

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. James Scott Bradley Martin, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of any of the patients or complainants 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 or 47... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

Indexed as: Martin, J. S. B. (Re)

**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. JAMES SCOTT BRADLEY MARTIN

PANEL MEMBERS:

DR. E. STANTON (CHAIR)
S. BERI
DR. P. CHART
R. PATTILLO
DR. M. DAVIE

Hearing Date: May 20, 2014
Decision Date: May 20, 2014
Release of Written Reasons: June 9, 2014

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons heard this matter at Toronto on May 20, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Martin committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has failed to maintain the standard of practice of the profession; and
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Martin is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, (the “Code”).

RESPONSE TO THE ALLEGATIONS

Dr. Martin admitted the first allegation in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegations of disgraceful, dishonourable or unprofessional conduct and incompetence.

FACTS AND EVIDENCE

The following Agreed Statement of Facts and Admission was filed as an exhibit and presented to the Committee:

PART I – FACTS

Background

1. Dr. James Scott Bradley Martin (“Dr. Martin”) is a 65-year-old physician who practises in fertility medicine at the Southern Ontario Fertility Technologies Inc. clinic (“SOFT”). He also practises in reproductive endocrinology. Dr. Martin graduated from the University of Western Ontario in 1976 and has had an independent practice certificate in Ontario since 1977.

Investigation by the College

2. This referral flows from an investigation under s. 75(1)(a) of the Health Professions Procedural Code (the “Code”) and two complaints regarding Dr. Martin’s fertility practice at SOFT.

The s. 75(1)(a) Investigation

3. On July 6, 2010, the Inquiries, Complaints and Reports Committee (“ICRC”) approved the appointment of investigators into Dr. Martin’s fertility practice under s. 75(1)(a) of the Code.
4. The College retained Dr. X to provide an opinion on Dr. Martin’s care of 28 patients whose charts had been obtained from Dr. Martin’s practice. Dr. X has been a professor emeritus of Obstetrics and Gynecology at the University of Western Ontario since 1995. Dr. X had been a professor in the Department of Obstetrics and Gynecology at the University of Western Ontario from 1982 to 1995. He is also the co-founder and is a former co-director of the Genesis Fertility Centre in Vancouver, British Columbia, and he is co-founder and co-director of the Olive Fertility Centre, where he currently practises fertility

medicine.

5. On the basis of the charts and an interview with Dr. Martin, and the information obtained from others involved with SOFT, Dr. X concluded that Dr. Martin has a sound background of training in gynecology and is current with the medical literature regarding infertility diagnosis and treatment. He found no evidence of a lack of knowledge or skill in Dr. Martin's practice of reproductive medicine. He also noted that the rate of ovarian hyperstimulation and multiple pregnancies in Dr. Martin's patients is not excessive.
6. Dr. X did, however, have significant concerns regarding Dr. Martin's lack of judgment and his standard of care. Dr. X summarized his opinion as follows:

This conclusion is based upon the cases reviewed, and is related to the number of intrauterine insemination ["IUI"] cycles with or without concomitant medication that he has performed in some of his patients. His main justification for doing so is that he still obtains pregnancies after six cycles of treatment (7% per cycle based on his abstract submitted), which is generally the accepted limit for the number of IUI cycles if pregnancy fails to occur. He justifies continuing treatment with IUI by referencing a single publication, Custers et al, Human Reproduction 2008 ... The pregnancy rate which he does obtain beyond six cycles of treatment is small and does not justify prolonging a move to more aggressive and more effective treatments of promoting fertility such as in vitro fertilization (IVF) or intracytoplasmic sperm injection when there is some impairment of sperm function or quality. I find on this basis of an excessive number of IUI treatment cycles performed in some cases that Dr. Martin's patient care falls below the standard of care.

7. Dr. X noted that women's fertility decreases with age, especially as they approach the age of 40. He expressed concern that patients relying on Dr. Martin's advice "may have lost their window of opportunity to achieve a pregnancy by delaying their progression [from IUI] to IVF".
8. In addition, Dr. X noted that important discussions regarding patients' options and

decisions about their treatment that Dr. Martin claimed took place - including, for example, conversations he claimed occurred with patients in which he or other clinic staff discussed moving to IVF and the patient(s) chose to continue with IUI - were not documented in their charts.

9. A copy of Dr. X's report of October 6, 2011 is attached at Tab 1 [to the Agreed Statement of Facts and Admission.]

The Patient A Complaint

10. In August 2010, Patient A contacted the College to complain about the care she had received from Dr. Martin between approximately 2001 and 2010.
11. Patient A's complaint was triggered by Dr. Martin's decision to terminate the weekly counselling appointments she had been having with him for years regarding an eating disorder. He told her in June 2010 that he had to stop seeing her because the Ministry of Health had advised him that counselling was outside his scope of practice and because the College was going to be auditing him soon. He told her he could see her until the end of June (for two more weeks). However, this was not true. When Patient A probed this claim with the Ministry of Health, she was told that there had been no such communication with Dr. Martin. Patient A also raised concerns regarding the quality of care she had received from Dr. Martin when she was engaged in fertility treatments with him beginning in October 2001, most particularly during her third attempt to conceive between 2005 and 2007.
12. The College retained Dr. Y, who is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in obstetrics and gynecology, and who is in active practice in Ottawa and is a professor at the University of Ottawa, to provide an opinion on Dr. Martin's care of Patient A.

13. Dr. Y noted that he is a fertility specialist and was not qualified to provide an expert opinion regarding the mental health treatment. Dr. Martin admits, however, that he is not specifically trained to counsel eating disorders and that he was outside his scope in the five years he engaged in this counselling. He also admits he erred when he misrepresented the reason he was stopping the counselling in his discussion with Patient A.
14. With respect to Dr. Martin's fertility treatment for Patient A, Dr. Y concluded that Dr. Martin failed to maintain the standard of practice of the profession. He summarized his opinion as follows:

The medical chart varies from almost no documentation of the most critical elements of [Patient A's] medical care to somewhat detailed unstructured notes...The medical chart as submitted has multiple diagnostic test results, hospital reports, but few signed entries by Dr. Martin or any other health professionals and as such it is very difficult to follow the flow of care and the interactions that occurred...

Patient A underwent 23 cycles of COH, many of them with more than 4 follicles; many of them with an estradiol near or above 10,000 pmol/L. Her IVF cycles saw unacceptably high levels of serum estradiol. Dr. Martin repeatedly states in his letter to the College that the patient was significantly hyperstimulated on many occasions; that he was concerned for her health and that IUI would be risky. The degree of hyperstimulation for the IVF cycles could also be considered as dangerous to her health. Yet he did not refuse to do the IUI. He did not withhold the hCG trigger injection. He did not insist on conversion to IVF. He did not stop the stimulation nor did he introduce measures to prevent moderate or severe hyperstimulation knowing that her renal function is compromised. When conversion to IVF was undertaken, it was at dangerously high levels of estradiol and with too many follicles. In this situation most responsible fertility specialists would cancel egg retrieval and give medications to prevent ovulation and allow the ovary to return to a more normal state.

Given the fact that Dr. Martin's cared for this patient for many years, he should have known that she would have a robust response to medication and should have adjusted the medications given to her, the protocols used or pursued other treatment regimens to reduce the risk of severe hyperstimulation. Given that Dr. Martin

is a fertility subspecialist, he should have known that he was repeatedly placing the patient at extreme risk of multiple medical complications including thrombosis, pulmonary emboli and stroke.

I have been doing IVF since 1983 and I have never had a patient with estradiol levels seen in this patient nor until I reviewed this file, have I ever seen a patient who was allowed to proceed to hCG injection with estradiols at these high and, very dangerous levels.

15. The report of Dr. Y received by the College on November 2, 2011 is attached at Tab 2 [to the Agreed Statement of Facts and Admission.]

The Patient B Complaint

16. In December 2010, the College received a letter of complaint from Patient B's husband, complaining about the care and treatment his wife received from Dr. Martin in August of 2009.
17. Patient B had an IUI at SOFT in July 2009 and in late August a blood test performed at the clinic revealed she was pregnant. However, nursing staff informed them that Patient B's hormone level was abnormal and the couple were told to return to the clinic 48 hours later for a further blood test.
18. Two days later another blood test was performed at SOFT, and due to the slow increase in the hormone level the staff advised that there was a risk of an ectopic pregnancy. They were told to return in another 48 hours.
19. In early September, a clinic nurse took another blood test and again cautioned about the abnormal blood work and risk of ectopic pregnancy. The couple was told to return to the clinic in late September for another ultrasound. At no point during these visits were they seen by Dr. Martin or any other physician.
20. At some point after the end of August, Dr. Martin put an undated sticky on Patient B's chart indicating that she should have another ultrasound "ASAP". No ultrasound was arranged prior to the late September date.

21. In September 2009, Patient B collapsed at home and was rushed to hospital where it was determined that she had a ruptured fallopian tube caused by an ectopic pregnancy.
22. Dr. Y reviewed Dr. Martin's care of Patient B, and concluded that it fell below the standard of practice of the profession. In summary, Dr. Y concluded that Dr. Martin lacked knowledge regarding the diagnosis and management of an ectopic pregnancy. He also expressed concerns about the systems in place at the clinic which failed to meet the standard in terms of the organization and management of Patient B's care between health care providers at the clinic. He found that "the lack of adequate documentation and the poor communication among health professionals at the SOFT clinic put this woman's life at risk".
23. Dr. Y raised the following specific concerns regarding Dr. Martin's care in this case:
- He should have had a high index of suspicion in September 2009 that Patient B had a left sided ectopic (tubal) pregnancy and he should have initiated steps to confirm or disprove the diagnosis at that time and initiated an appropriate intervention. If Patient B had not presented herself in a timely manner to the Emergency Department, it is likely that she would have ultimately collapsed at home from hemorrhagic shock.
 - He received multiple reports that suggested that Patient B was pregnant despite an earlier report of a negative pregnancy test. The gestation of the pregnancy was uncertain, but Dr. Martin never acted to meet with nor examine the patient, determine how many weeks pregnant she was or to advise his colleague or another colleague of the fact that Patient B was pregnant.
 - There are no notes, directions or other forms of documented communication in the patient chart that is shared with Dr. Martin's nursing colleagues and other health professionals. As medical director, Dr. Martin was responsible for all aspects of medical care at the clinic.
 - Aside from the laboratory test results, Dr. Martin made no signed and dated entries in the medical record. There is no record of any patient encounter with Dr. Martin, of any conversation by Dr. Martin with the patient or discussion of any treatment plan. Aside from the standard consent form, there is no indication that the risks of the IUI procedure were ever discussed with Patient

B and her partner. When the suspicion of an ectopic pregnancy was raised in Dr. Martin's mind, he made no documented effort to share his concern with the patient or her partner or to advise them of the signs and symptoms of an ectopic pregnancy and how to deal with the possibility.

24. Dr. Y concluded as follows:

When faced with a HCG level of over 2000mlU/L, uncertain dates and an empty uterus and a unilateral hemorrhagic adenexal mass, a competent gynecologist would have either transferred care to another physician, confirmed that his patient had a resolving ectopic pregnancy or proceeded to the appropriate intervention – surgery in this case.

Dr. Martin states that the patient's HCG levels were not called to his attention in this case. However, he acknowledges that it was his responsibility to follow up on and obtain this information. Dr. Martin acknowledges that he failed to maintain the standard of practice by failing to inform himself of, and act on, Patient B's HCG levels by the beginning of September 2009 at the latest.

25. A copy of Dr. Y's report of August 26, 2011 is attached at Tab 3 [to the Agreed Statement of Facts and Admission.]

PART II – ADMISSION

26. Dr. Martin admits the facts specified in paragraphs 1 to 25 above, and specifically acknowledges the deficiencies set out in the reports of Dr. X and Dr. Y.

27. Dr. Martin admits that the conduct described above constitutes professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 in that he failed to maintain the standard of practice of the profession.

FINDINGS

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

The Committee notes that Dr. Martin's failure to maintain the standard of practice is broad and includes failures in the clinical care that he provided to his patients, inadequate record keeping, practising outside his specialty and misinforming patients.

PENALTY AND REASONS FOR PENALTY

The Committee received a joint submission on penalty from the parties. The proposed penalty included a suspension, a reprimand, and terms, conditions and limitations that included supervision and monitoring as well as practice restrictions. The Committee has the power under s. 51 (2) of the *Health Professions Procedural Code* (the "Code") to order all elements of the proposed penalty. The parties also proposed that Dr. Martin pay costs to the College in the amount of \$40,140. The Committee has the power under section 53.1 of the Code, "in an appropriate case", to order that Dr. Martin pay all or part of the College's legal costs and expenses, its legal costs and expenses incurred in investigating the matter, and its costs and expenses incurred in conducting the hearing.

In considering the proposed penalty, the Committee was mindful of judicial direction that a joint submission should not be lightly set aside. The Committee recognized that the parties are more familiar with the circumstances and details of the matter than the Committee. The Committee should accept a joint submission unless the proposed penalty is so disproportionate to the misconduct that to accept it would be contrary to the public interest and would bring the administration of justice into disrepute.

The Committee also considered the well-established principles that apply to the imposition of a penalty. Denunciation of the misconduct, specific and general deterrence, rehabilitation and maintaining public confidence in the profession and its ability to regulate itself all apply in this matter. The overriding principle is protection of the public.

The reasons for the Order that follow will explain in detail the Committee's view. However it should be emphasized that the Committee was satisfied that as a result of the proposed penalty that the parties jointly submitted, Dr. Martin will be prohibited indefinitely from practising fertility medicine. Given the nature of the misconduct in this matter, the Committee could accept no less.

Seen in its entirety, the proposed penalty is a severe sanction, which is in keeping with the nature of the professional misconduct. The core concern is the failure to maintain the standard of practice in the clinical care of patients. The Committee was appalled by Dr. Martin's disregard for the well-being of patients whose ovaries were hyperstimulated, repeated attempts to achieve pregnancy through intrauterine insemination when more effective and appropriate means were available, and failure to follow up with respect to a patient whose parameters suggested an ectopic pregnancy. These deficiencies in Dr. Martin's practice go far beyond what would be expected of a physician of his specialist training and knowledge. Maintaining professional standards is expected by the public and is a fundamental professional responsibility.

The Committee was also troubled by the fact that Dr. Martin gave a patient false information about the reason he was stopping her counselling for eating disorders. Patients have the right to expect that members of the medical profession will behave with professional integrity toward them; this underpins the trust that patients have in their physicians. Such conduct reflects poorly on Dr. Martin, and it affects the reputation of the profession as a whole. Dr. Martin also admitted that counselling for eating disorders was outside his scope of practice, which is an additional failure to meet his professional responsibilities.

The two-month suspension, the reprimand, and the indefinite prohibition against Dr. Martin returning to fertility medicine, all serve to denounce Dr. Martin's misconduct. They also tell both Dr. Martin and the profession as a whole that this misconduct was serious and will not be treated lightly by the profession. Thus the proposed penalty serves the goals of specific and general deterrence. It also serves to maintain public confidence in the profession. The requirement that Dr. Martin must undertake remedial

education in medical ethics will serve a rehabilitative function. Dr. Martin's record-keeping practices were substandard as noted by both of the experts who reviewed the patient records. This is also unacceptable and requires specific remediation. The proposed penalty requires that Dr. Martin complete a medical record-keeping course, which is appropriate under the circumstances.

Patient safety is further addressed in the Order by the indefinite limitation of Dr. Martin's future practice exclusively to reproductive endocrinology. This is a narrow area in which Dr. Martin has expertise, and where the Committee had no evidence to suggest a failure to maintain professional standards. Interpretation of fertility-related ultrasound images will cease as of December 31, 2014, and while Dr. Martin will be permitted to continue interpreting images until then (after his suspension is served), he will be supervised by a Clinical Supervisor. The Committee was satisfied that this program of oversight will adequately protect the public during the short time that Dr. Martin continues to interpret these images. Furthermore, for an indefinite period Dr. Martin will be required to submit to unannounced inspections of his Practice Location(s) and patient records by the College for the purpose of monitoring his compliance with the Order. This will also serve to protect the public.

Costs in the amount of \$40,140.00 payable within 30 days of the Order have been agreed to by the parties. The Committee considered this to be an appropriate case in which to order costs. The Committee agreed that a significant proportion of the costs of the hearing should be borne by Dr. Martin and not the membership as a whole. The hearing was booked for a number of weeks and settled on the first day of the hearing.

In conclusion, the Committee considered the proposed penalty carefully. It agreed with counsel for the parties that it represents an appropriate sanction in this matter, and it accepted the joint submission.

ORDER

Therefore, having stated the findings in paragraph 1 of its written order of May 20, 2014, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Martin appear before the panel to be reprimanded.
3. the Registrar suspend Dr. Martin's certificate of registration for a period of two (2) months commencing July 1, 2014.
4. the Registrar impose the following terms, conditions and limitations on Dr. Martin's certificate of registration:
 - a) Effective immediately, Dr. Martin shall cease accepting new patients in his practice of fertility medicine;
 - b) Effective immediately, Dr. Martin shall not counsel or advise patients regarding eating disorders or any other matter falling outside his permitted scope of practice;
 - c) Effective July 1, 2014, Dr. Martin shall restrict his practice exclusively to reproductive endocrinology and the interpretation of fertility-related ultrasound images;
 - d) Without in any way restricting the generality of the restriction set out in paragraph 4(c) above, effective July 1, 2014, Dr. Martin shall be prohibited from practising fertility medicine in any respect, including, without limitation, the following:
 - i. Fertility-related assessment and investigations, including the performance or interpretation of fertility-related hysterosalpingograms, fertility treatment or fertility-related cycle-monitoring;
 - ii. Artificial insemination;
 - iii. In vitro fertilization including oocyte retrievals and/or embryo transfers;

- iv. Counseling or advising patients regarding fertility treatments, artificial insemination, or any other matter relating to fertility medicine; and
 - v. Decision making of any kind regarding the care and treatment of patients undergoing fertility treatment, artificial insemination, in vitro fertilization or any other treatment or procedure associated with fertility medicine;
- e) Within thirty (30) days of the date of this Order, Dr. Martin shall obtain a clinical supervisor acceptable to the College, who will supervise Dr. Martin's interpretation of fertility-related ultrasound images and who will sign an undertaking in the form attached hereto as Schedule "A" (the "Clinical Supervisor");
- f) If a Clinical Supervisor who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Martin 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;
- g) If Dr. Martin is unable to obtain a Clinical Supervisor in accordance with paragraphs 4(e) and 4(f) of this Order, he shall cease to interpret fertility-related ultrasounds until such time as he has done so, and the fact that he has ceased to practise shall be a term, condition and limitation on his Certificate of Registration until that time;
- h) Dr. Martin shall abide by all recommendations of his Clinical Supervisor with respect to practice improvements and education;
- i) Dr. Martin shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the

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

- j) Effective December 31, 2014, Dr. Martin shall be prohibited from interpreting ultrasound images and shall restrict his practice exclusively to reproductive endocrinology;
- k) For an indefinite period of time, Dr. Martin shall inform the College of each and every location where he practices including, but not limited to hospitals, clinics, and offices, in any jurisdiction (collectively, his "Practice Location(s)"), within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within 15 days of commencing practice at that location;
- l) For an indefinite period of time, Dr. Martin shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient records by a College representative for the purposes of monitoring his compliance with this Order;
- m) Dr. Martin shall, at his own expense, participate in and successfully complete an educational program satisfactory to the College in Ethics, with a report or reports to be provided to the College regarding Dr. Martin's progress and compliance. Dr. Martin shall complete this requirement by September 1, 2014 or, if no satisfactory program is available by that time, by the first possible opportunity thereafter;
- n) Dr. Martin shall, at his own expense, participate in and successfully complete an educational program satisfactory to the College in medical record-keeping. Dr. Martin shall complete this requirement by September 1, 2014 or, if no

satisfactory program is available by that time, by the first possible opportunity thereafter;

- o) Dr. Martin shall consent to the monitoring of his OHIP billings and cooperate with inspections of his practice and patient charts by College representatives for the purpose of monitoring and enforcing his compliance with the terms of this Order; and
 - p) Dr. Martin shall be responsible for any and all costs associated with implementing the terms of this Order.
5. Dr. Martin pay to the College costs in the amount of \$40,140 within 30 days of the date of this Order.

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