

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Gerry Adrianes Heymans, 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. Heymans,  
2018 ONCPSD 57**

**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. GERRY ADRIANES HEYMANS**

**PANEL MEMBERS:**  
**MR. P. GIROUX (CHAIR)**  
**DR. P. CASOLA**  
**DR. E. SAMSON**  
**MAJOR A. H. KHALIFA**  
**DR. P. ZITER**

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**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MS Z. LEVY**

**PUBLICATION BAN**

**Hearing Date:** October 12, 2018  
**Decision Date:** October 12, 2018  
**Release of Reasons Date:** November 9, 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 October 12, 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. The Order set out the Committee’s penalty and costs order with written reasons to follow.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Gerry Adrianes Heymans committed an act of professional misconduct:

1. under clause 51(1)(b.1) of the Health Professions Procedural Code which is schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the “Code”) in that he engaged in sexual abuse of a patient;
2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, 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 ALLEGATIONS**

Dr. Heymans admitted allegation 2 in the Notice of Hearing, that he 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. Counsel for the College withdrew allegation 1.

## **THE FACTS**

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

### **PART I - FACTS**

#### ***A. Background***

1. Dr. Gerry Adrianes Heymans (“Dr. Heymans”) is a 65 year old physician, practising family medicine in Ontario. Dr. Heymans received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on March 13, 1980.
2. At all relevant times, Dr. Heymans held privileges at a Hospital (the “Hospital”), in Ontario. Dr. Heymans resigned his hospital privileges on October 5, 2018. Dr. Heymans currently practices at Russell Meadows Retirement Community.

#### ***B. Patient A: Disgraceful, dishonourable or unprofessional conduct***

3. On a date in February 2015, around 12:25 p.m., Patient A arrived by ambulance at the Hospital’s Emergency Department. Patient A had been suffering from severe abdominal pain for around twenty-four (24) hours. Patient A was put into an Emergency room. She underwent x-rays and a CT scan. A physician, who was a member of the surgical team, later attended the Emergency room and examined Patient A’s abdomen. The physician told Patient A that she had a bowel obstruction and would be staying in the hospital overnight.
4. Later that evening, Dr. Heymans, attended on Patient A for further examination. As the patient’s family physician did not have privileges at the hospital, Dr. Heymans was assigned as the most responsible physician (MRP) for the admission. This was Patient A’s

first encounter with Dr. Heymans that day. According to Patient A, she had never been treated by Dr. Heymans in the past.

5. When Dr. Heymans came into the Emergency cubicle, Patient A was lying in a hospital bed. She was wearing only a hospital gown on her upper body, tied at the neck, and wearing underwear on her lower body. Patient A had a hospital blanket covering her legs and lower body. This blanket was pulled up above her waist.
6. Dr. Heymans introduced himself to Patient A and advised her that she would be admitted to hospital due to a bowel obstruction. He was standing up, leaning against a wall. While he was speaking to Patient A, and while still standing, Dr. Heymans fell asleep. After a short period of time, he woke up and continued talking to Patient A. According to Dr. Heymans, he apologized to Patient A and told her that it had been a long day.
7. Shortly thereafter, Dr. Heymans went over to Patient A and sat down on the side of the bed. He asked Patient A about her medical history. He appeared to fall asleep again during this encounter.
8. Dr. Heymans told the patient he was going to examine her and lowered the hospital blanket that was covering Patient A and lifted the hospital gown. After examining Patient A's abdomen, Dr. Heymans then proceeded to examine Patient A's breasts. Dr. Heymans documented the breast examination in Patient A's medical records.
9. Prior to examining Patient A's breasts, Dr. Heymans did not:
  - Explain to Patient A what he was doing and why he was conducting the exam;
  - Explain the steps involved;
  - Ascertain whether Patient A was comfortable with the steps involved; and
  - Ascertain whether Patient A consented to the exam.

According to Patient A, she felt violated and confused, responded to Dr. Heymans by saying “my breasts are just fine,” and pulled the hospital gown down.

10. Dr. Heymans explained to Patient A that she was going to be moved from Emergency to a room on a ward upstairs. He then left.
11. The next day, Patient A learned that Dr. Heymans would continue to provide care to her. Patient A was very upset by this. Patient A told a nurse that she did not want Dr. Heymans to continue to provide her care. The nurse told Patient A she did not have the ability to choose her physician while admitted at the hospital. Prior to Patient A’s discharge, Dr. Heymans was not informed of this information.
12. Patient A was discharged from the Hospital on a date in February, 2015. Dr. Heymans saw Patient A on each day she was admitted, except for the day she was discharged.

## **PART II – ADMISSION**

13. Dr. Heymans admits the facts above in paragraphs 1 to 12.
14. Dr. Heymans admits that the conduct set above constitutes professional misconduct, and admits specifically that his conduct constitutes 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, contrary to paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 (“O. Reg. 856/93”)

## **FINDING**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts on Liability. Having regard to these facts, the Committee accepted Dr. Heymans’ admission and found that he 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.

## **AGREED STATEMENT OF FACTS ON PENALTY**

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

### **PART I – FACTS**

#### **A. Relevant Undertakings**

1. On October 16, 2017, Dr. Heymans entered into a voluntary undertaking in lieu of an order under section 25.4 of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act*, S.O. 1991, C-18. A copy of the undertaking is attached at Tab 1 [to the Agreed Statement of Facts on Penalty].
2. Dr. Heymans entered into the undertaking after the College received the complaint that is the subject matter of these proceedings.
3. Dr. Heymans is also subject to a prior undertaking with the College, entered into on March 8, 2013. The undertaking arose from an inquiry that was initiated after the College received reports from colleagues who expressed concerns that Dr. Heymans appeared overly tired and had a tendency to experience drowsiness while seeing patients. Dr. Heymans entered into the undertaking, which certified (among other things) that he would:
  - a. not engage in direct patient care for more than forty five (45) hours per week; and
  - b. not work any overnight shifts.

A copy of the undertaking dated March 8, 2013 is attached at Tab 2 [to the Agreed Statement of Facts on Penalty].

**B. Prior History**

4. In December 2011, a patient alleged that Dr. Heymans had given her a hug while in the examining room. The Inquiries Complaints and Reports Committee (the “ICRC”) issued a written caution and directed a Specified Continuing Education or Remediation Program (a “SCERP”) under which Dr. Heymans was to complete the Understanding Boundaries Course. Dr. Heymans successfully completed the course on October 18 and 19, 2013. A copy of the ICRC decision is attached at Tab 3 [to the Agreed Statement of Facts on Penalty].
5. In May 2015, following the patient encounter that gave rise to these proceedings, the College conducted inquiries relating to Dr. Heymans’ sleep disorder. Dr. Heymans had been diagnosed with obstructive sleep apnea in 2001. In November 2015, as part of the College inquiries, Dr. Heymans agreed to undergo a sleep study that resulted in enhanced measures to assist Dr. Heymans with his sleep disorder. Since that time, Dr. Heymans and his sleep specialist have reported, to the College’s satisfaction, that Dr. Heymans’ sleep disorder has been well managed since the enhanced measures are in place.
6. Dr. Heymans has no prior history with the Discipline Committee.

**C. Changes to Practice**

7. In the Spring of 2015, following the complaint that gives rise to these proceedings, Dr. Heymans elected to cease responsibility as the “Most Responsible Physician” (MRP) for orphan patients at the Hospital (the “Hospital”).
8. In 2017, Dr. Heymans elected to take a leave of absence from the Hospital, including shifts in the Emergency Department, the skin clinic and ceased to follow his own patients who were admitted to hospital.



9. In May 2018, Dr. Heymans decided to further limit his practice by closing his primary care practice.
10. On October 15, 2018, Dr. Heymans resigned his hospital privileges at the Hospital.
11. Dr. Heymans' current practice is limited to the provision of care in retirement homes and long-term care facilities as set out in the Agreed Statement of Facts on Liability.

## **PART II – AGREEMENT AS TO PENALTY**

12. The parties agree that the appropriate penalty in this matter is set out in the draft Order filed at this hearing.

## **PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for Dr. Heymans made a joint submission as to an appropriate penalty and costs order.

In considering the proposed order, the Committee was mindful of the well-established principles in deciding an appropriate penalty. These principles include denunciation of the misconduct, general deterrence of the profession, specific deterrence of the member, appropriate rehabilitation of the member when possible, and maintenance of public confidence in the College's ability to regulate the profession in the public interest. The overarching principle is the protection of the public.

The Committee is also aware that a joint submission should be accepted by the Committee unless the proposed penalty would bring the administration of justice into disrepute, or is otherwise contrary to the public interest (*R. v. Anthony-Cook* 2016 SCC 43).

The Committee accepted the joint proposal by the parties as appropriate and commensurate to the misconduct found in this matter. In so doing, the Committee considered the following aggravating and mitigating factors.

### **Aggravating Factors**

Dr. Heymans' misconduct was multifaceted in nature. By his own admission, he fell asleep while examining Patient A. He examined Patient A with no consent and in a manner that lacked explanation. This left Patient A feeling very uncomfortable, violated, and confused.

Dr. Heymans has had prior issues with respect to patient boundaries as in 2012, he received a written caution at the ICRC "to respect patient boundaries at all times." A written caution at the ICRC arises when that committee is concerned about an aspect of a physician's practice, and believes the physician would benefit from some written direction as to how to conduct him or herself in the future. Together with that caution, the ICRC also directed continuing education, requiring him to complete the Understanding Boundaries course. This prior recent history is an aggravating factor in this case.

### **Mitigating Factors**

The Committee concluded that Dr. Heymans' decision to voluntarily settle this matter was a mitigating factor. His agreement in that regard saved the patient from the stress of having to testify, and saved the College the expense of a fully contested hearing.

It was also recognized that this was Dr. Heymans' first time before the Discipline Committee.

Further, Dr. Heymans has made significant voluntary changes to his practice since spring 2015, including:

- agreeing to not be the most responsible physician at the Hospital for orphan patients;

- in 2017, taking a leave of absence from the hospital including the emergency department, the skin clinic, and ceasing to follow his own patients admitted to hospital;
- in May 2018, further limiting his practice by closing his primary care practice;
- on October 5, 2018, resigning his hospital privileges; and
- limiting his current practice to provision of care in retirement homes and long-term care facilities.

The Committee viewed these voluntary changes as demonstrating insight and a desire to protect the public, and therefore considers them mitigating factors.

### **Case Law**

Counsel presented a Joint Book of Authorities which included three similar cases: *Ontario (College of Physicians and Surgeons of Ontario) v. Choptiany*, 2011 ONCPSD 29 (CanLII); *Ontario (College of Physicians and Surgeons of Ontario) v. Raja*, 2018 ONCPSD 22 (CanLII); and *Ontario (College of Physicians and Surgeons of Ontario) v. Wilson*, 2016 ONCPSD 46 (CanLII). While every case must be determined on its facts, the Committee agreed that the cases presented by counsel were similar on their material facts to this case. Like cases should be treated alike. Here, the Committee was satisfied that the joint submission on penalty in this case fell within the range of penalties in the three cases presented and therefore, was reasonable on the facts of this case and in light of the case law.

### **ORDER**

The Committee stated its finding of professional misconduct and incompetence in paragraph 1 its written order of October 12, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. the Registrar suspend Dr. Heymans' Certificate of Registration for a three (3) month period effective 12:01 a.m. on November 17, 2018.

3. the Registrar impose the following terms, conditions and limitations on Dr. Heymans' Certificate of Registration:

- (i) Dr. Heymans shall only practice medicine in facilities designated as Retirement Homes and/or Long-term Care Homes, as defined in the *Retirement Homes Act*, 2010, S.O. 2010 c.11 and the *Long-Term Care Homes Act*, 2007, S.O. 2007, c.8, and associated Regulations, unless otherwise approved of in writing by the College;
- (ii) Dr. Heymans shall engage in direct patient care no more than thirty (30) hours per week, and this restriction supersedes Dr. Heymans' undertaking signed on March 8, 2013, in so far as the maximum number of hours he is permitted to work per week;
- (iii) Dr. Heymans shall not engage in any professional encounters, in person or otherwise ("Professional Encounter(s)"), with patients of any age, unless in the continuous presence and under the direct observation of a monitor (the "Monitor") who is a regulated health professional and employed at the facility where Dr. Heymans provides care;
- (iv) Dr. Heymans shall maintain a log ("the Log") of all Professional Encounters with patients. Dr. Heymans shall ensure that the Monitor initials each entry on the Log for each patient seen in the Professional Encounter and shall make this Log available to the College upon request;
- (v) Dr. Heymans shall annually submit to the College, a report prepared by his sleep disorder specialist or his family physician, regarding Dr. Heymans' sleep disorder, commencing within one year of the date of this Order;
- (vi) Dr. Heymans shall inform the College of each and every location where he practices, in any jurisdiction (collectively my "Practice Location(s)") within fifteen (15) days of commencing practice at that location;

(vii) Dr. Heymans shall be responsible for any and all fees, costs, and expenses, associated with implementing and fulfilling the terms of this Order; and

(viii) Dr. Heymans shall provide irrevocable consent to the College to make appropriate enquiries of OHIP and/or any person or institution that may have relevant information, in order for the College to monitor compliance with this Order.

4. Dr. Heymans appear before the panel to be reprimanded.

5. Dr. Heymans 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. Heymans 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 October 15, 2018**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. GERRY ADRIANES HEYMANS**

Dr. Heymans,

It is unfortunate that you find yourself before the Committee today. You have been aware for many years that you suffer from a medical condition that could and did impact your professional abilities. Had you addressed the problem from the very beginning and taken better care of yourself, some of the issues may have been avoided.

Nevertheless, the Committee wishes to note the fundamental importance of proper and respectful boundaries in dealing with patients and advising them of the procedures you propose to undertake.

Failure to act appropriately undermines public trust in the profession and may cause patients to feel embarrassed or offended.

The Committee views the conduct in the matter at hand as highly unprofessional.

You have recognized the shortcomings in your abilities and have taken steps to rectify them.

We trust that you will not appear before us in the future.