient A started kicking and for that reason Dr. Brand grabbed his foot, "so he didn't hurt anyone or me".

13. Dr. Brand had recently undergone a partial nephrectomy, an abdominal surgery, and was concerned that Patient A's kicking might injure Dr. Brand. He therefore decided to restrain Patient A's feet and return him to his room.

14. Dr. Brand was terminated by the Leacock Care Centre on December 2, 2014.

ADMISSION

15. Dr. Brand admits the facts set out above, and admits that the conduct described constitutes an act of professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional contrary to section 1(1)33 of O. Reg. 856/93 made under the Medicine Act, 1991.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission of Liability. Having regard to these facts, the Committee found that Dr. Brand committed an act of professional misconduct in that engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

PENALTY AND REASONS FOR PENALTY

An Agreed Statement of Facts on Penalty was filed as an exhibit. It provided as follows:

1. The College of Physicians and Surgeons of Ontario ("the College") and Dr. Christopher Paul Brand ("Dr. Brand") agree to the following facts:

PRACTICE INFORMATION

2. Dr. Brand is a 65-year-old physician who received his certificate of independent practice in Ontario in 1979. He is a member of the Canadian College of Family Physicians and currently works in private practice at an office in Brechin, which is a relatively under-serviced area. He has been on active staff in the Department of General and Family Practice at Orillia Soldiers' Memorial Hospital for approximately 35 years.

PRIOR DISCIPLINE HISTORY

3. On January 22, 2002, Dr. Brand pleaded guilty to a charge of professional misconduct, as defined in para. 1(1)(33) of Ontario Regulation 856/93, in that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Discipline Committee ordered that Dr. Brand be reprimanded and that his certificate of registration be suspended for a period of four months, three months of which were to be suspended if Dr. Brand agreed to take an ethics course. The Decision

and Reasons for Decision of the Discipline Committee is attached at Tab 1 of the Agreed Statement of Facts on Penalty.

INCIDENT OF NOVEMBER 28, 2014

4. Dr. Brand was the Medical Director of the Leacock Care Centre (the "Centre"), a longterm care facility, from May 2001 until December 2014. Dr. Brand's position at the Centre was terminated as a result of the subject incident.
5. Staff at the Centre interviewed by the College's investigator, including the nurse who observed the incident and reported it to the Centre's Administrator, indicated that prior to the subject incident. Dr. Brand had a good relationship with the patient and communicated well with him.

ADMISSION

6. Dr. Brand admits the facts set out above.

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The Committee recognized its legal obligation to accept a joint submission unless to do so would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

The Committee carefully considered the joint submission and accepted the proposed order regarding penalty and costs as appropriate in the circumstances of this case. It included a two month suspension, the imposition of terms and conditions on Dr. Brand’s certificate of registration requiring instruction on medical ethics, professional behaviour and managing difficult patients, and payment of the costs of a one day hearing.

The Committee considered submissions from counsel on penalty principles as well as mitigating and aggravating factors, before coming to its decision with respect to the appropriateness of the penalty. The Committee also reviewed three cases with similar facts to Dr. Brand’s case, to address the principle that like cases should be treated alike.

It was a mitigating factor that, in admitting his misconduct, Dr. Brand recognized that his behaviour was unacceptable and an error in judgment. Furthermore, he was cooperative with the

College investigation and the hearing and showed full insight into his behavior. In admitting his misconduct, he spared witnesses the difficulty of testifying and saved the College time and expense of conducting a full contested hearing.

It was an aggravating factor that Patient A was an extremely vulnerable patient, in that he was elderly, institutionalized, and handicapped with little or no family support.

The two month suspension and reprimand is appropriate in that its sends a very strong message that the Committee will not condone this type of treatment of a patient. It also serves to ensure public confidence in the profession's ability to self-regulate in the public interest.

It further serves as both a general deterrent to the membership at large as well as a specific deterrent to Dr. Brand repeating such behaviour in the future.

The Committee considered that the individual instruction and self-study in medical ethics, professional behaviour and managing difficult patients would serve a rehabilitative objective.

The Committee also considered that the proposed costs order was appropriate, requiring Dr. Brand to reimburse the College the tariff amount of a one day hearing.

The Committee concluded that the jointly submitted penalty order properly reflects its disapproval of Dr. Brand's conduct and addresses the need to protect the public.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of October 18, 2016. On the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Brand appear before the Committee to be reprimanded.

3. The Registrar suspend Dr. Brand's certificate of registration for a two month period, to commence at 12:01 a.m. on October 19, 2016.

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

    i. At his own expense, Dr. Brand shall participate in and successfully complete, within 6 months of the date of this Order, individualized instruction satisfactory to the College and with an instructor approved by the College (the "Instructor"), on professional behavior and managing difficult patients. The Instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Brand; and

    ii. Prior to commencing individualized instruction, Dr. Brand shall engage in self-study in medical ethics, which shall include a literature review with a written report to be presented to, discussed with and reviewed by the Instructor.

5. Dr. Brand pay to the College its costs of this proceeding in the amount of $5,000.00 within thirty (30) days from the date of this Order.

At the conclusion of the hearing, Dr. Brand 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 October 18, 2016
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
AND
DR. CHRISTOPHER PAUL BRAND

It is unfortunate to find a well-respected and a long serving physician appearing before this Committee.

Society has given, physicians, the responsibility to care for our patients. It is the care of the most vulnerable that ranks high in our responsibility.

We must trust our patients with respect at all times. You have failed in your duty to this most vulnerable patient. There is no justification for this behaviour.

We note that you have admitted your error in judgement and have accepted your responsibility. This displays that you have insight and hope this kind of behaviour will not be repeated.

The fact that you have had a good relationship with your patient and loss of your position at the clinic and accepting your responsibility for your actions are all mitigating factors.

This penalty we believe will send a message to both your colleagues and the public that this kind of behaviour will not be tolerated and is not acceptable.