NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Jennifer Margaret Armstrong, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name or any information that could identify the patient 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.

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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. JENNIFER MARGARET ARMSTRONG

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
D. DOHERTY
DR. M. DAVIE
S. BERI
DR. C. CLAPPERTON

Hearing Date: December 15, 2014
Decision Date: December 15, 2014
Release of Written Reasons: January 16, 2015

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario (the "College") heard this matter at Toronto on December 15, 2014. At the conclusion of the hearing, the Committee stated its finding orally 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. Armstrong 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 she has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Armstrong 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 ALLEGATIONS

Dr. Armstrong admitted the first allegation in the Notice of Hearing, that she failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence in the Notice of Hearing.

THE FACTS

The following facts were set out in an Agreed Statement of Facts that was filed as an exhibit and presented to the Committee:

PART I – FACTS

1. Dr. Armstrong is a general practitioner with a special interest and additional training in environmental medicine. She received her MD from the University of Toronto in 1977 and has held a certificate of registration authorising independent practice from the College since January, 1986. She has focused her practice on environmental medicine since about 1997. She is a board member of the Environmental Health Association of Ontario (the "EHA-O").

Patient A

2. Patient A was 19 years old at the time Dr. Armstrong met and treated her. Patient A had previously been treated by environmental care practitioners. She had had two previous suicide attempts and several prior hospitalisations.

Dr. Armstrong's Involvement with Hospital 1 (the "Hospital")

3. In November, 2010, Patient A was involuntarily admitted to the Hospital on a Form 1. In November 2010 Patient A's mother sent an email to the EHA-O with respect to Patient A's admission to the Hospital. The email explained that the "ER physician formed [Patient A]", and that the Hospital was concerned about some "bizarre behaviour" on the part of Patient A, and her ability to manage her own care and safety.

4. In the email Patient A's mother advised that Patient A had previously been diagnosed with Multiple Chemical Sensitivities ("MCS") but that this diagnosis was not being recognized nor was Patient A being treated for MCS at the hospital. Patient A's mother sought the assistance of the EHA-O "to help [Patient A] get out of there and into a safe environment". A copy of Patient A's mother's email to the EHA-O is attached at Tab 1 [To the Agreed Statement of Facts].

5. As a result of receiving the email, Dr. Armstrong attended at the Hospital in November 2010, in her capacity as a board member of the EHA-O, along with two

other board members. They met with the Chief of Staff with respect to Patient A and provided information on environmental illness and chemical sensitivities by the Ontario College of Family Physicians (Environmental Health Committee). Dr. Armstrong did not provide medical treatment to Patient A at that time, nor did she have access to any of Patient A's records.

6. After her meeting with the Hospital, Dr. Armstrong had an email exchange with Patient A's mother in which Dr. Armstrong referred to the physicians with whom she had met as "not too bright". A copy of this email is attached at Tab 2 [To the Agreed Statement of Facts].

7. Patient A had originally been hospitalised involuntarily on a "Form 1". Once her status was changed to voluntary, she and her mother signed her out against medical advice. This occurred in November 2010.

Dr. Armstrong's Treatment of Patient A

8. In December 2010, Patient A attended on Dr. Armstrong for the first time. Dr. Armstrong noted that Patient A did not currently have a family doctor. Patient A's mother indicated that physicians who had been approached had refused to take her on as a patient.

9. At Patient A's first appointment with Dr. Armstrong in December 2010, Patient A's mother provided a summary of Patient A's medical history, including a history of cognitive decline and seizures. Patient A's mother reported that Patient A had been treated by a physician practising environmental medicine in the past and had improved considerably. In addition to the recent Form 1 stay at the hospital of which Dr. Armstrong was aware, Patient A's mother also reported Patient A's previous suicide attempts and hospitalisations in about January, 2009 and June, 2010.

10. Patient A attended on Dr. Armstrong in December 2010, January 2011 and April 2011. On each occasion, in assessing Patient A, Dr. Armstrong failed to perform

any mental health assessments. Dr. Armstrong recommended a regime of IV Vitamins which were administered between December 2010 and April 2011. Dr. Armstrong also treated Patient A with minerals and amino acids and lowered Patient A's thyroid medication in response to tests.

11. Dr. Armstrong did not see Patient A again after April 2011, although Patient A's siblings continued to see her for several more months. In May, 2011, Dr. Armstrong subsequently learned that Patient A committed suicide.

12. The College received a report about Patient A's death from the Office of the Chief Coroner in September, 2012, and commenced an investigation into Dr. Armstrong's care of Patient A on the basis of that report. Patient A's mother did not complain to the College.

Dr. Armstrong Failed to Maintain the Standard of Practice

13. Dr. Armstrong took no steps to investigate or treat Patient A's mental health issues. Nor did she take any steps to assist Patient A in finding a primary care physician or other specialist. Dr. Armstrong did not refer Patient A to a psychiatrist, psychologist or other mental health professional. Patient A did not find a family physician.

14. The College retained Dr. X to provide an opinion on the standard of care provided by Dr. Armstrong to Patient A. Dr. X concluded that Dr. Armstrong's care and treatment of Patient A failed to maintain the standard of practice of the profession and opined as follows:

> There were no conventional treatments offered or documented for her psychiatric symptoms. Patient was not treated for her psychiatric symptoms by another physician according to the chart. Dr. Armstrong did not refer this patient to another physician for the psychiatric symptoms or her seizures. The patient did not have a family physician. Instead, Dr. Armstrong concentrated on giving vitamins, minerals and amino acids, which are not the standard of care. Her focus regarding this patient was on chemical sensitivities and metal toxicities…

PART II - ADMISSION

15. Dr. Armstrong admits the facts in paragraphs 1 to 14 above.

16. Dr. Armstrong admits that she has committed an act of professional misconduct as provided by Ontario Regulation 856/93 made under the Medicine Act, 1991, in that by the conduct set out above she failed to maintain the standard of practice of the profession.

FINDING

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

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order, the terms of which are, in summary form:

(i) that Dr. Armstrong receive a reprimand;

(ii) that terms, conditions and limitations be placed on Dr. Armstrong's certificate of registration, including, but not limited to:

(a) clinical supervision and a reassessment of her practice in accordance with the terms of an undertaking signed by Dr. Armstrong;

(b) that Dr. Armstrong require all of her patients to have a family physician or certified specialist who will provide concurrent care and update Dr. Armstrong and that Dr. Armstrong will cease treating any of her current patients who have not arranged for concurrent care by January 31, 2015; and,

(c) that a sign be posted in Dr. Armstrong's office to advise patients of the requirements in (b); and,

(iii) that Dr. Armstrong pay costs to the College in the amount of $4,460.00.

The law is clear that where the parties make a joint submission, the Committee should not reject such a proposal unless the penalty proposed is so disproportionate to the finding that it would be contrary to the public interest and bring the administration of justice into disrepute. In considering the jointly proposed penalty, the Committee was mindful of the principles which underlie the crafting of a suitable disciplinary penalty, including: protection of the public, specific and general deterrence, the need to maintain the integrity of the medical profession and public confidence in its ability to self-regulate and wherever possible, rehabilitation of the physician. In order to achieve this, each case must be considered on its own specific facts in light of the misconduct. The Committee also considered other mitigating factors, as set out below.

The Committee reviewed carefully the evidence before it in considering the jointly proposed penalty. The Committee did not have evidence before it regarding environmental health assessment and treatment modalities. However, the Agreed Statement of Facts which was presented to the Committee included an excerpt of the expert opinion of Dr. X, who was retained to provide an opinion on the standard of care provided by Dr. Armstrong to Patient A. Dr. X concluded that Dr. Armstrong's care and treatment of Patient A failed to maintain the standard of care of the profession in that, among other things, there were no conventional treatments offered or documented for the patient's psychiatric symptoms, the patient was not treated for these symptoms by another physician (and did not have a family physician) and Dr. Armstrong did not refer the patient to another physician for these symptoms. Instead, Dr. X described that Dr. Armstrong concentrated on giving vitamins, minerals and amino acids which are not the standard of care.

The Committee was concerned that while Dr. Armstrong has a specific interest in a particular area of medicine, she failed as a general practitioner to consider the patient's

needs as a whole. General practitioners, if unable to provide care in a certain area, must refer for assistance. The Committee is confident that an order specifying that Dr. Armstrong only see patients who are also under the care of a family physician or appropriate specialist will ensure the protection of the patients in Dr. Armstrong's care in the future, and maintain the public's trust in the medical profession's ability to self-regulate.

Counsel for the College provided the Committee with the College's Policy Statement #3-11, Complementary/Alternative Medicine, for review. The Committee was advised that Dr. Armstrong intends to only provide complementary medicine and does not intend to carry on a general practice. Dr. Armstrong has undertaken to practise under supervision for one year and will undergo reassessment of her practice six to nine months after the completion of the supervision. The proposed terms, conditions and limitations on Dr. Armstrong's certificate of registration, by way of an undertaking with the College, will ensure that another physician is involved in the care of Dr. Armstrong's patients in the future.

Dr. Armstrong failed to maintain the standard of the profession by, among other things, failing to refer Patient A to another physician, and should be reprimanded. A reprimand will allow the Committee to denounce her conduct and send a message to the membership at large that there is an expected standard to which all physicians must practise and failure to meet such standards is not acceptable.

The Committee acknowledges the mitigating factors, namely Dr. Armstrong's admission and cooperation with the College by way of the Agreed Statement of Facts and Joint Submission on Penalty, and the fact that this case is her first appearance before the Discipline Committee.

Counsel for the College provided three cases for the Committee to review as it considered the appropriateness of the proposed penalty: *Haines, Sheffield* and *Drake*. While no two cases are alike and all cases must be considered on their own unique set of facts, these cases illustrate for the Committee that the proposed penalty (namely, a reprimand

together with terms, conditions and limitations on Dr. Armstrong's certificate of registration), is not inconsistent with the penalties imposed in other similar cases.

The Committee has the jurisdiction to award costs where appropriate. In this case, the Committee found that the order of costs of $4,460 to the College, representing a partial recovery on the costs of conducing the hearing, is appropriate. In the Committee's view, the cost of the hearing should be at least in part the responsibility of the member and not borne solely by the membership as a whole.

ORDER

The Discipline Committee delivered its finding and penalty and costs order at the conclusion of the hearing on December 15, 2014, the terms of which are the following:

1. The Discipline Committee finds that Dr. Armstrong has committed an act of professional misconduct under paragraph 191)2 of Ontario regulation 856/93 made under the *Medicine Act, 1991* ("o. reg. 856/93") in that she has failed to maintain the standard of practice of the profession in respect of Patient A.

2. The Discipline Committee orders Dr. Armstrong to appear before the panel to be reprimanded.

3. The Discipline Committee directs the Registrar to impose the following terms, conditions and limitations on Dr. Armstrong's certificate of registration:

   (a) Dr. Armstrong shall engage in clinical supervision and a reassessment of her practice in accordance with the terms of her undertaking, attached to this Order;

   (b) Effective immediately, Dr. Armstrong will require that all of her current patients have a family physician or certified specialist who will provide concurrent care and to whom she will send information about all treatment she initiates or she has initiated and any changes to that treatment that she

provides to the patient. Dr. Armstrong will provide each of her current patients (ie. patients of hers as of the date of this Undertaking) with a period of 45 days to obtain care from a primary care physician or appropriate specialist, and will not take on any new patient who does not have a primary care physician or appropriate specialist. Dr. Armstrong will cease treating any of her current patients who have not arranged concurrent care as set out above by January 31, 2015; and

(c) Dr. Armstrong shall post a sign in her waiting room and each of her examination rooms, in each of her practice locations, in a clearly visible location, that states: *"I require that all of my current patients have a family physician or certified specialist who will provide concurrent care and to whom I will send information about all treatment I initiate or have initiated and any changes to that treatment that I provide to our shared patient. I will provide each current patient with a period of 45 days from December 15, 2014 to obtain care from a primary care physician or appropriate specialist, and will not take on any new patient who does not have a primary care physician or appropriate specialist. I will cease treating any current patient who has not arranged concurrent care as set out above by January 31 2015."*

4**.** The Discipline Committee orders Dr. Armstrong to pay costs to the College in the amount of $4,460.00 within 60 days of the date of this Order.

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

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THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. JENNIFER MARGARET ARMSTRONG

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
D. DOHERTY
DR. M. DAVIE
S. BERI
DR. C. CLAPPERTON

Hearing Date: December 15, 2014
Decision Date: December 15, 2014
Reprimand Date: December 15, 2014
Release of Written Reasons: January 16, 2015

PUBLICATION BAN

TEXT of PUBLIC REPRIMAND
Delivered December 15, 2014
in the case of the
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
and
DR. JENNIFER MARGARET ARMSTRONG

Dr. Armstrong, the public expects that the medical profession maintain high standards, which provides appropriate care and protection of patients. The practice of medicine is a privilege. Patients place their trust in us to care for their overall health and wellbeing.

And when we, as practitioners, specialize in one area of medicine, we must ensure that we are part of a team and not act in a vacuum. Your failure to address your patient's needs in a comprehensive way contributed to serious consequences.

Your practice now will be severely restricted and supervised. And, we expect that you will adhere to the College's Policy 3-11 on Complementary Medicine. And, we trust that you have learned from this process and you will not be before us again. You may be seated.