

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Frederick Thomas Bray, 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. Bray,
2019 ONCPSD 37**

**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. FREDERICK THOMAS BRAY

PANEL MEMBERS:
MR. P. GIROUX
DR. E. STANTON
DR. S. HUCKER
MS. C. TEBBUTT
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. ELISABETH WIDNER

COUNSEL FOR DR. BRAY:

MR. JEFF MUTTER

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. JENNIFER MCALEER

Hearing Date: June 18, 2019
Decision Date: June 18, 2019
Written Decision Date: August 12, 2019

PUBLICATION BAN

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 June 18, 2019. At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Frederick Thomas Bray committed an act of professional misconduct. In its Order, the Committee also set out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

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

- a) under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and
- b) 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. Bray 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. Bray admitted the allegations of professional misconduct 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, and that he has failed to maintain the standard of practice of the profession. The College withdrew the allegation of incompetence.

THE FACTS

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

BACKGROUND

1. Dr. Frederick Thomas Bray (“Dr. Bray”) is a 54-year old physician practising medicine in Ottawa, Ontario.
2. Dr. Bray received his medical degree at McGill University in 1989. He received his certificate of registration authorizing independent practice in Ontario in 1992. Dr. Bray received his specialist qualification in internal medicine in 1993 and in gastroenterology in 2000.
3. At the relevant times, Dr. Bray was the sole physician and the Medical Director of an Out-of-Hospital Premises (“OHP”), operating as “Frederick T. Bray Professional Medicine Corporation” in Ottawa, Ontario, providing gastroenterology services.

OVERVIEW OF THE CASE

4. The Out-of-Hospital Premises Inspection Program, “OHPIP”, is administered by the College and applies to all premises outside a hospital (“OHP premises”) that perform procedures involving the use of anesthesia or sedation as defined in O.Reg. 114/94, made under the *Medicine Act*, 1991, (“the Regulation”), attached at Tab A [to the Agreed Statement of Facts on Liability]. Part XI of the Regulation sets out the definition of “procedure” for the purposes of the OHPIP. The OHP program is based on trust and relies on self-reporting from Medical Directors and physicians.
5. Mandatory standards for OHP premises are set out in Program Standards (“the Standards”), authorized under the Regulation and attached at Tab B [to the Agreed Statement of Facts on Liability]. Pursuant to Standard 2.2, the Medical Director of an OHP is responsible for the

duties outlined in the Standards. In order to ensure patient safety and quality of care, strict adherence is required to the detailed requirements set out in the Standards.

6. As set out in Standard 3.2, “Anesthesia”, medications producing “deep sedation”, including propofol, “must be administered by a physician qualified to provide deep sedation”. This point is further clarified in Standard 5.3 that states that general anesthesia can only be administered by an anesthesiologist.
7. By letter dated May 17, 2016, sent to all Medical Directors of OHPs, including Dr. Bray, Dr. Steven Bodley, then-chair of the Premises Inspection Committee (“PIC”), reminded Medical Directors that OHP Standard 3.2 required that only a qualified anesthesiologist is permitted to administer propofol. Attached at Tab C [to the Agreed Statement of Facts on Liability] is a copy of the letter from PIC dated May 17, 2016.

DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

8. In contravention of Program Standards and his duties as Medical Director, Dr. Bray administered propofol to patients, in the absence of an anesthesiologist or any other physician qualified to administer propofol in accordance with the Standards.
9. On July 19, 2017, the OHPIP conducted an inspection-assessment of Dr. Bray’s OHP. The inspection–assessment included a review of the premises’ controlled substances storage and included review of the care provided by the premises to sedated patients. Attached at Tab D [to the Agreed Statement of Facts on Liability] is a copy of the inspection-assessment report dated July 19, 2017. Dr. Bray did not advise the assessors that he was using propofol despite the fact that the assessors reviewed his practices and procedures around sedation and controlled substances.
10. The College became aware of Dr. Bray’s use of propofol through an anonymous report made to the College on August 3, 2017. As a result of the report, the College conducted an unannounced visit on August 24, 2017, and verified that Dr. Bray was administering propofol to patients without an anesthesiologist.

11. Twenty-five (25) patient charts were obtained in the College investigation. The charts were reviewed by an expert retained by the College, Dr. Ted Xenodemetropoulos, a gastroenterologist, whose *curriculum vitae* is attached at Tab E [to the Agreed Statement of Facts on Liability]. As set out in Dr. Xenodemetropoulos' report, attached at Tab F [to the Agreed Statement of Facts on Liability], Dr. Bray administered propofol to eleven (11) patients in contravention of Program Standards, in the absence of an anesthesiologist. The relevant patient charts as set out in the report are: Charts 6, 7, 10, 12, 16, 17, 18, 21, 22, 24 and 25. (*Note: The parties agree that Dr. Xenodemetropoulos identified 11 patient charts where propofol was administered (charts 6, 7, 10, 12, 16, 17, 18, 21, 22, 24 and 25) and that Dr. Xenodemetropoulos' report contains a typographical error in his conclusion in referring to only 9 patient charts.)

FAILURE TO MAINTAIN STANDARD OF PRACTICE

12. In respect of the eleven (11) patients to whom propofol was administered by Dr. Bray in the absence of an anesthesiologist, Dr. Xenodemetropoulos opined that Dr. Bray failed to maintain the standard of practice in his administration of intravenous propofol as additional sedation during procedures and displayed a moderate lack of judgment both in his role as Medical Director of the OHP and as most responsible physician to the patients in question.

13. Dr. Xenodemetropoulos concluded that Dr. Bray's use of propofol did not result in an increased risk of harm or injury in a sedation-related adverse event to the patients.

ADMISSION

14. Dr. Bray admits the facts specified above, and admits that, based on these facts, he has:

- (a) 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; and
- (b) failed to maintain the standard of practice of the profession.

FINDINGS

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts on Liability. Having regard to these facts, the Committee found that Dr. Bray committed an act of professional misconduct 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 in that he has failed to maintain the standard of practice of the profession.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Bray made a joint submission as to an appropriate penalty and costs order, which included: suspending Dr. Bray's certificate of registration for a period of four months; a public reprimand; and payment of costs to the College in the amount of \$6,000.00.

In assessing the jointly proposed penalty, the Committee was guided by the basic principles underlying penalty orders, namely: protection of the public; specific deterrence of the member and general deterrence of the broader profession; maintenance of the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest; and where appropriate, rehabilitation of the member.

The Committee was also mindful of the public interest test set out by the Supreme Court of Canada in *R. v. Anthony-Cook*, 2016 SCC 43. According to this test, the Committee must accept a jointly proposed penalty, unless that penalty would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

In evaluating the penalty proposed, the Committee reviewed the Agreed Statement of Facts on Liability and prior cases of this Committee as provided in a Joint Book of Authorities. The Committee also considered factors in aggravation and mitigation of the penalty. The Committee accepted the joint submission as appropriate, for the reasons set out below.

Nature of the Misconduct

Dr. Bray contravened OHPIP program standards and disregarded his responsibilities as a medical director by administering propofol to patients in the absence of an anesthesiologist or other physician qualified to do so. The Committee is greatly concerned that Dr. Bray did not inform the OHPIP assessors of his clinic's use of propofol. Although the assessors reviewed with Dr. Bray his practices and procedures with respect to sedation and controlled substances, Dr. Bray did not inform them that he was using propofol. A subsequent unannounced visit to the premises prompted by an unannounced report to the College confirmed that Dr. Bray was administering propofol to patients without an anaesthesiologist present. This was confirmed by the College expert, Dr. Xenodemetropoulos, who found in 11 out of 25 charts reviewed that Dr. Bray had administered propofol.

Aggravating Factors

Dr. Bray was well aware of his responsibilities as an OHP medical director. In fact, in May 2016, Dr. Steven Bodley, then chair of the Premises Inspection Committee, advised all medical directors that only a qualified anaesthesiologist is permitted to administer propofol. The Committee is appalled that Dr. Bray disregarded the very OHPIP standards that he was entrusted to uphold as medical director. In doing so, Dr. Bray failed to maintain the standard of practice of the profession. The Committee found that members would view Dr. Bray's conduct in failing to inform OHPIP assessors of his use of propofol and contravening OHP Program Standards, as disgraceful, dishonourable or unprofessional.

Mitigating Factors

Dr. Bray's admission to the misconduct and agreement to proceed with a joint submission on penalty saved the time and expense of a contested hearing and avoided the need for witnesses to testify. The Committee also noted that Dr. Bray has no prior history before the Discipline Committee.

Prior Cases

The Committee was provided with a Joint Book of Authorities containing two prior decisions of this Committee. While previous decisions of the Discipline Committee may serve as a guide in assessing the appropriateness of the penalty proposed, the Committee recognizes that no two cases are identical and the Committee is not bound by its prior decisions. The Committee does, however, accept as a principle of fairness that like cases should be treated alike.

In *CPSO v. Bélanger*, 2018 ONCPSD 18, the Committee found that Dr. Bélanger engaged in disgraceful, dishonourable, or unprofessional conduct. Specifically, Dr. Bélanger was found to be performing Level 2 procedures (i.e., those performed using IV sedation, regional anesthesia and tumescent anesthesia) at a clinic that had never been inspected under the College's Out-of-Hospital Premises Inspection Program ("OHPIP"), and did not meet program requirements. The Committee ordered a five-month suspension of Dr. Bélanger's certificate of registration, a reprimand, and the imposition of terms, conditions and limitations on his certificate of registration, including completion of educational training in ethics and professionalism and approval by the College's OHPIP prior to resuming his role as medical director of the clinic. Dr. Bélanger was also ordered to pay hearing costs to the College.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Kesarwani*, 2018 ONCPSD, Dr. Kesarwani was found to have engaged in disgraceful, dishonourable, or unprofessional conduct. Dr. Kesarwani informed OHPIP staff that he had relocated to a new location and since the move, had only been performing Botox injections, which do not fall within the purview of the OHPIP. At a subsequent unannounced visit by OHPIP staff, when asked for controlled substances records and surgical logs, Dr. Kesarwani acknowledged that he had in fact been performing out-of-hospital premises (OHP) procedures at the new location and had not disclosed this to the College's OHPIP as required. The Committee ordered a three-month suspension of Dr. Kesarwani's certificate of registration, a reprimand, and the imposition of terms, conditions and limitations on his certificate of registration, including completion of educational training in ethics and professionalism and approval by the College's OHPIP prior to resuming his role as

medical director of the clinic. Dr. Kesarwani was also ordered to pay hearing costs to the College.

The Committee found that the penalty proposed by the parties fell within the range of penalties imposed in similar cases.

Conclusion

The Committee accepted the parties' joint submission on penalty as an appropriate penalty in the circumstances of this case. A four-month suspension of Dr. Bray's certificate of registration and public reprimand act as specific and general deterrents, and emphasize to Dr. Bray and other members of the profession that this type of misconduct will not be tolerated. The Committee also concluded that this was an appropriate case in which to require Dr. Bray to pay costs.

ORDER

The Committee stated its findings in paragraph 1 of its written order of June 18, 2019. In its Order, the Committee ordered and directed on the matter of penalty and costs that:

1. The Registrar suspend Dr. Bray's certificate of registration for a period of four (4) months, commencing at 12:01 a.m. on June 19, 2019.
2. Dr. Bray attend before the panel to be reprimanded.
3. Dr. Bray pay costs to the College in the amount of \$6,000.00 within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Bray 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 June 18th, 2019
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. Federick Thomas Bray

Dr. Bray,

Individuals who are members of a self-governing profession, such as lawyers, accountants, architects and physicians, all have agreed to establish organizations that regulate their respective professions in the public interest. In those instances where a professional wilfully or otherwise chooses to ignore the rules and regulations of their governing body, this can result in adverse consequences to the public.

For a physician who ignores specific practice regulations, the patient may end up suffering significant harm or worse. Fortunately for you, your conduct did not result in any harm to patients. Your hubris in administering Propofol in an unapproved setting was for your own convenience. As a medical director and sole practitioner in your clinic, you were aware and had the obligation to ensure that a qualified anaesthesiologist administered Propofol. By contravening program standards you showed a lack of judgment.

The suspension of your Certificate of regulation (sic) for four months will send a signal that the College takes seriously this failure to maintain the Standard of Practice of the profession. It also confirms that the College will take the appropriate steps to protect the public.

We acknowledge you closed your clinic and are no longer acting as a medical director. We trust that this experience will be a guide to your future behaviour once you've resumed your professional activities. You may be seated.