NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Pinto, this is notice that the Discipline Committee ordered a ban on the publication or broadcasting of the names or any information that could disclose the identity of patients, and any information that could identify them, referred to orally or in the exhibits filed at the hearing. subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the Regulated Health Professions Act, 1991.

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

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

Indexed as: **Ontario (College of Physicians and Surgeons of Ontario) v. Pinto, 2017 ONCPSD 5**

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

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. CHRISTOPHER PINTO

PANEL MEMBERS:

DR. W. KING (CHAIR)
MS. D. DOHERTY
DR. P. POLDRE
MR. P. GIROUX
DR. W. MCCREADY

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. A. BLOCK

COUNSEL FOR DR. PINTO:

MR. J. FREEDLANDER
MR. A. MATHESON

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Hearing Date: **December 19, 2016**
Decision Date: **December 19, 2016**
Release of Reasons Date: **February 9, 2017**

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 December 19, 2016. At the conclusion of the hearing, the Committee stated its finding that Dr. Pinto committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATION

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

1. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO THE ALLEGATION

Dr. Pinto admitted the allegation 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.

THE FACTS

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

PART I - FACTS

1. Dr. Christopher Pinto ("Dr. Pinto") received a certificate of registration authorizing independent practice in Ontario in 1975. He practises family medicine in Toronto, Ontario.

A. The Inquires Complaints and Reports Committee Ordered a Specified Continuing Education Program

2. On April 23, 2014, the Inquiries, Complaints and Reports Committee ("ICRC") considered a complaint that Dr. Pinto failed to administer his office practice in an appropriate manner by failing to provide a patient's medical records to the Workers Safety Insurance Board ("WSIB") when requested by both the WSIB and the complainant.

3. The ICRC identified a number of concerns when it considered the complaint:

- Dr. Pinto's response to the complaint was that he was unable to find the requested records. Dr. Pinto is required to maintain an adult patient's chart for 10 years from the date of the last entry into the record. He therefore ought to have had the records available when they were requested of him in 2008;

- Dr. Pinto maintained he could not find the records. This is unacceptable, as it is a physician's responsibility to maintain records safely. If Dr. Pinto could not find the file, as he claimed, he should have told this to his patient and the WSIB in a timely fashion;

- Dr. Pinto's response to the WSIB requests for timely information was dismissive, and may have had a deleterious effect on his patient's welfare.

4. The ICRC disposed of the complaint by requiring Dr. Pinto to attend the College to be cautioned and to require him to undertake a specified continuing education and

remediation program (a "SCERP"). A copy of the ICRC Decision is attached at Tab 1 of the Agreed Statement of Facts and Admission.

5. The SCERP ordered by the ICRC requires Dr. Pinto to:

- engage in focused educational sessions with a preceptor acceptable to the College in the topic of office practice and management.
- maintain a log of requests for documentation throughout the preceptorship, noting all request details, dates of requests and responses to the requests.
- undergo a reassessment which will consist of a review of office practice and management approximately six months following the completion of the preceptorship.

6. It is Dr. Pinto's responsibility to engage a preceptor acceptable to the College to complete the SCERP.

7. Dr. Pinto appealed the decision to the Health Professions Appeal and Review Board ("HPARB"). In a decision dated May 12, 2015 attached at Tab 2 of the Agreed Statement of Facts and Admission, HPARB confirmed the ICRC's decision.

B. Dr. Pinto Failed to Comply with the SCERP

8. Following the release of HPARB's decision, commencing June 2, 2015, the College's Compliance Case Manager requested that Dr. Pinto propose the name of a preceptor for College approval so that Dr. Pinto could engage in the educational sessions ordered by the ICRC.

9. Dr. Pinto proposed potential preceptors on June 22, and then on August 7 and August 12, 2015. The proposed preceptors were either unacceptable to the College or unwilling to perform the task requested.

10. The Compliance Case Manager wrote to Dr. Pinto, through his counsel, on August 27, 2015 requesting that Dr. Pinto follow-up with a potential proposed preceptor. Dr. Pinto, through his counsel, indicated he would follow up. The Compliance Case Manager heard nothing further regarding this preceptor.

11. The Compliance Case Manager wrote to Dr. Pinto, through his counsel, on September 14 and September 23, 2015 requesting an update. The College received no response for some time.

12. On November 10, 2015, Dr. Pinto, through his counsel, was advised that if he did not provide the name of a preceptor by November 18, 2015, the Compliance Case Manager would bring this matter to the attention of the ICRC to consider his non-compliance with the SCERP.

13. On November 16, 2015, Dr. Pinto proposed another preceptor. However, the proposed preceptor had not been approached by Dr. Pinto and ultimately, did not agree to act as preceptor.

14. The ICRC considered Dr. Pinto's failure to comply with the SCERP on February 10, 2016. Dr. Pinto had still not obtained a preceptor by that time. The ICRC referred allegations of professional misconduct to the Discipline Committee.

15. An additional preceptor was not proposed by Dr. Pinto until March 17, 2016, after allegations of professional misconduct were referred to the Discipline Committee.

16. On April 25, 2016, the College finally received an executed undertaking from an acceptable preceptor (attached at Tab 3 of the Agreed Statement of Facts and Admission), almost one year after HPARB confirmed the ICRC's SCERP.

17. Dr. Pinto's preceptor provided a report to the College on August 15, 2016. In reviewing Dr. Pinto's record management system, he noted that Dr. Pinto has failed

to maintain a log of requests for documentation (noting all request details, dates of requests and responses to the requests) as required in the ICRC's Order, referred to in paragraph 5 above. Dr. Pinto had begun to create an electronic log but it was not complete and did not contain the required information.

PART II - ADMISSION

18. Dr. Pinto admits the facts contained in paragraphs 1-17 of this Agreed Statement of Facts and admits that he 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 by failing to comply with the April 2014 order of the ICRC requiring that he complete a SCERP by:

(a) failing to engage a preceptor acceptable to the College in a timely fashion; and

(b) failing to maintain a complete log of requests for documentation throughout the preceptorship, noting all request details, dates of requests and responses to the requests.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee found that Dr. Pinto 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.

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 proposed penalty order consisted of a reprimand and costs payable to the College of $5,000.00 within 30 days of the order.

In considering the proposed penalty order, the Committee was mindful of the well-established principles applicable to the imposition of an appropriate penalty. These include protection of the public, maintenance of public confidence in the College's ability to regulate the profession in the public interest, denunciation of the misconduct, specific deterrence of the member and general deterrence of the profession. The penalty must also consider the potential for rehabilitation of the member, when appropriate.

The Committee was also aware of the Supreme Court's direction that a joint submission on penalty should be accepted unless the proposed penalty would bring the administration of justice into disrepute or is otherwise not in the public interest.

The Committee accepted the proposed penalty as an appropriate sanction and found that it was proportional to the misconduct in this matter. The reasons for the Committee's decision are enunciated below.

Analysis

Nature of the Misconduct

The Committee limited its analysis of Dr. Pinto's misconduct to the period of time after the May 12, 2015 HPARB decision, which confirmed the decision of the College's ICRC. Dr. Pinto's professional misconduct was discrete and related to his failure to comply with the SCERP order to find an acceptable preceptor and to maintain a log of requests for documentation throughout the preceptorship.

The Committee viewed Dr. Pinto's efforts from May 2015 onward as half-hearted. For example, submitting the name of preceptor without having secured that person's consent to act as a preceptor struck the Committee as unprofessional. In addition, the College's compliance case manager's request for follow-up on August 27, 2015 did not generate a response until November 10, 2015, despite an indication after the August request that follow-up would be forthcoming. When that proposed preceptor was not acceptable to the College, Dr. Pinto did not propose another preceptor until March 17,

2016. By that time, the matter had been referred to the Discipline Committee by the ICRC. The Committee found that this sequence of events demonstrated a lack of respect for the College.

Mitigating Factors

The Committee recognized that Dr. Pinto's actions in admitting his misconduct should be considered a mitigating factor. This saved the need for witnesses to testify and saved the College the expense of a fully-contested hearing.

In addition, the Committee noted that this was the first time that Dr. Pinto has come before the Discipline Committee.

Case Law

The case law cited below illustrates a range of appropriate penalties consistent with the penalty proposed by the parties.

In *CPSO v. Tadros (2010),* the member failed to comply with the College's request for transcriptions of 23 illegible patient charts. After a period of five months, only two chart transcriptions were delivered. The final remaining transcriptions were available to the College after another two months. In this case, the penalty was a reprimand and costs for a one-day hearing.

The Committee found this case to be most similar to that of the case before it. The total time of the delay was approximately the same. The absence of a previous discipline history and the member's admission of misconduct as mitigating factors mirrored the case of Dr. Pinto.

In *CPSO v. Portugal (2010),* the member did not provide a patient with copies of his medical records despite 13 requests over a two-year period. Furthermore, Dr. Portugal had demonstrated a pattern of similar misconduct over a period of 12 years related to his failure to provide medical records. As a mitigating factor, the Committee noted that by

cooperating with the College in the discipline matter, the time and expense of a contested hearing had been avoided. The penalty for Dr. Portugal was a reprimand, costs for a one-day hearing, and a one-month suspension of his certificate of registration, to be suspended if he implemented the advice of an organization/efficiency expert to improve his office management. The penalty also included successful completion of the College's Medical Ethics and Informed Consent Course.

The Committee reviewed Dr. Portugal's case and noted that the penalty was similar to that proposed for Dr. Pinto, as the one-month suspension from practice was suspended upon the member's compliance with prescribed terms and conditions.

In *CPSO v. Lowe (2015)*, the member breached an undertaking to complete a communications course. After repeated efforts by a College compliance monitor to have the course completed were unsuccessful, the matter was referred to the Discipline Committee. Dr. Lowe failed to appear before the Discipline Committee. At a second Discipline hearing, the penalty was a reprimand and costs for two hearing days.

In its review of Dr. Lowe's case, the Committee noted that the failure to comply related to one discrete issue, as did the matter of Dr. Pinto, and that a reprimand was considered appropriate.

In *CPSO v. Achiume (2015)*, the member failed to comply with an ICRC-ordered SCERP regarding medical record-keeping for over three years. As an aggravating factor, Dr. Achiume had three prior Discipline Committee findings against him. His penalty included a reprimand, costs associated with a one-day hearing, and a suspension that was suspended if he completed the required SCERP.

In comparison to the matter under consideration, the Committee concluded that the Achiume case demonstrated a longer period of non-compliance. Furthermore, the multiple prior Discipline Committee findings represented a serious aggravating factor.

Conclusion

The Committee concluded that the penalty proposed by the parties represented an appropriate sanction, given all of the circumstances in this matter and when reviewed in the context of the cases presented.

Having regard to the misconduct described above, the Committee agreed that a reprimand would denounce Dr. Pinto's misconduct as well as provide specific deterrence for the member as well as serving as a general deterrent to the profession as a whole.

The Committee recognized that as Dr. Pinto now has an acceptable preceptor and is implementing a system for documenting requests for medical records, measures to protect the public are underway.

Ordering the costs of a one-day hearing as partial recovery of costs of the Committee and legal counsel is appropriate, fair, and reasonable in the circumstances.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1of its written order of December 19, 2016. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Pinto appear before the panel to be reprimanded.

3. Dr. Pinto pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date this Order.

At the conclusion of the hearing, Dr. Pinto 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 December 19, 2016
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
AND
DR. CHRISTOPHER PINTO

Dr. Pinto, the people of Ontario, through their government have granted the College of Physicians and Surgeons the duty and the privilege of regulating the medical profession in the public interest.

Likewise membership in the College is a privilege which must not be under rated. It is the duty of members to comply with orders of the College, complete in every particular and in a timely fashion. Your efforts at compliance were half-hearted at best and demonstrated a lack of respect for your governing body. For example, submitting the name of preceptor without having contacted him or her to ensure willingness is hard to characterize as "best efforts".

Moreover the periods of apparent inactivity from September to November 2015 and then from November 2015 to March 2016 are inexcusable.

Indeed it appears that the only stimuli that lead to action on your part was the referral to discipline. It would be a sorry state of affairs if every order of the ICRC could only be resolved by referral for professional misconduct.

While it may be unrealistic to expect that the discipline process will change your attitude, we fervently hope that it will at least change your behaviour.