NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Lionel Gines Martinez, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients or any information that would identify patients referred to orally or in the exhibits filed at the hearing. This order was made under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Martinez, 2020 ONCPSD 29

DISCIPLINE COMMITTEE
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**
which is Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. LIONEL GINES MARTINEZ

PANEL MEMBERS:

MR. J.P. MALETTE, Q.C. (CHAIR)
DR. M. DAVIE
MR. J. LANGS
DR. H. BADALATO

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MR. KIRK MAIJALA

COUNSEL FOR DR. MARTINEZ:

MS GLYNNIS BURT
MR. MARC FLISFEDER

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS JENNIFER McALEER

Hearing Date and Decision Date: May 11, 2020
Release of Order Date: May 14, 2020
Release of Reasons Date: July 6, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario ("the College") heard this matter by teleconference on May 11, 2020. On May 14, 2020, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Martinez 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.

The Notice of Hearing further contained an allegation of incompetence.

RESPONSE TO THE ALLEGATIONS

Dr. Martinez admitted the first two allegations in the Notice of Hearing on the basis of the Facts in the Agreed Statement of Facts and Admission, set out below (Exhibit 2). Dr. Martinez also entered a plea of no contest to the second allegation in the Notice of

Hearing on the basis of the facts set out in the Statement of Uncontested Facts, set out below (Exhibit 3).

The College withdrew the allegation of incompetence upon the finding of professional misconduct.

THE FACTS

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

BACKGROUND

1. Dr. Lionel Gines Martinez ("Dr. Martinez") is a 58-year-old family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") on July 22, 1999.

2. At the relevant times, Dr. Martinez practised at A+ Medical Clinic in Toronto, Ontario.

I –REASSESSMENT PURSUANT TO 2014 UNDERTAKING

3. In 2014, Dr. Martinez entered into an undertaking with the College that required him to complete a period of supervision with respect to his medical record-keeping and undergo a reassessment of his practice. Dr. Martinez's Undertaking to the College dated September 5, 2014 is attached at Tab 1 to the Agreed Statement of Facts and Admission.

4. Pursuant to the terms of the 2014 Undertaking, after the supervision of Dr. Martinez's practice was complete, the College conducted a reassessment of Dr.

Martinez's practice with a focus on his medical record keeping. The College retained Dr. Brian Silver, an experienced family physician, to conduct the reassessment. Dr. Silver provided a reassessment report to the College, dated May 4, 2017. In his report, Dr. Silver opined that Dr. Martinez failed to maintain the standard of practice of the profession in his record keeping in seventeen (17) out of twenty (20) charts reviewed. Dr. Silver's primary concerns were legibility, organization and completeness of Dr. Martinez's chart entries and Cumulative Patient Profiles. Dr. Silver also opined that Dr. Martinez displayed a lack of knowledge, skill, and judgment by prescribing a high-dosage steroid ointment to a patient to treat breast intertrigo (an inflammatory skin condition), and by failing to document vital statistics, such as height and weight, for his diabetic patients. A copy of Dr. Silver's reassessment report is attached at Tab 2 to the Agreed Statement of Facts and Admission.

5. In his response to Dr. Silver's reassessment report, Dr. Martinez advised that he had decided to engage in further remedial steps regarding his recordkeeping, as well as management of skin conditions. He also advised that he left his previous practice location and had also moved to an electronic medical record system ("EMR") to address issues of legibility. Dr. Martinez provided examples of more recent electronic chart entries from his practice for Dr. Silver to review. A copy of Dr. Martinez's response to Dr. Silver's report dated June 23, 2017 is attached at Tab 3 to the Agreed Statement of Facts and Admission.

6. Dr. Silver provided an addendum report stating that Dr. Martinez's response did not change his opinion with respect to whether Dr. Martinez maintained the standard of practice of the profession in the charts previously reviewed. Dr. Silver commented that the more recent sample medical records showed improvement over the earlier charts, but noted typographical errors and omissions in five charts. A copy of Dr. Silver's addendum report dated July 16, 2017 is attached at Tab 4 to the Agreed Statement of Facts and Admission.

II – TIME-BASED BILLING CODES

7. On March 23, 2015, the College received information from the National Investigative Unit of Medavie Blue Cross, the provider that administers the Interim Federal Health Program (the "IFHP") on behalf of the Canadian government. The IFHP provides limited, temporary health coverage for certain groups, including refugees and refugee claimants in Canada. Ontario physicians submit billing claims to the IFHP based on fee codes set out in the Ontario Health Insurance Plan ("OHIP") Schedule of Benefits.

8. Medavie Blue Cross advised the College that it had concerns regarding Dr. Martinez's practice after conducting a review of his billing claims and conducting an onsite audit of his practice. Medavie Blue Cross's concerns included:

   a) overlapping time stamps for time-based billing codes;

   b) multiple patients seen at the same time on the same date; and

   c) patient records for time-based services that did not include time stamps indicating the duration of the service provided.

9. Medavie Blue Cross provided examples of each concern documented in its review of Dr. Martinez's billing claims and patient records. A copy of the letter from Medavie Blue Cross dated March 23, 2015, with attachments, is attached at Tab 5 to the Agreed Statement of Facts and Admission.

10. Under the OHIP Schedule of Benefits, mental health care services, including Cognitive Behavioural Therapy ("CBT"), are time-based services. Time-based billing codes, including K005 (Primary Mental Health Care) and K007 (Individual Psychotherapy), are fee codes in the OHIP Schedule of Benefits that are claimed

by physicians in time units based on the amount of time the physician spends rendering the service to the patient. Under the OHIP Schedule of Benefits, to claim these "K-Codes", physicians are required to spend a minimum amount of time with the patient per unit claimed, and to document in the patient's permanent medical record the time that the service started and ended. Excerpts from the OHIP Schedule of Benefits relating to time-based services are included in Tab 6 to the Agreed Statement of Facts and Admission at pp. 18-28.

11. Based on the information from Blue Cross, the College conducted an investigation of Dr. Martinez's billing claims and his provision of CBT.

12. The College retained Dr. Nancy Merrow, an experienced family physician and chief of staff at Orillia Soldiers Memorial Hospital, as a Medical Inspector to opine on whether Dr. Martinez maintained the standard of practice of the profession in his provision of time-based mental health services and in his billing claims. Dr. Merrow reviewed thirty (30) of Dr. Martinez's patient charts, as well as his billing claims and day sheets, and conducted an interview of Dr. Martinez. A copy of Dr. Merrow's report to the College dated December 19, 2015, is attached at Tab 6 to the Agreed Statement of Facts and Admission.

13. In her report, Dr. Merrow concluded, based on the discrepancies between Dr. Martinez's patient encounter logs, patient records, and billing claims, that Dr. Martinez did not meet the standard of practice in terms of his administrative oversight of his office and his billing claims, including:

    a) submitting claims for lengthy visits without any evidence that the patient required services that would take 30-90 minutes to deliver;

    b) submitting claims for counselling at the same visit as another assessment without a distinct diagnosis as required by the OHIP Schedule of Benefits;

c) submitting claims to OHIP when he should have submitted them to the Workplace Safety and Insurance Board; and

d) frequently submitting claims for providing CBT in circumstances in which the only warranted service was an intermediate assessment, and/or without documenting sufficient information (including any goal, plan, or outcome) to demonstrate that the service was provided.

14. Dr. Merrow observed that Dr. Martinez used the term “CBT” loosely to describe all kinds of discussions with his patients, and there was little evidence of Dr. Martinez practicing CBT with any kind of methodology. Dr. Merrow concluded that Dr. Martinez displayed a lack of knowledge and skill with respect to his practice of CBT, and a lack of judgment with respect to recording inaccurate start and stop times for patient encounters.

15. Dr. Martinez provided a response to Dr. Merrow’s report dated February 8, 2016, a copy of which is attached at Tab 7 to the Agreed Statement of Facts and Admission.

16. Dr. Merrow provided an addendum report dated February 17, 2016, in which she addressed Dr. Martinez’s response to her report. Dr. Merrow’s opinion with respect to Dr. Martinez’s provision of CBT, billing issues, and poor documentation remained unchanged. A copy of the addendum report dated February 17, 2016, is attached at Tab 8 to the Agreed Statement of Facts and Admission.

17. Dr. Martinez wrote to the College on July 22, 2016, acknowledging that he was solely responsible for all of his billing errors. A copy of Dr. Martinez’s letter dated July 22, 2016, is attached at Tab 9 to the Agreed Statement of Facts and Admission.

18. Dr. Martinez advised the College on December 10, 2018, that he had entered into a voluntary repayment agreement with the Ministry of Health to repay the amount of $29,275.27 in respect of improperly claimed K-Codes.

19. On January 8, 2019, the Ministry of Health wrote to Dr. Martinez to confirm the voluntary repayment agreement, indicating that the agreed upon amount of $29,275.27 reflects 30% of the services that Dr. Martinez improperly claimed as K005 primary mental health care for the period reviewed by the Ministry. The Ministry of Health acknowledged that this arrangement represents a full and final resolution of the incorrect claims for billing code K005 with service dates between April 2014 and May 2016. A copy of the Ministry's letter of January 8, 2019 is attached at Tab 10 to the Agreed Statement of Facts and Admission.

20. On November 18, 2015, the College investigator spoke with a representative of Medavie Blue Cross. The investigator was informed that Dr. Martinez had started making repayments to Medavie Blue Cross and at that point had repaid $500.

21. In November 2019, Dr. Martinez also entered into an agreement with Medavie Blue Cross to repay the outstanding amount of $3,336.65 in respect of his improper billing claims. Dr. Martinez has made full repayment of the amount owing to Blue Cross. A copy of a letter from Dr. Martinez to Blue Cross dated November 18, 2019, as well as copies of money orders from Dr. Martinez to Blue Cross, are attached at Tab 11 to the Agreed Statement of Facts and Admission.

III – DIAGNOSTIC IMAGING REFERRALS

22. On January 22, 2016, the College received information from the Ministry of Health and Long-Term Care (the "Ministry") advising that it had reviewed claims to the Ontario Health Insurance Plan ("OHIP") for diagnostic studies rendered at an independent health facility where Dr. Martinez was listed on the claim to OHIP

as the referring physician. The letter stated that the majority of patients referred in the period of April 1, 2014, to January 21, 2016 underwent multiple diagnostic studies on a single service date. Further, the Ministry reviewed requisitions and interpretive reports for a number of patients referred in this time period and stated in the letter that there was no medical necessity for the imaging tests. A copy of the letter from the Ministry dated January 22, 2016, is attached at Tab 12 to the Agreed Statement of Facts and Admission.

23. Based on the information from the Ministry, the College conducted an investigation of Dr. Martinez's practice.

24. The College retained Dr. Linda Klapwyk as a Medical Inspector to review Dr. Martinez's practice, in particular his ordering of diagnostic imaging, and to opine on whether Dr. Martinez's care met the standard of practice of the profession. Dr. Klapwyk is an experienced family physician and professor of family medicine at the University of Toronto. Dr. Klapwyk reviewed Dr. Martinez's OHIP billing claims and twenty-five (25) of Dr. Martinez's patient charts and conducted an interview of Dr. Martinez. Dr. Klapwyk provided a report to the College, dated March 4, 2017, a copy of which is attached at Tab 13 to the Agreed Statement of Facts and Admission.

25. Dr. Klapwyk concluded that Dr. Martinez failed to maintain the standard of practice of the profession. Dr. Klapwyk opined that, in twenty-four out of twenty-five patient charts reviewed, there was evidence of diagnostic testing, including x-rays, ultrasounds, bone density scans, cardiac testing, and/or mammography ordered by Dr. Martinez without an indication for doing the tests.

26. In his interview with Dr. Klapwyk, Dr. Martinez blamed his office staff for adding tests onto his requisition forms without his knowledge by checking off additional tests on the requisition forms after Dr. Martinez had signed them. Assuming this

was the case, Dr. Klapwyk noted there was no documented concern by Dr. Martinez at follow-up visits with patients about the amount of testing that had been done without Dr. Martinez's authorization. Dr. Martinez advised Dr. Klapwyk that he had been aware of tests being added since 2014, and told Dr. Klapwyk that he had attempted to resolve the issue by speaking to office staff and the clinic's owner. Dr. Martinez acknowledged that he did not call the police, perform a practice audit, or document his concerns.

27. Dr. Klapwyk opined that if Dr. Martinez ordered the diagnostic imaging tests, he displayed a lack of knowledge or judgment and did not maintain the standard of practice of the profession.

28. Dr. Klapwyk also opined that even if the tests were ordered by Dr. Martinez's office staff without his knowledge, Dr. Martinez still failed to maintain the standard of practice of the profession as follows:

    a) Dr. Martinez failed to protect his patients from harm due to unnecessary tests, worry, and radiation exposure;

    b) Dr. Martinez demonstrated a profound lack of judgment in not documenting any concern about tests being done that he did not order or notifying appropriate authorities when he became aware of tests being ordered in his name; and

    c) Dr. Martinez was complicit in his staff's actions by continuing to review patient test results from 2014 to 2016 without documenting any concerns or taking actions other than speaking with his staff.

29. In Dr. Klapwyk's opinion, Dr. Martinez exposed his patients to a risk of harm or injury.

30. Dr. Klapwyk also expressed concerns about other aspects of Dr. Martinez's care including inadequate knowledge of vitamin B12 deficiency, vaccinations, illegible records, and instances of inappropriate billing in which Dr. Martinez billed OHIP for codes that were not supported by his documentation, as well as specific care-related concerns in four patient charts.

31. Dr. Martinez provided a response to Dr. Klapwyk's report, dated April 13, 2017, in which he acknowledged Dr. Klapwyk's comments about the ordering of unnecessary tests. Dr. Martinez wrote that he "recognizes that he ought to have taken further steps in and after 2014 to stop the unnecessary and inappropriate ordering of x-rays and other diagnostic studies for his patients." A copy of Dr. Martinez's response is attached at Tab 14 to the Agreed Statement of Facts and Admission.

32. Dr. Klapwyk provided an addendum report dated November 29, 2017, in which she addressed Dr. Martinez's response to her report. Dr. Klapwyk's opinion with respect to Dr. Martinez's care remained unchanged. A copy of Dr. Klapwyk's addendum report is attached at Tab 15 to the Agreed Statement of Facts and Admission.

ADMISSION

33. Dr. Martinez admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct, in that:

    (a) He failed to maintain the standard of practice of the profession, under paragraph 1(1)(2) of of O. Reg. 856/93, made under the *Medicine Act, 1991* ("O. Reg. 856/93"); and

    (b) 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 O. Reg 856/93.

Further, the parties submitted a Statement of Uncontested Facts and Plea of No Contest, which was filed as an exhibit and presented to the Committee:

1. Dr. Lionel Gines Martinez ("Dr. Martinez") is a 58-year-old family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") on July 22, 1999.

2. At the relevant time, Dr. Martinez practised at A+ Medical Clinic in Toronto, Ontario.

3. In January 2017, the College received information from Sun Life Financial ("Sun Life"), an insurance provider, that Dr. Martinez had provided medical referrals for orthotic devices while working at a facility that Sun Life was investigating, called "Therapeutic Mobile Care" ("TMC"). Sun Life advised the College that Dr. Martinez had admitted that he had signed prescription forms for patients without seeing or assessing them. Sun Life also advised that Dr. Martinez offered to make repayments to Sun Life. A copy of a letter from Sun Life dated January 31, 2017, is attached at Tab 1 to the Statement of Uncontested Facts and Plea of No Contest.

4. Based on the information provided by Sun Life, the College investigated Dr. Martinez's orthotics-prescribing practice.

5. Sun Life provided the College with a summary of an interview its investigators conducted of Dr. Martinez. According to the interview summary, Dr. Martinez told the Sun Life investigators that he initially did not pre-sign any forms at TMC, and

that he saw patients and prescribed only what they needed; however, this "morphed" into him pre-signing prescriptions for orthotics without seeing patients, allowing the clinic and patients to submit claims and receive payment. A copy of Sun Life's summary of its interview of Dr. Martinez is attached at Tab 2 to the Statement of Uncontested Facts and Plea of No Contest.

6. The College conducted an interview of Dr. Martinez, during which Dr. Martinez provided information that was false and misleading, and inconsistent with what he told Sun Life. Contrary to what he told Sun Life, Dr. Martinez stated in his interview by the College that he saw and examined all the patients for whom he prescribed devices. Dr. Martinez also told the College that his statements to the Sun Life investigators about pre-signing prescriptions were not accurate.

PLEA OF NO CONTEST

7. Dr. Martinez does not contest the facts specified above, and does not contest that, based on these facts, he engaged in professional misconduct, in 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, under paragraph 1(1)33 of O. Reg 856/93.

RULE 3.02 – PLEA OF NO CONTEST

Rule 3.02 of the Rules of Procedure of the Discipline Committee regarding a plea of no contest states:

> 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.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission and the Statement of Uncontested Facts and Plea of No Contest. Having regard to these facts, the Committee found that Dr. Martinez committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession, and 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

FACTS ON PENALTY

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

BACKGROUND

1. During the time period relevant to the allegations, Dr. Martinez worked at a clinic called “A+ Medical”. Dr. Martinez worked at A+ Medical from 2011 until 2016.

2. Dr. Martinez currently works at clinics in Toronto and Vaughan. His practices consist primarily (but not exclusively) of psychotherapy.

3. In his current practice settings, Dr. Martinez utilizes EMR systems, which help him address the organization, completeness, and legibility of his medical records.

DR. MARTINEZ’S HISTORY WITH THE COLLEGE

4. Dr. Martinez does not have any discipline history.

5. In early 2009, as a result of a public complaint to the College about his conduct and care, Dr. Martinez was cautioned in writing by the Complaints Committee about the importance of undertaking and documenting a thorough history and physical examination, and ensuring that the necessary investigations are ordered with appropriate follow-up. The Committee also cautioned Dr. Martinez to review mandatory reporting requirements for Ontario physicians. A copy of the Complaints Committee’s decision dated April 2009 is attached at Tab 1 to the Agreed Statement of Facts Regarding Penalty.

DR. MARTINEZ’S 2009 UNDERTAKING AND 2013 REASSESSMENT

6. In 2009, as a result of concerns regarding his prescribing practices that arose in two College investigations, Dr. Martinez entered into an undertaking with the College (the “2009 Undertaking”). In the 2009 Undertaking, Dr. Martinez agreed to voluntarily resign his prescribing privileges for Narcotic Drugs and Narcotic

Preparations, to complete professional education in medical record-keeping and prescribing skills, and to submit to a reassessment of his practice. A copy of Dr. Martinez's 2009 Undertaking to the College is attached at Tab 2 to the Agreed Statement of Facts Regarding Penalty. Copies of the ICRC's decisions in respect of Dr. Martinez dated September 2009 are attached at Tab 3 to the Agreed Statement of Facts Regarding Penalty.

7. In 2013, pursuant to the terms of the 2009 Undertaking, the College retained Dr. Irene Cohen to conduct a reassessment of Dr. Martinez's practice. Dr. Cohen is an experienced family physician who was also the medical director of the Thames Valley Family Health Team. In her reassessment report, Dr. Cohen opined that Dr. Martinez overall met the standard of practice of the profession and did not display a lack of knowledge, skill or judgment. However, Dr. Cohen expressed some concerns about Dr. Martinez's record-keeping and boundary-setting with patients. Dr. Cohen also expressed concerns about Dr. Martinez's billings in a number of charts. Dr. Cohen recommended that Dr. Martinez undergo a further period of clinical supervision with respect to these issues. A copy of Dr. Cohen's reassessment report dated August 16, 2013 is attached at Tab 4 to the Agreed Statement of Facts Regarding Penalty. Dr. Cohen provided an addendum to her report dated September 10, 2013, a copy of which is attached at Tab 5 to the Agreed Statement of Facts Regarding Penalty.

8. As a result of the concerns identified by Dr. Cohen, Dr. Martinez agreed to enter into the 2014 Undertaking, which superseded his 2009 Undertaking with the College. A copy of the 2014 Undertaking is attached at Tab 1 to the Agreed Statement of Facts and Admission.

SUBSEQUENT REMEDIATION EFFORTS BY DR. MARTINEZ

9. Following receipt of Dr. Silver's addendum report dated July 16, 2017, attached as Tab 4 to the Agreed Statement of Facts and Admission, Dr. Martinez delivered a further response to the College, dated November 29, 2017. In his response, Dr. Martinez advised the College that he had requested literature from the CMA and completed self-study in a number of areas in which Dr. Silver had expressed concerns about his care. Dr. Martinez provided a list of the resources that he told the College he had reviewed. Dr. Martinez also advised the College that he had "shadowed" a dermatologist in November 2017, and had engaged in 12 hours of one-on-one training on the topic of psychotherapy. A copy of Dr. Martinez's November 29, 2017 response along with the list of resources he told the College he had reviewed is attached at Tab 6 to the Agreed Statement of Facts Regarding Penalty.

10. Dr. Martinez attended the University of Toronto Medical Recordkeeping course on June 22, 2017, and attended a Continuing Medical Education course on cardiovascular disease in diabetes on November 8, 2017. A copy of Dr. Martinez's certificate of attendance for the Medical Recordkeeping Course is attached at Tab 7 to the Agreed Statement of Facts Regarding Penalty. A copy of Dr. Martinez's certificate of Attendance for the CME course is attached at Tab 8 to the Agreed Statement of Facts Regarding Penalty.

11. On November 23, 2018, the College was advised of additional continuing education activities Dr. Martinez had pursued since responding to the addendum report of Dr. Silver on November 29, 2017. Dr. Martinez advised the College that he had completed additional CME activity covering topics including: mindfulness-based chronic pain management, mental health care, and the provision of psychotherapy. A copy of Dr. Martinez's letter to the College dated November 23,

2018, with enclosed certificates of attendance and completion, is attached at Tab 9 to the Agreed Statement of Facts Regarding Penalty.

12. Since November 23, 2018, Dr. Martinez has completed additional continuing education activities on topics including mental healthcare and dialectical behavioural therapy. Copies of the certificates Dr. Martinez has received for completion of these programs are attached at Tab 10 to the Agreed Statement of Facts Regarding Penalty.

Joint Submission

Counsel for the College and counsel for Dr. Martinez made a joint submission as to an appropriate penalty and costs order, which would consist of a reprimand, a 12-month suspension of Dr. Martinez's certificate of registration; specific terms, conditions and limitations on Dr. Martinez's certificate of registration, along with an order for Dr. Martinez to pay costs to the College in the amount of $6,000.00.

Although the Committee has discretion to accept or reject a joint submission on penalty, the law provides that the Committee should not depart from a joint submission, unless the proposed penalty would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony-Cook* 2016 SCC 43).

The Committee is cognizant of the well-established principles that must be considered when imposing a penalty. These principles are first and foremost public protection, specific deterrence, general deterrence, maintaining the integrity of the profession and public confidence in the ability of the College to regulate in the public interest and, where appropriate, the rehabilitation of the member. Proportionality and denunciation of the misconduct are also important principles.

Aggravating Factors

It is important for the Committee to consider the aggravating factors in each case when determining the appropriate penalty. While this is the first time Dr. Martinez has appeared for a Discipline hearing, it is not the first time he has had interaction with his regulatory body. Indeed, he was cautioned regarding the need for proper and complete documentation of patient care back in 2009, by the Complaints Committee, in response to a public complaint. He entered into an undertaking at that time and was to obtain education in record-keeping amongst other terms, conditions and limitations on his certificate of registration. He was reassessed in 2013 as a term of that undertaking, and while he was found to meet the standard of practice, there was still concern about his record-keeping and boundary setting. This led to further supervision and another undertaking in 2014. It is the reassessment from the 2014 undertaking that gives rise to some of the issues in question at this hearing. It is apparent that Dr. Martinez has been having significant difficulties for quite some time.

From a review of the facts regarding the time-based fee code irregularities, the loose use of the Cognitive Behaviour Therapy code, the IFHP patient appointment time overlaps, the unnecessary multiple diagnostic imaging studies from 2014 to 2016 and, as outlined in the statement of uncontested facts, the inappropriate orthotics prescribing in 2017, it is clear to the Committee that Dr. Martinez's misconduct is not simply a one-off occurrence. Rather, his misconduct is multifaceted with great breadth and has occurred over a prolonged period of time. It is also further aggravating that these transgressions occurred during periods of undertakings with the College when Dr. Martinez's practice and conduct ought to have been exemplary. It shows he did not take his governing body seriously and did not put the safety of his patients first. These are aggravating factors.

It is also uncontested that Dr. Martinez was not initially forthright and honest in all his dealings with College investigators. While it is not an aggravating factor for a physician

to deny allegations (even if the allegations are subsequently proved), it is an aggravating factor if a physician refuses to cooperate with an investigation or misleads the investigators. The evidence in this case is that the College conducted an interview of Dr. Martinez, during which Dr. Martinez provided information that was false and misleading, and inconsistent with what he told Sun Life. The fact that he provided false and misleading information during the conduct of the investigation is an aggravating factor.

Mitigating Factors

It is important to consider that since 2017, Dr. Martinez has acknowledged that he is responsible for his shortcomings. The Committee was presented with evidence that he has been taking steps to remediate and is committed to correcting his practice. He is using electronic medical records (EMR) and has started at a new office with a limited general practice mostly providing psychotherapy. He has taken online and in-person educational courses including mindfulness-based chronic pain management, mental health care, and the provision of psychotherapy. He shadowed a dermatologist and has taken the University of Toronto Record-Keeping Course.

The fact that the hearing proceeded with an Agreed Statement of Facts and a Statement of Uncontested Facts, along with his admission and plea of no contest are mitigating insofar as resources have been spared and witnesses did not have to attend at the hearing. Dr. Martinez has repaid his agreed upon debt to OHIP for his K code billing errors. As well, he has repaid his debt to Medavie Blue Cross for his inaccurate billing of IFHP patients. These responsible actions indicate Dr. Martinez has some insight now into his misconduct. Given his long history with the College, the Committee gave little weight to Dr. Martinez's 2015 personal troubles alluded to as a mitigating factor. Nor does the Committee consider it mitigating that the work environment at A+ Medical Clinic was problematic. If the office staff ordered additional unnecessary tests on Dr. Martinez's signed requisitions without his knowledge, Dr. Martinez ought to have

addressed this issue once it became known to him. It was Dr. Martinez's responsibility to act in the best interest of his patients to protect them once he became aware.

Prior Cases

The Committee has accepted as a principle of fairness that generally, like cases should be treated alike. However, prior Committee decisions are not binding as precedent. The parties presented a joint book of cases for the Committee to consider, which illustrate a range of penalties in past similar cases.

The case of *Ontario (College of Physicians and Surgeons of Ontario) v. McIntosh,* 2020 ONCPSD 7 (CanLII) is similar to the current case. Dr. McIntosh also practiced at A+ Medical Clinic in Toronto, Ontario. By way of a Statement of Uncontested Facts and a plea of no contest, the Committee found Dr. McIntosh had also ordered many unnecessary diagnostic imaging investigations for many patients. He, like Dr. Martinez, also blamed the office staff for ordering tests on his signed requisitions without his knowledge. He also was involved in an orthotics prescribing scheme. This case is distinguished from Dr. Martinez's in that, on the date of his discipline hearing, Dr. McIntosh resigned his Certificate of Registration and agreed never to reapply. The penalty was a reprimand and costs. The Committee noted that but for his resignation, they would have revoked his certificate. The Committee notes that Dr. McIntosh took money for the orthotics scheme. There is no evidence that Dr. Martinez gained financially from the orthotics overprescribing.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Wong, R. C. K.,* 2014 ONCPSD 3 (CanLII), Dr. Wong, a family doctor, was found to have failed to maintain the standard of practice with respect to completion of the Special Diet Allowance forms (SDA forms), as well as with respect to his record keeping and his OHIP billing. A finding of unprofessional conduct was made with respect to Dr. Wong's failure to satisfy himself that his patients suffered from the disorders that he confirmed on the SDA

forms. The Committee ordered a six-month suspension along with a reprimand. The Committee stated in its decision that it did not believe that a longer suspension was justified, given its conclusions regarding both the fine and the extent of supervision and monitoring. The Committee also took into account Dr. Wong's belief, misguided though it was, that his primary purpose was helping his patients. The Committee ordered terms, conditions and limitation on his certificate of registration including a preceptorship and reassessment of his practice. The Committee also imposed a $35,000.00 fine payable to the Minister of Finance, and costs for the hearing. Both the liability and penalty phases of this hearing were contested.

Ontario (College of Physicians and Surgeons of Ontario) v. Hui, 2016 ONCPSD 11 (CanLII), dealt with professional misconduct by an emergency room doctor in Manitoba. He misled the College of Physicians and Surgeons of Manitoba (CPSM) in its investigation into his practise with a nurse practitioner. The nurse practitioner was seeing patients alone and billing home visits under Dr. Hui’s billing number. Dr. Hui was aware. This was not allowed. The Inquiry Panel of the CPSM found that Dr. Hui had committed acts of professional misconduct. Given that Dr. Hui was not licensed to practice in Manitoba at the time of the hearing, the penalty ordered by the Inquiry Panel of the CPSM included a reprimand, and a fine of $10,000.00 in lieu of a period of suspension. In the Ontario College proceeding, Dr. Hui admitted that the governing body of a health profession in a jurisdiction other than Ontario had found that Dr. Hui committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct. The Committee accepted the joint submission and ordered a reprimand, a five-month suspension, and terms, conditions and limitation on his certificate of registration, including a requirement to take an ethics course, and to have a practice monitor for billings for one year. Costs were also ordered. It was agreed that Dr. Hui cooperated with the Ontario College’s investigation into his conduct in Manitoba.

The last case put before the Committee was *Ontario (College of Physicians and Surgeons of Ontario) v. Nahri*, 2015 ONCPSD 9 (CanLII). Dr. Nahri had allowed the international medical graduates she was supposed to be closely supervising to be called “Doctor”. They were not licensed and saw patients alone, and used Dr. Nahri’s pre-signed prescription pads with her knowledge. Dr. Nahri admitted she had failed to maintain the standard of practice of the profession, and that she had 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. The Committee accepted the joint submission on penalty and ordered a six-month suspension, a reprimand, imposed terms, conditions and limitations on Dr. Nahri’s certificate of registration, including that she complete an ethics course and undergo at least 12 months of supervision with a reassessment of her practice.

Dr. Martinez, in contrast to Dr. Wong, Dr. Hui and Dr. Nahri, has multiple areas of transgressions over time so his misconduct is worse than that in the other cases. The Committee notes, however, that Dr. Martinez has changed practise location and the scope of his practice, and has shown some rehabilitation potential. Additionally, he is at a much earlier career stage than Dr. McIntosh and the Committee is persuaded that with stringent supervision there is a reasonable prospect of rehabilitation. This is in contrast to Dr. McIntosh, who was at the end of his career.

The Committee is persuaded, taking into account the particular circumstances of this case, the test from *R.* v. *Anthony-Cook* and the penalties ordered in the cases referred to above, that the proposed penalty should be accepted.

CONCLUSION

Dr. Martinez committed a very broad range of misconduct over a considerable time. Such failures demand a significant sanction.

The lengthy suspension of Dr. Martinez's Certificate of Registration will serve to send a message of specific deterrence to Dr. Martinez, as well as general deterrence to the membership at large, that such misconduct is not tolerated. The substantial sanction of a 12-month suspension will also serve to maintain the integrity of the profession and the public confidence in the ability of the College to regulate the profession in the public interest. The proposed penalty must provide protection to the public. The public will be protected by the high level of clinical supervision that Dr. Martinez's practise will be subjected to when he returns to work. A final safeguard for the public will be the reassessment of Dr. Martinez's practise after the year of supervision. The reassessment of Dr. Martinez's practice after the 12 months of supervision will ensure he continues to keep records that meet the standard of the profession and that the public is protected .It is appropriate in this case that there be an element of rehabilitation as well in the penalty. The PROBE course in Ethics will serve to help Dr. Martinez learn from his transgressions and provide him with the tools to avoid future misconduct. Finally, a reprimand from the Committee will serve to denounce the egregious misconduct of Dr. Martinez and should serve as a deterrent to the profession. With respect to proportionality, the Committee finds the proposed penalty is appropriate given the nature of the misconduct and the physician's blameworthiness. It is of utmost importance that the public be protected from schemes such as the over ordering of unnecessary diagnostic tests. Dr. Martinez should have stopped this practice as soon as he discovered it. Additionally, the orthotics prescribing scheme was also not in the patients' best interests. Dr. Martinez has demonstrated acceptance of responsibility and a desire to improve through his educational endeavours over the last four years. The Committee is hopeful that the PROBE course in ethics will help Dr. Martinez going forward in his career.

Finally, the Committee has the jurisdiction to order costs in appropriate cases. The parties have agreed upon $6,000.00 for the cost of the hearing. The Committee agrees this is warranted given the findings for the College.

ORDER

The Committee stated its findings in paragraph 1 of its written order released following the hearing. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. **THE DISCIPLINE COMMITTEE ORDERS** Dr. Martinez to attend before the panel to be reprimanded.

3. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to suspend Dr. Martinez's certificate of registration for a period of twelve (12) months, commencing May 12, 2020 at 12:01 a.m.

4. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to place the following terms, conditions and limitations on Dr. Martinez's certificate of registration:

Compliance with Policy re Suspension

a. Dr. Martinez shall comply with the College Policy "Closing a Medical Practise";

Professional Education

b. Dr. Martinez will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Martinez will complete the PROBE program at the next available opportunity, and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

Clinical Supervision

c. Upon the conclusion of the suspension of Dr. Martinez's certificate of registration under paragraph 3 above, Dr. Martinez shall practise under the guidance of a clinical supervisor acceptable to the College (the "**Clinical Supervisor**") who shall sign an undertaking in the form attached at Schedule "A," for twelve (12) months, on the terms set out below and as described in Schedule "A" (the "**Clinical Supervision**").

d. For an initial period of three (3) months, Dr. Martinez will practise under High Level Clinical Supervision. During High Level Clinical Supervision, Dr. Martinez will meet with the Clinical Supervisor once every two (2) weeks, at which meetings the Clinical Supervisor will:

1. Review a minimum of fifteen (15) of Dr. Martinez's patient records, to be selected at the sole discretion of the Clinical Supervisor, and the associated OHIP claims or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Martinez;

2. make recommendations to Dr. Martinez for practice improvements and ongoing professional development, and inquire into Dr. Martinez's compliance with the recommendations; and

3. keep a log of all patient charts reviewed along with patient identifiers.

e. After three (3) months of High Level Clinical Supervision, if the Clinical Supervisor is satisfied that Dr. Martinez's patient records, care, and associated OHIP billings meet the standard of practice of the profession, the Clinical Supervisor may recommend to the College that supervision be reduced to Moderate Level Clinical Supervision for three (3) months.

f. Upon the recommendation of the Clinical Supervisor and approval of the College to commence Moderate Level Clinical Supervision, Dr. Martinez will meet with the supervisor once every month for a period of three (3) months, at which meetings the Clinical Supervisor will:

    1. Review a minimum of fifteen (15) of Dr. Martinez's patient records, to be selected at the sole discretion of the Clinical Supervisor, and the associated OHIP claims or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Martinez;

    2. make recommendations to Dr. Martinez for practice improvements and ongoing professional development, and inquire into Dr. Martinez's compliance with the recommendations; and

    3. keep a log of all patient charts reviewed along with patient identifiers.

g. After three (3) months of Moderate Level Clinical Supervision, if the Clinical Supervisor is satisfied that Dr. Martinez's patient records, care, and associated OHIP billings meet the standard of practice of the profession, the Clinical Supervisor may recommend to the College that supervision be reduced to Low Level Clinical Supervision for the balance of the Clinical Supervision period of twelve (12) months.

h. Upon the recommendation of the Clinical Supervisor and approval of the College to commence Low Level Clinical Supervision, Dr. Martinez will meet with the supervisor once every two (2) months, at which meetings the Clinical Supervisor will:

    1. Review a minimum of fifteen (15) of Dr. Martinez's patient records, to be selected at the sole discretion of the Clinical Supervisor, and

the associated OHIP claims or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Martinez;

2. make recommendations to Dr. Martinez for practice improvements and ongoing professional development, and inquire into Dr. Martinez's compliance with the recommendations; and

3. keep a log of all patient charts reviewed along with patient identifiers.

Other Elements of Clinical Supervision

i. Dr. Martinez shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor including, but not limited to, any recommended practice improvements and professional development.

j. The Clinical Supervisor shall submit written reports to the College:

1. At least once every two (2) weeks during High Level Clinical Supervision;

2. At least once per month during Moderate Level Clinical Supervision; and

3. At least once per two (2) months during Low Level Supervision;

or more frequently if the Clinical Supervisor has concerns about Dr. Martinez's standard of practice.

k. Dr. Martinez shall ensure that Schedule "A" to this Order is signed and delivered to the College by an approved Clinical Supervisor prior to the conclusion of the suspension of his certificate of registration.

l. If a person who has given an undertaking in Schedule "A" to this Order is unable or unwilling to fulfill its provisions, Dr. Martinez shall, within fourteen (14) days of receiving notice of the same, ensure that he has delivered to the College an executed undertaking in the same form from a similarly qualified person who is acceptable to the College.

m. If Dr. Martinez is unable to obtain a Clinical Supervisor as set out in this Order, he shall cease practicing medicine until he has obtained a Clinical Supervisor acceptable to the College, and this will constitute a term, condition, or limitation on his certificate of registration, which will be included on the College's public register.

n. Dr. Martinez shall consent to the disclosure by the Clinical Supervisor to the College, and by the College to the Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Martinez's compliance with this Order. This shall include, without limitation, providing the Clinical Supervisor with any reports of any assessments of or prior clinical supervision of Dr. Martinez's practice in the College's possession.

Reassessment

o. Approximately six (6) months after the Clinical Supervision above has ceased, Dr. Martinez will submit to a reassessment (the "**Reassessment**") of his family medicine and psychotherapy practice, including but not limited to his medical record keeping, care, and OHIP billings, by an assessor or assessors selected by the College (the "**Assessor(s)**"). The Reassessment may include reviews of patient charts and associated OHIP claims submissions or planned OHIP claims submissions, direct observation of Dr. Martinez's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by

the College. The results of the Reassessment will be reported to the College and may form the basis of further action by the College.

p. Dr. Martinez shall cooperate fully with the Reassessment and with the Assessor(s). Dr. Martinez shall consent to the disclosure among the Clinical Supervisor, the College, and the Assessor(s) of all information any of them deems necessary or desirable to complete the Reassessment and to monitor Dr. Martinez's compliance with this Order. This shall include, without limitation, providing the Assessor(s) with any reports of any assessments of or clinical supervision of Dr. Martinez's practice in the College's possession.

Compliance and Monitoring

q. Dr. Martinez shall inform the College of each and every location where he practices, including but not limited to hospitals(s), clinic(s) and office(s), in any jurisdiction, within ten (10) days of this Order. Going forward, he shall inform the College of any and all new Practice Locations in any jurisdiction five (5) days in advance of commencing practice at that location.

r. Dr. Martinez shall give his irrevocable consent to the College to make enquiries of the Ontario Health Insurance Plan ("OHIP") and/or any person or institution who may have relevant information, in order for the College to monitor his compliance with the provisions of this Order.

s. Dr. Martinez shall be responsible for any and all costs associated with implementing the terms of this Order.

5. **THE DISCIPLINE COMMITTEE ORDERS** Dr. Martinez to pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of this Order.

Schedule "A"

UNDERTAKING OF CLINICAL SUPERVISOR TO THE COLLEGE

1. I am a practising member of the College, certificate of registration number _____.

2. I have read the Order of the Discipline Committee of the College dated _____, 2021 (the "Order").

3. I acknowledge that I have reviewed, or will review as soon as practicable, the materials regarding Dr. Martinez's practice provided to me by the College including the Agreed Statement of Facts and Admission with attachments, Statement of Uncontested Facts and Plea of No Contest with attachments, and the Agreed Statement of Facts Relevant to Penalty with attachments, as well as the College's Guidelines for College-Directed Clinical Supervision.

4. I undertake that commencing from the date of the conclusion of the suspension of Dr. Martinez's certificate of registration, I shall act as Clinical Supervisor for Dr. Martinez ("Clinical Supervisor"), for twelve (12) months ("Clinical Supervision").

5. I undertake that during the period of Clinical Supervision, I will, at minimum:

   (a) Review the materials provided by the College and have an initial meeting with Dr. Martinez to discuss practice improvement recommendations. Meetings will take place at Dr. Martinez's Practice Location, or another location approved by the College;

   (b) For an initial period of three (3) months, supervise Dr. Martinez under High Level Clinical Supervision. During High Level Clinical Supervision, I will meet with Dr. Martinez once every two (2) weeks, at which meetings I will:

      i. review a minimum fifteen (15) of Dr. Martinez's patient records, to be selected my sole discretion, and the associated OHIP claims submissions or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Martinez;

      ii. make recommendations to Dr. Martinez for practice improvements and ongoing professional development, and inquire into Dr. Martinez's compliance with the recommendations; and

      iii. keep a log of all patient charts reviewed along with patient identifiers.

(c) After the initial period of three (3) months, if I am satisfied that Dr. Martinez's patient records, care, and associated OHIP billings meet the standard of practice of the profession, I may recommend to the College that supervision be reduced to Moderate Level Supervision for three (3) months.

(d) Upon my recommendation and upon the approval of the College to commence Moderate Level Clinical Supervision, I will meet with Dr. Martinez once every month, at which meetings I will:

i. review a minimum fifteen (15) of Dr. Martinez's patient records, to be selected at the sole discretion of the Clinical Supervisor, and the associated OHIP claims submissions or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Martinez;

ii. make recommendations to Dr. Martinez for practice improvements and ongoing professional development, and inquire into Dr. Martinez's compliance with the recommendations; and

iii. keep a log of all patient charts reviewed along with patient identifiers.

(e) After three (3) months of Moderate Level Clinical Supervision, if I am satisfied that Dr. Martinez's patient records, care, and associated OHIP billings meet the standard of practice of the profession, I may recommend to the College that supervision be reduced to Low Level Clinical Supervision for the balance of the Clinical Supervision period of twelve (12) months.

(f) Upon my recommendation and upon the approval of the College to commence Low Level Clinical Supervision, I will meet with Dr. Martinez every two (2) months, at which meetings I will:

i. review a minimum fifteen (15) of Dr. Martinez's patient records, to be selected at the sole discretion of the Clinical Supervisor, and the associated OHIP claims submissions or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Martinez;

ii. make recommendations to Dr. Martinez for practice improvements and ongoing professional development, and inquire into Dr. Martinez's compliance with the recommendations; and

iii. keep a log of all patient charts reviewed along with patient identifiers.

6. I undertake to submit a written report to the College, at minimum:

   (a) Once every two (2) weeks during High Level Clinical Supervision;

   (b) Once per month during Moderate Level Clinical Supervision; and

   (c) Once every two (2) months during Low Level Supervision.

7. My written reports to the College described in section 6 above shall be in reasonable detail, and shall contain all information I believe might assist the College in evaluating Dr. Martinez's standard of practice, as well as Dr. Martinez's participation in and compliance with the requirements set out in the Order.

8. I undertake that I shall immediately notify the College if I am concerned that:

   (a) Dr. Martinez's practice may fall below the standard of practice of the profession;

   (b) Dr. Martinez may not be in compliance with the provisions of Dr. Martinez's Undertaking with the College; or

   (c) Dr. Martinez's patients may be exposed to risk of harm or injury.

9. I acknowledge that Dr. Martinez has consented to my disclosure to the College and all other Clinical Supervisors and Assessors of all information relevant to any of the following:

   (a) Dr. Martinez's Undertaking;

   (b) the provisions of this, my Clinical Supervisor's undertaking;

   (c) any Reassessment of Dr. Martinez's practice;

   (d) monitoring compliance with Dr. Martinez's Undertaking.

10. I acknowledge that all information that I become aware of in the course of my duties as Dr. Martinez's Clinical Supervisor is confidential information and that I am prohibited, both during and after the period of Clinical Supervision, from communicating it in any form and by any means except in the limited circumstances set out in section 36(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "RHPA").

11. I undertake to notify the College and Dr. Martinez in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.

12. I undertake to immediately inform the College in writing if Dr. Martinez and I have terminated our Clinical Supervision relationship, or if I otherwise cannot fulfill the provisions of my undertaking.

Dated at _____, this _____ day of _____, 2021

_____

Dr.

_____ _____

Witness *(print name)* Witness *(Signature)*

TEXT of PUBLIC REPRIMAND
Delivered August 27, 2020
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. LIONEL GINES MARTINEZ

Dr. Martinez:

The Committee is appalled by the broad scope of your transgressions, which have a common thread of dishonesty and questionable ethics.

You have demonstrated a clear pattern over time, and in various settings, of dishonesty and failing to put the well-being of patients first.

You failed your patients by not taking steps to stop the inappropriate ordering of unnecessary diagnostic imaging studies, exposing your patients to potential harm. You knew this was happening, but did not stop it.

You have a clearly established pattern of dishonesty, which includes the following:

- You were dishonest in respect of your billings to Medavie Blue Cross.
- You were dishonest in respect of your billings to OHIP.
- You were dishonest when prescribing orthotic devices without having seen or assessed patients.
- You were dishonest when you told College investigators that you had seen or examined all patients for whom you had prescribed orthotic devices.

Practicing medicine in Ontario is a privilege, not a right. You would do well to bear that in mind.

The long suspension of your certificate followed by a very rigorous period of supervision and reassessment of your practice should impress upon you the seriousness of your misconduct.