## 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 there shall be a ban on publication of the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45… is guilty of an offence and on conviction is liable,
>
> (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
>
> (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Martin, 2018 ONCPSD 61**

**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:** **MR. J. LANGS (CHAIR)**
**DR. P. POLDRE**
**MR. M. KANJI**
**DR. J. WATTERS**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:**

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**MS S. MARTENS**
**MS A. H. PLUMB**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR. R. COSMAN**

# PUBLICATION BAN

**Hearing Date:** **September 25, 2018**
**Decision Date:** **September 25, 2018**
**Written Decision Date:** **November 23 2018**

## 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 September 25, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out the Committee's penalty and costs order, with written reasons to follow.

## THE ALLEGATIONS

The Notice of Hearing alleged that Dr. James Scott Bradley 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.

The Notice of Hearing also alleged that Dr. Martin 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. Martin admitted the allegation of professional misconduct in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. Dr. Martin also admitted that he is incompetent.

## THE FACTS

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

1. Dr. James Scott Bradley Martin is a 69-year-old obstetrician-gynecologist who received his certificate of registration authorizing independent practice in June 1977.

2. Throughout the relevant time, Dr. Martin practised in London, Ontario.

**Patient A**

3. In 2016, staff in the Ministry of Health and Long-Term Care contacted the College with inquiries regarding Dr. Martin's prior approval application for a fourteen year old female-to-male transgender patient seeking sex reassignment surgery (a mastectomy), Patient A. As a result of the Ministry's inquiries, investigators were appointed under section 75(1)(a) of the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act, 1991.

4. At the time the investigation began, Dr. Martin described his practice as focused on transgender care and hormone replacement therapy. He indicated that he saw approximately thirty patients a week, spending fifteen hours a week in direct patient contact.

5. Dr. Herbert "Joey" Bonifacio, a pediatrician and adolescent medicine specialist, was retained to review Dr. Martin's care of Patient A. Dr. Bonifacio's report, received on July 11, 2017, forms part of this Agreed Statement of Facts and Admission and is attached at Tab 1 [to the Agreed Statement of Facts and Admission].

6. Among other things, as found by Dr. Bonifacio:

    - Dr. Martin did not meet the standard of practice of the profession regarding care for adolescents with gender dysphoria in his care of Patient A;
    - Dr. Martin prescribed cross-sex hormones to Patient A, who was then thirteen years old, at their first visit. Cross-sex hormones have many side effects, including

infertility, and more time is necessary to process this information so that adolescents can make an informed decision. Dr. Martin lacked judgment in this regard;

- Dr. Martin lacked judgment regarding determination of mental health needs and supports. The mental health portions of the patient chart were limited, and he did not specifically address common mental health diagnoses that co-occur with gender dysphoria in adolescents, such as depression and anxiety. There was no mental health assessment before initiating cross-sex hormones;
- Dr. Martin's conduct could expose patients to harm or injury, based on his prescribing cross-sex hormones to a young patient at the first visit with minimal mental health history-taking and the lack of assurance that the patient has sought and is accessing appropriate mental health resources and supports.

7. Dr. Bonifacio provided an addendum to his report, attached at Tab 2 [to the Agreed Statement of Facts and Admission], in which he advised that his opinion had not been affected after reviewing a response to it submitted by Dr. Martin.

8. Dr. Martin failed to maintain the standard of practice of the profession and was incompetent in his care of Patient A.

**Patient B**

9. In 2016, a relative complained to the College about Dr. Martin's treatment of Patient B, an adolescent male-to-female transgender patient. The complainant voiced concerns that Dr. Martin had prescribed hormone replacement therapy and was prepared to approve sex reassignment surgery without a mental health assessment.

10. Dr. Bonifacio was retained to review the patient's care. His report, received on July 11, 2017, forms part of this Agreed Statement of Facts and Admission and is attached at Tab 3 [to the Agreed Statement of Facts and Admission].

11. Among other things, as found by Dr. Bonifacio:

- Dr. Martin did not meet the standard of practice of the profession regarding care for adolescents with gender dysphoria in his care of Patient B;
- Dr. Martin prescribed cross-sex hormones to Patient B, who was then sixteen years old, at their first visit. Cross-sex hormones have many side effects, including infertility. Although Patient B was sixteen years old at the time of consultation, age alone is not a criterion for initiation of cross-sex hormones. More time is necessary to process the information regarding side effects so that adolescents can make an informed decision. Dr. Martin lacked judgment in this regard. The short length of the first consultation (described by Dr. Martin as thirty minutes), at which cross-sex hormones were prescribed, was also concerning, given the time required for an informed consent discussion to take place;
- Dr. Martin lacked judgment regarding determination of mental health needs and supports. The mental health portions of the patient chart were limited and the notes were similar from visit to visit. Dr. Martin did not specifically address common mental health diagnoses that co-occur with gender dysphoria in adolescents, such as depression and anxiety. There was no mental health assessment before initiating cross-sex hormones;
- Dr. Martin's conduct exposed patients to harm or injury, based primarily on Dr. Martin's initiation of cross-sex hormones at the first visit, as well as Dr. Martin's lack of understanding regarding the need to assess an adolescent patient's mental health.

12. Dr. Martin failed to maintain the standard of practice of the profession and was incompetent in his care of Patient B.

**Admission**

13. Dr. Martin admits the facts set out above, and admits that, based on these facts,

    (a) he thereby failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991, and

(b) he 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, S.O. 1991, c. 18.

**FINDING**

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 has failed to maintain the standard of practice of the profession. The Committee also found that Dr. Martin is incompetent.

**AGREED STATEMENT OF FACTS REGARDING PENALTY**

The following facts were set out in the Agreed Statement of Facts Regarding Penalty, which was filed as an exhibit at the hearing and presented to the Committee:

**Dr. Martin's Discipline History**

1. Dr. Martin was previously the subject of a finding by the Discipline Committee on June 9, 2014. The Committee found that he failed to maintain the standard of practice of the profession in his fertility practice and directed the Registrar to suspend Dr. Martin's certificate of registration for a period of two months and restrict his practice to reproductive endocrinology and the interpretation of fertility-related ultrasound images, among other things. Dr. Martin admitted that he provided an excessive number of intrauterine insemination ("IUI") treatment cycles in some cases, delaying patients from moving on to more effective treatment options. He also, among other things, failed to document important discussions regarding patients' treatment options that he claimed took place, including about patients choosing to continue with IUI rather than try other interventions. The Discipline Committee's Decision and Reasons for Decision are attached at Tab 1[to the Agreed Statement of Facts Regarding Penalty].

**Dr. Martin's Complaints Committee/Inquiries, Complaints and Reports Committee History**

2. On April 11, 2014, in response to a complaint from a patient, the Inquiries, Complaints and Reports Committee ("ICRC") cautioned Dr. Martin regarding improper OHIP billing and advised him regarding the adequacy of his record-keeping and documentation with patients who exceed six IUI procedures. The ICRC's decision is attached at Tab 2 [to the Agreed Statement of Facts Regarding Penalty].

3. On August 15, 2014, in response to a complaint from a couple regarding infertility treatment as well as communications with Dr. Martin and his staff, the ICRC cautioned Dr. Martin to ensure that he responded promptly to communications from the College about complaints, and advised him regarding documentation, to ensure that he fully documents patient interactions. The ICRC's decision is attached at Tab 3 [to the Agreed Statement of Facts Regarding Penalty].

4. On June 10, 2016, the ICRC considered investigations into three complaints from families of transgender patients. As a result, the ICRC required Dr. Martin to attend in person for cautions. The ICRC's decisions in these three cases are attached at Tab 4 [to the Agreed Statement of Facts Regarding Penalty]. The complaints also grounded a broader investigation into Dr. Martin's hormone and transgender practice. The ICRC's decision in this investigation, dated June 10, 2016, is attached at Tab 5 [to the Agreed Statement of Facts Regarding Penalty]. In its decision, the ICRC required Dr. Martin to complete a specified continuing education or remediation program ("SCERP") regarding transgender care, including moderate clinical supervision and a reassessment.

**Clinical Supervision**

5. As required by the specified continuing education and remediation program ordered by the ICRC in June 2016, Dr. Martin retained a clinical supervisor for transgender care, Dr. Raymond Fung. Dr. Fung provided reports, which are attached at Tab 6 [to the Agreed

Statement of Facts Regarding Penalty]. Dr. Fung identified areas for improvement with respect to Dr. Martin's failure to adequately canvas and document mental health issues and history, and his practice of initiating hormone therapy during initial visits, sometimes before appropriate examinations (such as baseline blood testing) had been completed and acted upon. During the course of the clinical supervision, Dr. Fung documented that Dr. Martin made improvements to these aspects of his practice. At the conclusion of the clinical supervision, Dr. Fung stated that he had "no major concerns," but he continued to identify areas for improvement.

**Dr. Martin's Status Pending the Discipline Hearing**

6. The ICRC made an interim order to protect patients under section 25.4 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, on August 22, 2017. The interim order is attached at Tab 7 [to the Agreed Statement of Facts Regarding Penalty]. Among other things, it required that Dr. Martin refrain from providing transgender care to any new patients under the age of eighteen, and that he practise under clinical supervision in providing transgender care to existing patients under the age of eighteen.

7. Dr. Martin subsequently advised the College that he had chosen not to obtain a clinical supervisor. Accordingly, as of September 23, 2017, under the terms of the order Dr. Martin was required to cease providing transgender care to patients under the age of eighteen.

8. As of August 16, 2018, Dr. Martin permitted his certificate of registration to expire.

**Dr. Martin's Undertaking**

9. Dr. Martin has entered into an undertaking, attached at Tab 8 [to the Agreed Statement of Facts Regarding Penalty], by which, among other things, he has undertaken to resign his certificate of registration and not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction.

## PENALTY AND REASONS FOR PENALTY

### Joint Submission

Counsel for the College and counsel for Dr. Martin made a joint submission as to an appropriate penalty and costs order. They proposed that Dr. Martin be ordered to appear before the Committee to be reprimanded and to pay costs to the College in the amount of $6,000.00.

It was noted that Dr. Martin had resigned his certificate of registration effective September 24, 2018 and has undertaken not to apply or re-apply for registration to practise medicine in Ontario or elsewhere. In light of this undertaking, the College was not seeking a more serious penalty, which it would have done in the absence of such undertaking.

The threshold for rejecting the parties' joint submission on penalty is high. In *R. v. Anthony-Cook*, 2016 SCC 43, the Supreme Court of Canada made it clear that a joint submission on penalty should be accepted, unless to do so would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

### Analysis

#### *Nature of the Misconduct*

The findings of professional misconduct and incompetence in this case arise from complaints to the College about Dr. Martin's care of two adolescent patients with gender dysphoria whom he first saw in August 2015.

The Committee was deeply troubled by Dr. Martin's gross failure to meet the standard of practice of the profession and his incompetence. First, for neither patient did Dr. Martin address common mental health diagnoses that co-occur with gender dysphoria in adolescents, such as depression and anxiety. He obtained minimal mental health history and sought no assurance that appropriate mental health resources and supports were in place. Second, Dr. Martin prescribed

cross-sex hormones to both patients at their first visit. One of the patients was 13 years of age at the time. Cross-sex hormones have many side effects, including some that are irreversible

Patients need time to process such serious information and for there to be an informed consent discussion. Dr. Martin disregarded these critical decision-making needs of his patients. He failed to address his patients' mental health status and inappropriately prescribed on their first visit to him. Dr. Martin's care fell outside accepted clinical guidelines and lacked proper justification. Dr. Martin demonstrated a lack of judgement and his care exposed his patients to harm or injury.

***Aggravating Factors***

The patients whose care is the focus of this case were adolescents with gender dysphoria. They are members of a particularly vulnerable group. Dr. Martin's conduct exposed his patients to potential harm or injury by his prescribing of cross-sex hormones at their first visit, and by failing to properly address their mental health status, needs and supports.

Dr. Martin has a prior history with the Discipline Committee. In 2014, the Committee found that Dr. Martin failed to maintain the standard of practice of the profession in his fertility practice. In its reasons for penalty, the Committee stated that it was appalled by Dr. Martin's disregard for the well-being of his patients. The Committee ordered a two-month suspension and a reprimand, prohibited Dr. Martin from practising fertility medicine, and indefinitely restricted his practice to reproductive endocrinology and interpretation of fertility-related ultrasound images. Although the clinical failings at issue in 2014 differ from those in the present case, the Committee expected that Dr. Martin would have become particularly vigilant in his attention to practice standards in his chosen area of medicine.

Dr. Martin has a prior history with the Inquiries, Complaints and Reports Committee. Twice in 2014, in response to patient complaints, the ICRC cautioned Dr. Martin about his clinical documentation and improper OHIP billing, among other matters.

In 2016, the ICRC considered three complaints from families of transgender patients. The ICRC cautioned Dr. Martin in person and required him to retain a supervisor for his transgender practice. This involvement with the ICRC took place after the conduct at issue in the present hearing and, consequently, the 2016 ICRC findings cannot be considered as an aggravating factor in this case.

***Mitigating Factors***

Dr. Martin has admitted his professional misconduct and incompetence. This spared the witnesses the burden of having to testify at the hearing and reduced the time and expense of a contested hearing.

Also, Dr. Martin has cooperated with College-directed clinical supervision in the past. During the period of clinical supervision, the clinical supervisor made recommendations to Dr. Martin and documented improvements in those aspects of his practice.

Dr. Martin has not provided transgender care for individuals under 18 years of age since September 2017, in compliance with an interim order of the ICRC.

Dr. Martin has resigned his certificate of registration and undertaken never to reapply to practise medicine in Ontario or elsewhere. In doing so, he has accepted responsibility for his misconduct and public protection is ensured. His undertaking not to reapply to practise medicine goes further than an order of the Committee can go. A physician whose certificate of registration is revoked can normally apply for reinstatement after one year from the revocation order.

***Prior Cases***

The Committee recognizes that it is not bound by decisions in prior cases but may find them of assistance and useful as a guide with respect to the range of penalties imposed for similar misconduct.

College counsel presented four cases in which physicians were found, among other things, to have failed to maintain the standard of practice of the profession and to have engaged in disgraceful, dishonourable, or unprofessional conduct. In each instance, the physician signed an undertaking to resign their certificate of registration and never to apply or re-apply to practise medicine in Ontario or elsewhere. In each instance, the jointly submitted penalty of a reprimand, with a costs order, was accepted as an appropriate disposition of the case.

In *CPSO v. Guindon* 2012 ONCPSD 10 (CanLII), the failure to meet the standard of practice was very broad, identified in 23 of 25 patient charts reviewed, and in all 27 patient encounters that were observed. Patients were exposed to significant risk of harm. There was as well a finding that the physician had breached a term, condition, or limitation on her certificate of registration. The physician had no prior discipline history and accepted responsibility for her misconduct.

In *CPSO v. Farazli* 2014 ONCPSD 26 (CanLII), there were extensive findings relating to the physician's failure to meet the standard of practice and disgraceful, dishonourable and unprofessional conduct. Additionally, she was found to be incompetent and to have contravened the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts contrary to s 1(1) 27 O Reg. 856/93. The physician had shown a blatant disregard for her patients' care and safety, behaved in an abusive and insensitive manner, and failed to adhere to basic infection control practices. She exposed thousands of patients to distress and risk and placed a large burden on the health care system. The Committee stated that it would have imposed a severe penalty had the physician not resigned and agreed never to practise again.

In *CPSO v. Dubins* 2016 ONCPSD 34 (CanLII), Dr. Dubins was found to have failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct. A single patient was the focus of the allegations. The physician used graphic sexual imagery in aversive hypnotherapy for smoking cessation, invited the patient to loosen his pants while under hypnosis, and failed to maintain a clean office. The Committee was appalled by the physician's insensitivity and poor judgment. The Committee found aggravating that Dr. Dubins demonstrated his insensitivity in treating the patient while the patient was under hypnosis, by instruction to his patient to undo his belt and pants button and lower his fly while he

was undergoing the hypnosis. The Committee stated that hypnotherapy patients are highly vulnerable and that it is particularly important that physicians recognize and not abuse the vulnerability of their patients under hypnosis or in any other situation. The physician had previously been cautioned by the Complaints Committee for similar misconduct.

In *Jiaravuthisan* 2016 ONCPSD 50 (CanLII), the findings of professional misconduct, for failure to maintain the standard of practice of the profession and disgraceful, dishonourable or unprofessional conduct, were based on the physician's conduct with two patients, in which he demonstrated a lack of sensitivity and respect for his patients' right to dignity and privacy. The physician had not appeared before the Discipline Committee previously.

Counsel for Dr. Martin pointed out that unlike in the noted above cases, there was no allegation that Dr. Martin had engaged in disgraceful, dishonourable or unprofessional conduct. Counsel for Dr. Martin presented two further cases for the Committee's consideration. In both cases, the physicians had resigned and undertaken not to apply or re-apply to practise medicine in any jurisdiction. Jointly submitted penalty proposals of a reprimand as well as a costs order were accepted in each case.

In the first case, *CPSO v. Cameron* 2018 ONCPSD 25 (CanLII), the physician was found to have failed to maintain the standard of practice of the profession in respect of his narcotic prescribing and exposing many patients to a risk of harm over a number of years. He had two prior discipline findings of disgraceful, dishonourable or unprofessional conduct, not directly related to the misconduct in question. The Committee ordered terms, conditions and limitations on the physician's certificate of registration until his undertaking to resign took effect.

In the second case, *CPSO v. Prevost* 2015 ONCPSD 14 (CanLII), the physician was found to have failed to maintain the standard of practice of the profession and to be incompetent. There were wide-ranging clinical concerns and a risk of harm to a large number of patients. The Committee noted the physician's blatant disregard for his patients' well-being and stated that it would have undoubtedly ordered revocation if the physician had not resigned.

The cases present a wide variance of different kinds and breadth of professional misconduct and a variance in relation to the number and vulnerability of patients affected. The Committee acknowledges the submissions of counsel that there is a spectrum of misconduct where the penalty of a reprimand and a costs order is appropriate, in the context of a physician's resignation and an undertaking not to seek to practise medicine again in any jurisdiction. Removal of a physician from practice ensures the protection of the public from physician misconduct and incompetence.

**Conclusion**

The Committee accepts the jointly proposed penalty as reasonable, within the range of penalties in other similar cases, and consistent with the relevant penalty principles.

Protection of the public is paramount. Dr. Martin's resignation of his certificate of registration and undertaking never to apply or re-apply to practise medicine in any jurisdiction will serve this goal effectively. This information will be available to the public on the College's register.

The Committee would have revoked Dr. Martin's certificate of registration had he not resigned. Following revocation of their certificate of registration, physicians have a statutory entitlement to seek reinstatement after one year if the revocation was for a finding other than sexual abuse. With his resignation and undertaking, Dr. Martin has withdrawn from the practice of medicine and has given up the possibility of ever returning to the practice of medicine.

Dr. Martin's resignation in conjunction with an order for a reprimand will convey to the public and the profession the seriousness of his misconduct and that such misconduct will not be tolerated. Dr. Martin's resignation and undertaking will convey to the public and the profession that a physician whose failures to meet the standard of practice of the profession are serious and who is incompetent will not be permitted to remain a member of the profession.

Specific deterrence and rehabilitation are not relevant in this case, in that Dr. Martin will not practise medicine in Ontario or elsewhere in the future.

**Costs**

The Committee finds that this is an appropriate case to require Dr. Martin to pay costs to the College of $6,000.00 for a one-half day hearing.

**ORDER**

The Committee stated its finding of professional misconduct and incompetence in paragraphs 1 and 2 of its written order of September 25, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Martin appear before the panel to be reprimanded.

4. Dr. Martin pay to the College its costs of this proceeding in the amount of $6,000.00 within sixty (60) days from the date of this Order.

**TEXT of PUBLIC REPRIMAND**
**Delivered October 23, 2018**
**in the case of the**
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**
**AND**
**DR. JAMES SCOTT BRADLEY MARTIN**

Dr. Martin,

It is extremely regrettable that your career ends in this manner. Your undertaking to resign and never to practise medicine again reflects the magnitude of your failures.

- Failure to assess the mental state of young vulnerable patients who no doubt were struggling with life altering choices.

- Failure to give time for such patients to consider the implications of your advice.

- Failure to properly advise on the risks of medication which you prescribed.

You have no doubt caused considerable anguish not only to those patients but to their families as well.

In this specialized sensitive area of practice, patients expect and deserve considered, thoughtful guideline based care.