Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Tamari, 2018 ONCPSD 43

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. EREZ TAMARI

PANEL MEMBERS: **DR. W. KING (CHAIR)**
MR. J. LANGS
DR. P. HENDRY
MS G. SPARROW
DR. E. STANTON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS L. CADER

COUNSEL FOR DR. TAMARI:

MS N. NICOLA
MR S. RONAN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date: June 13, 2018
Decision Date: June 13, 2018
Release of Written Reasons: August 16, 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 June 13, 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. Erez Tamari 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; and

2. 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 ALLEGATIONS

On the basis of an Agreed Statement of Facts (Exhibit 2), Dr. Tamari admitted allegation 2 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, in that he breached the terms of a Discipline Committee Order, and that he failed to provide requested information on ongoing College investigations on his Application for Reappointment to the Hospital where he had privileges.

On the basis of a Statement of Uncontested Facts (Exhibit 3), Dr. Tamari pleaded no contest to allegation 2 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, in relation to allegations that he failed to respond to patient requests to transfer their medical records to other physicians or third parties, such as insurers, in a timely and professional manner, and that he acted inappropriately in the administration and management of his practice.

The College withdrew allegation 1.

PART I – STATEMENT OF UNCONTESTED FACTS

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

1. Dr. Tamari is a 61 year-old family physician who received his certificate of registration authorizing independent practice in 1983. For approximately 30 years, Dr. Tamari operated a family medicine practice in Mississauga, and held hospital privileges at Trillium Health Partners, the Credit Valley Hospital in Mississauga.

Disgraceful, Dishonourable or Unprofessional Conduct Involving Specific Patients

Patient A

2. In May 2014, the College received a letter of complaint from Patient A on behalf of himself, his wife, and their daughter, all of whom had been patients of Dr. Tamari. In the complaint, Patient A stated that Dr. Tamari had been their family physician for more than 20 years. The complainant expressed concerns regarding Dr. Tamari's conduct and practice management in relation to all three patients in 2013 and 2014. The family's concerns included having to physically attend at Dr. Tamari's office to schedule appointments because of blocked/restricted telephone access to his office.

3. As a result of the issues raised in their complaint, the family found a new family physician. By letter dated March 10, 2014, Patient A advised Dr. Tamari of their decision to leave his practice. In that letter Patient A requested copies of their medical records and provided signed consents from all three patients. Patient A and his family's records were provided to the College on July 25, 2014, after Patient A's contact with the College.

Patient B

4. In February 2015, the College received a letter of complaint from Patient B, a 51 year-old female, who had been a long-standing patient of Dr. Tamari. Patient B's past medical history included a workplace injury in late 2013 while working as a flight attendant. In May 2014, Patient B attended an appointment with Dr. Tamari to request completion of a medical report pertaining to her disability insurance claim with Sun Life Financial ("Sun Life"). Dr. Tamari provided partial copies of select test results to Sun Life on August 15, 2014; however, medical information remained outstanding at the time of her complaint, despite repeated requests.

5. On August 28, 2014, Patient B attended an appointment with another family doctor, Dr. MN, and requested transfer into her practice. Dr. MN made written requests for Patient B's medical records from Dr. Tamari in August 2014, and again in October 2014, and received no response. In January 2015, Dr. MN's office contacted Dr. Tamari's office by telephone again to request Patient B's medical records. On January 13, 2015, Dr. MN received 115 pages of Patient B's medical records by facsimile from Dr. Tamari. The records received did not include any clinical encounter notes.

6. On June 15, 2015, the College Investigator, George Reed, wrote to Sun Life requesting information pertaining to Patient B's claim and Sun Life's requests for her medical information. The Abilities Case Manager with Sun Life responded to Mr. Reed confirming that requested documentation was still missing including clinical/chart notes, recent specialist consultation reports and tests/investigations.

7. After notifying Dr. Tamari of the complaint on February 18, 2015, Mr. Reed requested Dr. Tamari's response to the complaint as well as all original office records pertaining to Patient B for the time period 2014 – 2015. On April 16, 2015, Dr. Tamari's counsel advised that Patient B's paper chart had been destroyed after Dr. Tamari's conversion to an electronic medical record keeping system, and that the electronic file containing Patient B's recent records was corrupted and could not be opened. The available records were provided to the College.

Patient C

8. In June 2016, the College received a letter of complaint from Patient C, who had been a long-standing patient of Dr. Tamari until August 2015, when Patient C relocated to the United States ("U.S."). As outlined in his letter of complaint, Patient C had concerns regarding Dr. Tamari's failure to provide his medical records to Patient C's U.S. physician in order to obtain medical insurance and life insurance in the U.S. Despite repeated requests to Dr. Tamari between September 2015 and May 2016 by the insurance company and by Patient C, Dr. Tamari failed to provide Patient C's records. At the time of Patient C's complaint to the College, Dr. Tamari had still not provided his records.

9. On July 5, 2016, the College Investigator, Lindsay Turnbull, confirmed that Patient C and his insurance company had made numerous, unsuccessful requests to Dr. Tamari for his records.

10. In the course of the investigation, Ms. Turnbull requested and received a detailed chronology setting out multiple attempts made between September 2015 and October 2016 by the third party retained by Patient C's insurer to obtain the required medical information. The Attending Physician's Statement requested by the insurer was received from Dr. Tamari on November 16, 2016.

11. On January 3, 2017, Patient C advised that Dr. Tamari had provided his medical records in December 2016.

Mr. Y

12. In May 2016, the College received a letter of complaint from Mr. Y, whose children were patients of Dr. Tamari. Mr. Y expressed concern regarding the difficulties he experienced over the past year in attempting to arrange an appointment with Dr. Tamari to discuss and receive updated information regarding his children's health. Specifically, Dr. Tamari had not responded to repeated telephone calls by Mr. Y to Dr. Tamari's office between March 22 and May 15, 2016.

13. On July 6, 2016, Mr. Y advised that Dr. Tamari's office contacted him in mid-June, 2016, after receiving notification of his complaint to the College. He was provided an appointment with Dr. Tamari, which he attended on June 24, 2016. Mr. Y also expressed some concerns to the College regarding Dr. Tamari's aggressive communications with him during that appointment.

14. Despite multiple requests made by the College in August, October, and December 2016, Dr. Tamari did not respond to the complaint.

Patient D

15. In March 2017, the College received a letter of complaint from Patient D, on behalf of herself, her husband and their three children, all of whom were patients of Dr. Tamari. As outlined in her letter of complaint, Patient D was concerned that Dr. Tamari failed to transfer her family's medical records to their new doctor, Dr. GF, after numerous requests to do so. She also expressed concern that Dr. Tamari failed to respond to a request by Patient D's husband's insurer for an Attending Physician's Statement.

16. On April 17, 2017, the College received correspondence from Dr. GF describing her written requests to Dr. Tamari in June 2016 for Patient D's and her family's medical records, which included forms authorizing the release of their records.

17. In the course of the investigation, the College requested and obtained information from Patient D's disability insurer, Manulife Financial ("Manulife"), pertaining to Patient D's husband's claim and Manulife's request for the Attending Physician's Statement. Supporting documentation was provided by the Director of Underwriting Risk Management, Retail Markets at Manulife in April 2017.

18. Dr. Tamari was notified of the complaint in a letter dated March 21, 2017. A copy of the records and a response to the complaint was requested on March 31, 2017. Further reminder letters were sent in May requesting the original office records for Patient D and her family for 2015 – 2017.

19. Dr. Tamari's counsel requested an extension of time to respond in May and again in June. After the second deadline, Ms. Turnbull wrote again to Dr. Tamari's counsel requesting his response and all the medical records regarding Patient D's complaint by July 4, 2017.

20. On July 13, 2017, Dr. Tamari's counsel provided a CD containing the medical records for Patient D, her husband and one of her children, indicating that the records for the other two children would follow shortly. Dr. Tamari explained that he had faced challenges in providing the records, including computer problems.

21. Although the records provided on July 13, 2017 could be viewed, they could not be printed without a password, which was unknown. Test results and lab reports for the two remaining children were provided on July 24, 2017. The clinical notes were not provided, as Dr. Tamari's computer had been infected with a virus, which prevented retrieval of the electronic medical records.

22. On August 23, 2017, Ms. Turnbull requested copies of all medical records and the Cumulative Patient Profile for each family member. On September 28, 2017, Dr. Tamari's counsel provided a further copy of medical records for Patient D, her husband and one of her children. A further request for response, copies of all medical records and all Cumulative Patient Profiles was made to his counsel on October 27, 2017.

23. On November 2, 2017, Dr. GF advised that as of that date, no records were received from Dr. Tamari. On November 7, 2017, the Manulife representative confirmed that Patient D's husband's application for a "contract feature" in his policy (providing increased coverage if medically necessary) was denied because they did not receive all of the information they required.

Patient E

24. In July 2017, the College received a letter of complaint from Patient E, who was a patient of Dr. Tamari for 24 years. In this letter, Patient E advised that in late July 2016, she became ill and needed to apply for mortgage insurance benefits. In September 2016, she asked Dr. Tamari to complete a form for her insurer, Canada Life Assurance Company ("Canada Life"). As outlined in her letter of complaint, Patient E was concerned that Dr. Tamari failed to provide the necessary form to Canada Life within 90 days, as they had discussed. Patient E stated that in early January 2017, Dr. Tamari advised Patient E that he had faxed the form to Canada Life. After several days, Patient E contacted Dr. Tamari's office and was told that Dr. Tamari would be re-faxing the forms from his home office. Patient E stated that Canada Life never received the necessary documentation and that her file was closed.

25. In April 2017, Patient E requested a copy of her medical records from Dr. Tamari. As of January 4, 2018, Patient E confirmed that she had not yet received her medical records.

26. Dr. Tamari was notified of the complaint on August 8, 2017 and his response was requested on August 16, 2017. Dr. Tamari's counsel requested an extension to September 22, 2017 to provide Dr. Tamari's written response, which was granted. On October 27, 2017, Ms. Turnbull again requested Dr. Tamari's response to Patient E's complaint. On December 8, 2017, the records were provided to the College.

Patient F

27. In July 2017, the College received a letter of complaint from Patient F, who was a patient of Dr. Tamari since the early 1990's. In his letter of complaint, Patient F stated that he was a pedestrian involved in a motor vehicle accident in May 2016 when he was struck by a truck. Patient F saw Dr. Tamari a few times in a six month period, but needed to see Dr. Tamari more frequently to address his health issues. Despite attempts, he was not able to do so owing to Dr. Tamari's availability. Patient F found a new family doctor, Dr. BJ, in May 2017, with the help of his pain clinic doctor and his lawyer. In his complaint, Patient F indicated that, at that time, he requested that his medical records be transferred to his new doctor. Dr. BJ also requested the medical records from Dr. Tamari.

28. Dr. BJ advised the College that a release of records request was completed on May 23, 2017 and faxed to Dr. Tamari's office the following day. After repeated verbal and written requests, a copy of Patient F's chart was provided to him on July 28, 2017 and Patient F brought the records to Dr. BJ on August 3, 2017.

29. Dr. Tamari was notified of the complaint on August 8, 2017. On August 16, 2017, Ms. Turnbull sent the notification letter to Dr. Tamari's counsel, requesting a response and, on August 22, 2017, his counsel requested an extension of the deadline to provide Dr. Tamari's written response to September 22, 2017, which was granted. The College received a copy of Dr. Tamari's clinical notes and records for Patient F on September 28, 2017.

Patient G

30. In January 2018, the College received a letter of complaint from Patient G. In August 2017, Patient G and his wife received a letter from Dr. Tamari indicating that he had closed his family practice. They had been patients of Dr. Tamari since 1987. In his letter of complaint, Patient G stated that on August 23, 2017 he sent a letter to Dr. Tamari's office, as per the instructions in Dr. Tamari's letter, requesting copies of his and his wife's

medical records. Patient G called both Dr. Tamari's old office and his new office on numerous occasions from September 2017 to January 2018. On these occasions he was told by Dr. Tamari's staff that Dr. Tamari had received his request and was working on it.

31. Ms. Turnbull notified Dr. Tamari of the complaint in January 2018 and requested his response and a copy of the medical records. Dr. Tamari's counsel called Ms. Turnbull and advised that she was working on obtaining his response. Reminder letters were sent on April 2 and 24. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

Patient H

32. In October 2017, the College received a letter of complaint from Patient H. In July 2017, Patient H and his wife received a letter from Dr. Tamari indicating that he had closed his family practice. They had been patients of Dr. Tamari since 1990. In his letter of complaint, Patient H stated that he and his wife found a new family physician, Dr. SE, in August and release forms were faxed to Dr. Tamari's office that month. No response was received from Dr. Tamari's office and the release forms were re-faxed by Dr. SE on two different dates in October 2017. As of February 20, 2018, Dr. SE had not received Dr. Tamari's medical records. In his complaint, Patient H stated that his wife has suffered from migraines for many years and, as a result, it is important for her new physician to know what tests have been conducted and what treatments have been attempted.

33. Ms. Turnbull notified Dr. Tamari of the complaint in November 2017 and, in February 2018, requested Dr. Tamari's response and a copy of the complainants' medical records. Reminder letters were sent in March and April. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

Patient I

34. In February 2018, the College received a letter of complaint from Patient I. In August 2017, Patient I and his wife received a letter from Dr. Tamari indicating that he had closed his family practice. They had been patients of Dr. Tamari since approximately 1987, and their two children had been patients since their births in the early 1990's. In his letter of complaint, Patient I stated that he had left Dr. Tamari's practice in May 2017 on account of repeated cancelled appointments by Dr. Tamari and, as a result, poor management of Patient I's health. On August 17, shortly after receiving Dr. Tamari's letter, Patient I hand-delivered 4 written requests for the family's medical records to Dr. Tamari's receptionist. Over the following months, Patient I made numerous, monthly calls and left messages with Dr. Tamari's receptionist. Patient I suffers from a chronic condition and his new family physician, Dr. EM, believes that a request for medical records was sent by her office in May 2017, when he first became a patient. As of May 2018, records had not been received by Dr. EM or Patient I.

35. Ms. Turnbull notified Dr. Tamari of the complaint in February 2018 and, in March 2018, requested Dr. Tamari's response and a copy of the complainants' medical records. A reminder letter was sent in April. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

Patient J

36. In March 2018, the College received a letter of complaint from Patient J. In July 2017, Patient J received a letter from Dr. Tamari indicating that he had closed his family practice. He had been a patient of Dr. Tamari since approximately 1993. In his letter of complaint, Patient J stated that he found a new family physician, Dr. AO, in August and a release form was faxed to Dr. Tamari's office that month requesting a summary of his medical records, relevant consult and lab reports and immunization records. Following this written request, Patient J made numerous calls to Dr. Tamari in September, October,

December, January and March. On each of these calls, Dr. Tamari's staff confirmed that the messages were being relayed to Dr. Tamari.

37. On March 28, 2018, Ms. Turnbull notified Dr. Tamari of the complaint and requested Dr. Tamari's response and a copy of the complainant's medical records. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

Disgraceful, Dishonourable or Unprofessional Conduct – Generally

Administration and Management of Practice

38. With respect to all of the complaints described above, with the exception of Patient F, the medical records that Dr. Tamari provided to the College were incomplete and/or illegible. In addition, Dr. Tamari failed to take appropriate measures to back up his medical records when he converted from paper charts to electronic medical records. As a result, when a number of patient charts were corrupted the records were lost in their entirety.

39. Several of the patients listed above described difficulties they had experienced when scheduling appointments with Dr. Tamari's office. There were often issues with the messaging service and staff was not available or unresponsive in relation to inquiries regarding records or booking appointments. Communication and coverage were of particular importance since Dr. Tamari was absent, intermittently, from his practice over the years. This mismanagement impacted his patients' access to care.

PART I – PLEA OF NO CONTEST

40. Dr. Tamari does not contest the facts in paragraphs 1 to 39 above, nor does Dr. Tamari contest that, based on these facts 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, under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O/Reg. 856/93").

PLEA OF NO CONTEST: RULE 3.02 OF THE DISCIPLINE COMMITTEE'S RULES OF PROCEDURE

Rule 3.02 of the Discipline Committee's Rules of Procedure regarding a plea of no contest states as follows:

> 3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:
>
> (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
> (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
> (c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

PART II – AGREED STATEMENT OF 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. Tamari is a 61 year-old family physician who received his certificate of registration authorizing independent practice in 1983. For approximately 30 years, Dr. Tamari operated a family medicine practice in Mississauga, and held hospital privileges at Trillium Health Partners, the Credit Valley Hospital in Mississauga.

Disgraceful, Dishonourable or Unprofessional Conduct

Breach of Discipline Committee Order

2. On May 18, 2012, the Discipline Committee of the College made a finding of professional misconduct and ordered the Registrar to impose terms, conditions and limitations on Dr. Tamari's certificate of registration ("Discipline Committee Order").

3. One term of the Discipline Committee Order required Dr. Tamari to maintain a log of all requests received for third party reports and medical records, which was to indicate when such requests were made and when they were fulfilled ("Log").

4. The relevant portion of the Log was requested in each of the College's investigations described above. With respect to Patients B, C, D, E, F, G, H, I and J and their families, Dr. Tamari failed to maintain a complete and accurate Log of all requests for third party reports and medical records, and responses to such requests.

5. For example, for the purposes of illustrating the problem, with respect to Patient B, the College obtained a copy of Dr. Tamari's Third Party Log Book 2014. The Attending Physician's Statement ("APS") requested by Patient B for Sun Life appears on the Log. It shows that the APS was requested on May 22, 2014 and was sent on June 24, 2014. However, there is no entry for Patient B's clinical notes/records, which were also required by Sun Life, nor is there an entry for the request to transfer Patient B's medical records to Dr. MN. Similarly, the Third Party Log Book 2015, which was obtained by the College regarding Patient C, does not list Patient C's or Prudential's requests. Dr. Tamari never provided his Log for 2016 or 2017.

Provision of Information to Trillium Health Partners

6. Early in January 2017, Dr. Tamari completed and submitted his 2017/2018 application for re-appointment to Trillium Health Partners ("Application for Re-Appointment"), where he

had held hospital privileges for several decades. As of January 2017, Dr. Tamari was the subject of at least four investigations at the College in relation to patient complaints.

7. Despite these ongoing investigations, as well as other College investigations conducted in 2016, on his Application for Re-appointment Dr. Tamari answered "No" to the following question: In the last year, have you been or are you currently the subject of any complaint or investigation to or review by a licensing body with respect to your practice? If yes, please provide dates and details.

PART II – ADMISSION

8. Dr. Tamari admits the facts in paragraphs 1 to 7 above and admits that, based on these facts, 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 under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O/Reg. 856/93).

FINDING

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

AGREED STATEMENT OF FACTS REGARDING PENALTY

The following facts were set out in an Agreed Statement of Facts Regarding Penalty that was filed as an Exhibit at the hearing:

COLLEGE HISTORY

Discipline Committee History

May 2012

1. On May 18, 2012, the Discipline Committee found that Dr. Tamari committed an act of professional misconduct in 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. In particular, Dr. Tamari admitted that he failed to respond in a timely manner to repeated requests for medical records made by an insurance company in 2009 for the purpose of processing his patient's claim under her travel insurance policy.

2. The Discipline Committee ordered, *inter alia*, that Dr. Tamari's certificate of registration be suspended for one month, that he undergo a preceptorship in practice management for no less than six months, followed by a reassessment, and that he maintain a log of requests for third party reports and medical records, which shall indicate when such requests were made and when they were fulfilled. A copy of the Decision and Reasons for Decision of the Discipline Committee dated June 6, 2012 is attached at Tab 1 [to the Agreed Statement of Facts on Penalty].

April 2000

3. On April 3, 2000, the Discipline Committee found that Dr. Tamari committed an act of professional misconduct in that he failed to provide a report relating to an examination or treatment performed by him to his patient within a reasonable time after the patient had requested such a report. Dr. Tamari admitted that he failed to respond to repeated requests for a patient's medical records made by an insurance company, the patient, the patient's employer and the College over a period of fourteen months.

4. In addition, the Discipline Committee found that Dr. Tamari committed an act of professional misconduct in that he failed to respond appropriately or within a reasonable

time to a written inquiry from the College. During an investigation, the College confirmed that Dr. Tamari had failed to transfer the medical records of a patient and her children to their new physician, despite several requests over a period of four months. The Complaints Committee of the College had reviewed this investigation and required Dr. Tamari to attend the College in person to be cautioned about his disregard for the requests by his patients for their medical records. Dr. Tamari failed to respond to numerous attempts to schedule this attendance and, ultimately, a date was selected without his input. Dr. Tamari failed to attend at the College at the appointed time which, according to the Discipline Committee, showed blatant disregard for the self-governance of the medical profession.

5. The Discipline Committee ordered, *inter alia*, that Dr. Tamari's certificate of registration be suspended for one month. A copy of the Decision and Reasons for Decision of the Discipline Committee dated August 10, 2000 is attached at Tab 2 [to the Agreed Statement of Facts on Penalty].

Public Complaints Resulting in Cautions in Person

6. In January 1995, the College received a complaint from a former patient of Dr. Tamari. The complaint related to: (i) Dr. Tamari's failure to transfer the patient and her children's medical records to her new physician in a timely manner; and (ii) the fact that the original medical records were subsequently lost as a result of Dr. Tamari's inappropriate transfer of same. In March 1996, after reviewing the investigation, the Complaints Committee directed that Dr. Tamari attend the College to be cautioned regarding his failure to cooperate with the College during the course of the investigation. He was cautioned in writing with respect to the importance of patient records and the need to respond to requests for the transfer of records in a timely and professional manner. Finally, the Complaints Committee counselled Dr. Tamari regarding his obligation to retain patient records for at least 10 years, as well as the requirement that he transfer only copies of records and maintain originals in a secure location for the prescribed period of time. A copy of the March 1996 Complaints Committee Decision and Reasons is attached at Tab 3 [to the Agreed Statement of Facts on Penalty].

7. On May 1, 1991, the Complaints Committee directed that Dr. Tamari be counselled in writing following a complaint by a patient that Dr. Tamari failed to maintain the standard and failed to provide a record. The complainant appealed the decision to the Health Disciplines Board ("Board") and on December 4, 1992 the Board directed further investigation. On February 15, 1993, the Complaints Committee directed that Dr. Tamari be counselled in writing regarding the importance of effective communication with patients following discharge from hospital and also directed that Dr. Tamari be admonished in person "regarding the importance of undertaking, and his personal responsibility to ensure, the transfer of requested records within a reasonable period of time, and, where there is some indication that they are needed by new physicians for imminent treatment purposes, then to do so on an urgent and priority basis". A copy of the May 1, 1991 Complaints Committee decision and direction and a copy of the February 15, 1993 Complaints Committee Decision are attached at Tab 4 [to the Agreed Statement of Facts on Penalty].

DR. TAMARI'S HEALTH AND CHANGED SCOPE OF PRACTICE

8. In March 2017, Dr. Tamari began seeing a new psychiatrist, Dr. Nabil Philips, and he has been under Dr. Philips' care since that time. Based on his review of Dr. Tamari's history, Dr. Philips reached a new primary diagnosis which was different from what Dr. Tamari had been diagnosed with in the past. To address the new diagnosis, Dr. Philips started a new treatment regime. Dr. Tamari has been under this treatment for approximately one year.

9. In January 2018, Dr. Tamari entered into a four-year health monitoring contract with the Ontario Medical Association's Physician Health Program ("PHP Contract"). A copy of the PHP Contract is attached at Tab 5 [to the Agreed Statement of Facts on Penalty]. The PHP Contract requires, among other things, meetings with Dr. Philips, and compliance with his clinical advice and guidance, as well as regular meetings with a PHP Monitor. It also requires that his behaviour in the workplace be monitored by a workplace monitor and that he will remain under the care of a designated family physician.

10. On January 29, 2018, Dr. Tamari signed an undertaking with the College, in which he agreed to abide by the terms of the contract with the Physician Health Program (the "PHP") he had entered on January 11, 2018, and to remain in the monitoring arrangement with the PHP for four years.

11. The College received a report from Dr. Philips in March 2018. In this report, Dr. Philips describes Dr. Tamari's diagnosis and treatment. It also describes a repeated pattern of behaviour which continued unabated for a number of years, and opines that this "has had a significant impact on his work that is necessary to run his day-to-day operation, i.e., patients' correspondence, paperwork, and practice organization". Dr. Philips' reports that "Dr. Tamari has displayed significant improvement as evidenced by his ability to cope with unforeseen circumstances in his interpersonal life." Dr. Philips report, dated March 8, 2018, is attached at Tab 6 [to the Agreed Statement of Facts on Penalty].

12. In a letter dated April 19, 2018, the PHP Clinical Coordinator, Judi Platt, and the PHP Medical Director, Dr. Joy Albuquerque, confirmed that Dr. Tamari has been completely compliant with all aspects of his monitoring program. They also note the PHP's satisfaction with Dr. Tamari's progress in the monitoring program and with his commitment to his ongoing well-being. The letter dated April 19, 2018 is attached at Tab 7 [to the Agreed Statement of Facts on Penalty].

13. In connection with his behavioural treatment, Dr. Tamari advises that he has put in measures with a view to preventing recurrence of his unprofessional behaviour. According to Dr. Philips these include: a structure and routine for addressing his administrative tasks during a part of each day; adherence to a limited, regular exercise routine; and a change in his work structure. In July 2017, Dr. Tamari closed his solo family medicine practice. He now shares office space with a family physician and has shared administrative support. He has also changed the scope of his practice; his current practice is limited to minor surgical procedures and surgical assisting. Dr. Tamari advises that this has had the effect of reducing the administrative tasks in his practice that were primarily responsible for his previous conduct.

Conduct Extended to Other Patients

14. In addition to the facts set out in the Agreed Statement of Facts and Admission and the Statement of Uncontested Facts, Dr. Tamari acknowledges that, throughout the time in which he practiced family medicine, as well as in the closing of his family practice, he has repeatedly failed to provide medical records and reports/forms to patients and to third parties in a timely manner, including with respect to patients other than those specified in this proceeding.

15. Dr. Tamari has taken steps to rectify these issues, as set out in this Agreed Statement of Facts on Penalty.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Tamari made a joint submission as to an appropriate penalty and costs order which included: a six-month suspension; the imposition of terms, conditions and limitations an Dr. Tamari's certificate of registration as outlined in the draft order; a reprimand; and that Dr. Tamari pay costs to the College in the amount of $10,180.00, within ninety (90) days of the date of the Order.

The Committee is aware that pursuant to the Supreme Court of Canada decision in *R. v. Anthony-Cook*, 2016 SCC 43, a joint submission on penalty must be accepted, unless to do so would bring the administration of justice into disrepute, or would otherwise be contrary to the public interest.

The Committee's determination on penalty is based, first, on the guiding and most important principle of protection of the public. The Committee was also mindful that the penalty should serve as a general deterrent to the profession and a specific deterrent to the member, that it should express the profession's denunciation of the misconduct, that it be proportionate to the misconduct, that it serve to uphold the honour and integrity of the profession and maintain the

public's confidence in the College's ability to regulate the profession in the public interest. Where appropriate, the penalty should serve to rehabilitate the member.

College counsel reviewed in her submissions several prior decisions of the Discipline Committee: *CPSO v. Fenton*, 2017 ONCPSD 16, *CPSO v. Botros* 2015 ONCPSD 42, *CPSO v. Gutman* 2017 ONCPSD 47, *CPSO v. Portugal*, 2010 ONCPSD 12, *CPSO v. Romanescu*, 2015 ONCPSD 26, *CPSO v. Stewart*, 2007 ONCPSD 20, *CPSO v. Varenbut*, 2015 ONCPSD 40, *CPSO v. Wassermann*, 2013 ONCPSD 15.

The Committee accepts the general principle of fairness that like cases should be treated alike. However, the Committee recognizes that it is not required to impose the "least restrictive" penalty, which would be consistent with its objectives (*CPSO v. McIntyre* (2017)).

While the Committee appreciates that prior decisions of the Discipline Committee may be of assistance in its determination of an appropriate penalty, the Committee is not bound by those decisions as each case before it is unique, and the Committee must carefully consider the specific facts of the case before it as well as any mitigating and aggravating factors.

Having considered the specific facts of this case as well as the previous decisions cited, the Committee accepted the parties' joint submission on penalty and costs in this matter.

Aggravating Factors

This case raises a number of serious issues and concerns.

Failure to Respond to Patient Requests to Transfer Medical Records or Provide Third Party Reports

Dr. Tamari has a history with the College of not complying with patient requests to transfer medical records, dating back to February 22, 1995, when a patient filed a complaint with the Complaints Committee alleging that Dr. Tamari had failed to transfer their family's medical

records to a new physician in a timely manner, despite repeated requests to do so. The Complaints Committee directed that Dr. Tamari be cautioned in person regarding the importance of patient records and the need to respond to requests for the transfer of records in a timely and professional manner.

At a discipline hearing on April 3, 2000, Dr. Tamari admitted that he failed without reasonable cause to provide a report or certificate relating to an examination or treatment performed by the member or his authorized representative within a reasonable time, after the patient or his or her authorized representative had requested such a report or certificate. In that matter, one incident involved Dr. Tamari refusing to provide an insurance company with information it required in regard to one of his patients. Another incident involved a former patient requesting that her and her children's records be transferred to another physician. Despite a signed patient release and several requests over four months to transfer the records, Dr. Tamari failed to do so. Furthermore, despite many telephone calls and letters, Dr. Tamari failed to respond to the Complaint's Committee's request that he appear before it to be cautioned.

At the May 18, 2012 discipline hearing, Dr. Tamari admitted that he failed to respond in a timely manner to requests made by his patient's insurance company in 2009 for the purpose of processing the patient's claim under a travel insurance policy.

The patient complaints that are the subject of this discipline proceeding are strikingly similar to the patient complaints in Dr. Tamari's previous history with the College, as noted above.

It is apparent to this Committee, notwithstanding his health issues, that Dr. Tamari has not learned from his previous experience before the Complaints Committee and Discipline Committee. Previously, Dr. Tamari has received a caution from the Complaints Committee in regard to failing to transfer medical records in a timely manner. In addition, at his April 3, 2000 discipline hearing, Dr. Tamari received a reprimand and a one-month suspension of his certificate of registration, which would be suspended provided that he consent to an inspection of his practice. On May 18, 2012, the Discipline Committee ordered a four-week suspension of

his certificate of registration, a reprimand and the imposition of a number of terms, conditions and limitations on his certificate of registration.

In considering the jointly proposed penalty, the Committee was mindful of the recidivism, the seriousness of the misconduct, and also Dr. Tamari's previous history with the College which the Committee considered to be a significant aggravating factor.

It was Dr. Tamari's professional obligation and responsibility to respond in a timely manner to his patients' requests to transfer the requested medical records to another treating physician or provide reports to third parties. Dr. Tamari has failed to do so on many occasions dating back to 1994. Failure to transfer medical records in a timely manner can compromise patient care when the records are to be transferred to another treating physician, or compromise the processing of an insurance claim if a third party report requested by an insurance company is not received. Given his previous history with the College, Dr. Tamari has been made aware on more than one occasion of the serious consequences of ignoring a patient's request to transfer their medical records to a third party.

Dr. Tamari's blatant disregard of his professional responsibility to transfer medical records in a timely manner and his blatant disregard for his governing body cannot and, indeed, will not be tolerated by the public or the profession. The evidence before this Committee documents a prolonged and recurring pattern of unacceptable conduct. Therefore, the Committee considers the serious penalty of a six-month suspension to be appropriate in this case. It will send a clear message not only to Dr. Tamari, but also to the profession, that such behavior will not be tolerated.

Failure to Accurately Complete a Hospital Application for Re-Appointment

Honesty and integrity are fundamental pillars of the profession. Hospitals and other public institutions rely on applicants for appointment or reappointment to complete their appointment/reappointment forms accurately. Dr. Tamari failed in his professional responsibility to act honestly and with integrity when he answered "No" to the question on his hospital

reappointment form asking if he was the subject of any complaint or investigation or review by a licensing body. Dr. Tamari was the subject of at least four College investigations.

Failing to accurately complete an Application for Re-Appointment to a hospital or any other public institution misleads the institution. This failure is unacceptable and will not be tolerated. It requires a significant penalty that will not only serve as a specific deterrent to Dr. Tamari, but will also serve as a general deterrent to the profession.

Breach of a Discipline Committee Order

One of the terms of the May 18, 2012 Discipline Committee order was that Dr. Tamari maintain a log of all requests received for third party reports and medical records, and that this log indicate when such requests were made and when they were fulfilled. It was Dr. Tamari's responsibility to maintain a log and he failed to do so. Breaching an order of the Discipline Committee is a very serious matter. By breaching an order, Dr. Tamari demonstrated disregard for his governing body. Orders are put in place by the Discipline Committee to protect the public. When a physician breaches an order of a College committee, it has the potential to erode the public's confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest. Breaching an order is unacceptable and will not be tolerated. The public must be reassured that Discipline Committee orders that are put in place for public protection will be stringently enforced and that non-compliance will be sanctioned with a significant penalty.

In summary, the Committee found the following factors to be significantly aggravating in this case:

i) Dr. Tamari's previous discipline history with the College related to issues similar to those before this Committee. There were two Discipline Committee findings: the first one in 2000, and the second in 2012. In addition, there were two decisions of the Complaints Committee, dating back two decades, both dealing with the lack of timely

transfer of patient records on the part of Dr. Tamari. Dr. Tamari was required to be cautioned in writing and admonished in-person in relation to this issue.

ii) Dr. Tamari breached the 2012 Discipline Committee order with respect to maintaining a log of third party requests. It was Dr. Tamari's professional responsibility to ensure that he maintains the log as ordered, through personal compliance or supervision of his assistant.

iii) Dr. Tamari continued to breach the term of the order after learning he was the subject of multiple College investigations.

iv) Dr. Tamari did not accurately complete the re-appointment application for hospital privileges by answering "No" to the following question: "In the last year have you been or are you currently the subject of any complaint or investigation to or review by a licensing body with respect to your practice?"

v) Dr. Tamari failed to take appropriate steps to protect the integrity of his patient records when he converted to an electronic medical record system. This resulted in patient records being corrupted and in some cases permanently lost. This had significant ramifications for those patients who elected to leave Dr. Tamari's practice and had transferred their care to other physicians or who had made an application to an insurance company for disability benefits.

Mitigating Factors

While Dr. Tamari's misconduct was of a very serious nature and there were a number of significant aggravating factors, the following mitigating factors were also considered by the Committee:

i) Dr. Tamari agreed to an Agreed Statement of Facts and a Statement of Uncontested Facts and a joint submission on penalty, thus saving time and expense for the

Committee, as well as sparing a number of witnesses from having to attend and testify at a contested hearing.

ii) Dr. Tamari has taken a number of steps, both inside and outside of his practice, to minimize the likelihood of recurrence of similar misconduct. These include sharing an office space and administrative support with another physician and narrowing his scope of practice, which minimizes many of the administrative tasks that previously caused Dr. Tamari to be overwhelmed and resulted in the professional misconduct.

iii) Dr. Tamari has sought treatment for his personal health issues that, in the opinion of his treating physician, have been the cause of his misconduct. The Medical Director of the Physician Health Program (PHP) reports that Dr. Tamari has been fully compliant with all aspects of his monitoring program, which was a condition of the undertaking that Dr. Tamari signed with the College on January 29, 2018.

iv) By agreeing to the joint submission on penalty and by recognizing that there are consequences for his actions Dr. Tamari has demonstrated insight into his misconduct.

Conclusion

After careful consideration, the Committee accepted the parties' jointly proposed penalty and costs order.

A public reprimand will express the Committee's, the public's and the profession's denunciation of Dr. Tamari's misconduct.

As a condition on his certificate of registration, Dr. Tamari will be required to indefinitely maintain a log of all requests for medical records and third party reports made by patients and

submit it to the College on a monthly basis. A College appointed supervisor will meet with Dr. Tamari at least once a month, review the log and the corresponding charts, as well as review ten current patient charts on a random basis, to ensure accessibility, legibility and completeness. This condition will serve to protect the public.

In addition, Dr. Tamari will not engage in the practice of general family medicine or act as a primary care provider for any patient and will have his practiced restricted to performing minor surgical procedures in an office-based setting and surgical assisting in a hospital-based setting. To facilitate continuity of patient care, Dr. Tamari will be required to deliver all existing medical records to all patients and/or third parties included in the Notice of Hearing as well as those family members referenced in the underlying complaints of the patients included in the Notice of Hearing. Dr. Tamari will include in a log the receipt of patient requests and delivery of medical records to the patients and family members. Dr. Tamari will also be required to employ and retain an administrative assistant who will be present at all times that Dr. Tamari is practising in his office, which should address the concerns raised by patients that they had difficulty contacting Dr. Tamari or scheduling appointments.

While the Committee is sympathetic to Dr. Tamari's health issues and acknowledges that he is currently in compliance with the Physician Health Program, the Committee considers these restrictions on his certificate of registration are appropriate to further protect the public.

In respect to rehabilitation, the requirement to successfully complete a personalized ethics course will address the issue of honesty and integrity related to Dr. Tamari's failure to accurately complete his hospital privileges reappointment form.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of June 13, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Tamari attend before the panel to be reprimanded.

3. the Registrar suspend Dr. Tamari's certificate of registration for a period of six (6) months commencing immediately.

4. the Registrar impose the following terms, conditions and limitations on Dr. Tamari's certificate of registration:

    (i) Dr. Tamari shall not engage in the practice of general family medicine or be the primary care provider for any patient whatsoever;

    (ii) Dr. Tamari's practice shall be restricted to:

        (a) performing minor surgical procedures in an office-based setting. This includes assessing and preparing a patient for the minor procedure, as well as providing follow-up and treatment of related complications stemming from those procedures; and
        (b) surgical assisting in a hospital-based setting, provided that a member of the College of Physicians and Surgeons of Ontario is in attendance and performing the surgery;

    (iii) Commencing immediately, Dr. Tamari shall maintain a log of all requests for medical records and third party reports made by patients, other physicians or third parties. The Log shall indicate when such requests were made and when they were fulfilled (the "Log"), and Dr. Tamari shall submit this Log to the College on a monthly basis for an indefinite period of time. For greater clarity, Dr. Tamari is responsible for maintaining the Log and submitting it to the College during the time that his certificate of registration is suspended;

    (iv) Within sixty (60) days of the date of the receipt of valid patient consent, Dr. Tamari shall deliver all existing medical records to all patients and/or third parties

included in the Notice of Hearing, including the medical records of those family members referenced in the underlying complaints of the patients included in the Notice of Hearing. The receipt of patient consents and delivery of medical records to the patients and family members addressed in this paragraph, shall be included in the Log, referenced in paragraph 4 (iii) above;

(v) Dr. Tamari shall retain and employ an administrative assistant who will be present at all times that Dr. Tamari is practising in his office;

(vi) Dr. Tamari shall participate in and successfully complete one-on-one individualized educational instruction in ethics with an instructor approved by the College, and provide proof thereof to the College within six (6) months of the date of this Order;

(vii) Upon his return to practice, Dr. Tamari shall practise under the supervision of a College-approved supervisor or supervisors (the "Supervisor(s)") who will sign an undertaking in the form attached hereto as Schedule "A" [to the Order]. For a period of twelve (12) months thereafter, the Supervisor shall supervise the management of Dr. Tamari's practice. The supervision of his practice management shall contain the following elements:

(a) The Supervisor will meet with Dr. Tamari in person a minimum of once a month;
(b) The Supervisor will review the Log and corresponding charts, as necessary, to ensure the timely provision of complete records and reports, and, in addition, ten (10) current patient charts selected on a random basis by the Supervisor to ensure accessibility, legibility and completeness;
(c) Dr. Tamari shall fully cooperate with, and shall abide by any recommendations of his Supervisor, including any recommended practice management improvements and ongoing professional development;

(d) The Supervisor will submit written reports to the College, at minimum, once per month, for the first three (3) months, and every other month thereafter;

(e) If a Supervisor who has given an undertaking in the form attached at Schedule "A" to the Order is unwilling or unable to continue to fulfill its terms, Dr. Tamari shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time;

(f) If Dr. Tamari is unable to obtain a Supervisor in accordance with paragraph 4 (vii) of this Order, he shall cease practising medicine immediately until such time as he has done so, and the fact that he has ceased practising medicine will constitute a term, condition or limitation on his certificate of registration until that time.

(viii) Dr. Tamari shall inform the College of each and every location where he practises in any jurisdiction (his "Practice Locations)") within five (5) days of returning to practice and shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

(ix) Dr. Tamari shall submit to, and not interfere with, unannounced inspections of his Practice Locations) and patient charts by a College representative for the purposes of monitoring and enforcing his compliance with the terms of this Order.

(x) Dr. Tamari shall be responsible for any and all costs associated with implementing the terms of this Order.

(xi) Dr. Tamari shall consent to the College making enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, including his administrative assistant, in order for the College to monitor and enforce his compliance with the terms of this Order.

5. Dr. Tamari pay to the College costs in the amount of $10,180.00, within ninety (90) days of the date of this Order.

At the conclusion of the hearing, Dr. Tamari 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 13, 2018
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. EREZ TAMARI

Dr. Tamari,

The protection of the public is the primary concern of this College and the Profession. The evidence presented to us sets out a prolonged and recurring pattern of unacceptable conduct. The ramifications of your actions on your patient were undoubtedly severe. Patients were unable to provide critical records that may well have impacted their long term health. In some cases the result created financial hardship. In one case a patient was denied insurance coverage.

Your history with the College complainant Committee and Discipline Committee dates back over 20 years. It is essential to regulation of the profession that members comply and respect the regulations that govern them. You breached your undertaking to the College to maintain a log. You failed to report your interaction with the College to your hospital. This conduct is unacceptable.

We acknowledge that you have had serious medical challenges and you are commended for the steps you are taking to address the same. We encourage you to continue those efforts and that there will be no further appearances before this Committee.