Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Otto, 2018 ONCPSD 46

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. GEORGE WILLIAMS OTTO

PANEL MEMBERS: **DR. C. CLAPPERTON (CHAIR)**
MR. M. KANJI
DR. I. ACKERMAN
MR. J. LANGS
DR. P. POLDRE

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS K. HEAP
MS M. KELLYTHORNE

COUNSEL FOR DR. OTTO:

MS M. E. JONES

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date: **April 23, 2018**
Decision Date **April 23, 2018**
Release of Written Reasons: **August 24, 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 April 23, 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. George Williams Otto committed an act of professional misconduct:

1. under paragraph 1(1)33 of O. Reg. 856/93, in that he has 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.

RESPONSE TO THE ALLEGATIONS

Dr. Otto admitted to the allegation in the Notice of Hearing, that he has committed an act of professional misconduct in that, he has engaged in conduct that constitutes an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

THE FACTS

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

FACTS

1. Dr. George Williams Otto ("Dr. Otto") received a certificate of independent practice in 1988. He practises family medicine in Toronto, Ontario.

2. As set out in greater detail below, Dr. Otto failed to provide records in a timely manner when requested on behalf of three patients.

A. Relevant College History

3. On May 1, 2013, the Inquiries, Complaints and Reports Committee advised and cautioned Dr. Otto in two separate cases to respond promptly and properly to requests for patient records.

B. Patient A

4. On April 13, 2016, a lawyer for Patient A sent a letter by fax to Dr. Otto's office, requesting Patient A's complete client file and enclosing an executed authorization and direction. The fax was received by Dr. Otto's office. Dr. Otto failed to respond to the request.

5. On August 15, 2016, Patient A's lawyer sent another letter to Dr. Otto's office by fax and by regular mail. He repeated his request for Patient A's file and noted that time was of the essence. The letter was received by Dr. Otto's office. Dr. Otto failed to respond to the request.

6. On September 28, 2016, Patient A's lawyer contacted the College regarding Dr. Otto's ongoing failure to provide Patient A's file as requested. The College investigator requested Dr. Otto's response by letters dated October 3, 2016 and November 14, 2016.

7. On December 9, 2016, Dr. Otto submitted a letter of response to the College. In his letter, Dr. Otto advised that he had provided the records to Patient A's counsel on October 1 , 2016.

C. Patient B

8. On November 16, 2015, counsel for Patient B sent a letter by regular mail to Dr. Otto's office, requesting Patient B's complete client file and enclosing an executed authorization and direction. The letter was received by Dr. Otto's office. Dr. Otto failed to respond to the request.

9. Counsel for Patient B sent two further letters to Dr. Otto's office by regular mail on January 18, 2016 and June 14, 2016, repeating his request for Patient B's file. Both letters were received by Dr. Otto's office. The final letter stated in bold that the matter had become urgent. Dr. Otto failed to respond to these requests.

10. On August 24, 2016, counsel for Patient B contacted the College regarding Dr. Otto's ongoing failure to provide Patient B's file as requested. The College investigator requested Dr. Otto's response by letters dated August 30, 2016 and October 25, 2016.

11. On December 9, 2016, Dr. Otto submitted a letter of response to the College. In his letter, Dr. Otto advised that he had provided the records to Patient B's counsel on October 19, 2016.

D. Patient C

12. On January 4, 2017, the College received a letter from counsel for Patient C requesting assistance in obtaining copies of her client’s records from Dr. Otto. As advised in her letter, Patient C's counsel had sent four requests to Dr. Otto for Patient C's records by letters dated February 12, March 12, April 14 and May 14, 2014. The final three request letters included the following statement in bold font: "If you have

not seen this patient, please confirm in writing." Dr. Otto failed to respond to these requests.

13. In his response to the College, dated February 16, 2017, Dr. Otto stated that he had no record of receiving the requests from Patient C's counsel and apologized if the letters were received and missed by an administrative error. Dr. Otto also noted that Patient C's first name was spelled inconsistently, in that a single letter in the middle of Patient C's first name was different in counsel's letter and in the four request letters. Dr. Otto stated that he did have records related to a patient with the name indicated on the request letters and would provide them upon receipt of an executed consent form. Patient C's surname was spelled correctly throughout, and her birthdate was included in the four request letters.

ADMISSION

14. Dr. Otto admits the facts set out above, and admits that the conduct described above constitutes an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Otto’s admission and found that he 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 Agreed Statement of Facts Regarding Penalty was filed as an Exhibit at the hearing:

1. Dr. George Williams Otto ("Dr. Otto") has been the subject of a number of prior investigations, cautions and disciplinary decisions by the College.

2. In responding to the investigations regarding the complaints made on behalf of Patients A and B, Dr. Otto advised the College investigator on December 8, 2016 that "In order to prevent similar oversights and delays, I have directed that all requests for patient records received by my office be logged into a journal. Each week, I personally review the journal to ensure requests have been attended to in a timely manner. If not, I personally ensure my office staff immediately attends to the request...I am confident that the system now implemented at my office will assist us in responding to patient record requests in a timely and appropriate manner."

3. Dr. Otto's previous involvement with the College includes the following:

    a. In November 2012, the Inquiries, Complaints and Reports Committee cautioned Dr. Otto in person and accepted his undertaking in resolution of an investigation into issues regarding his practice, including his use of a physician assistant and his inadequate record-keeping. Among other things, Dr. Otto undertook to complete a medical record-keeping course. [Tab 1 to the Agreed Statement of Facts regarding Penalty]

    b. On May 1, 2013, the Inquiries, Complaints and Reports Committee advised and cautioned Dr. Otto in two separate cases to respond promptly and properly to requests for patient records. In one case, counsel for the patient advised that he had written four letters to Dr. Otto requesting a copy of the patient's records and had telephoned on numerous occasions. In the other case, counsel for the patient advised that he had written three

letters requesting records on the patient's behalf and had called numerous times. In both cases, Dr. Otto advised the College that he had since set up a binder to record patient record requests, which he reviewed weekly. [Tabs 2 and 3 to the Agreed Statement of Facts regarding Penalty].

c. In a decision dated October 5, 2015, relating to his completion of Special Diet Allowance forms, the Discipline Committee made findings of professional misconduct. Dr. Otto admitted that his record-keeping did not meet the standard of practice. The Committee administered a public reprimand, suspended Dr. Otto's registration for two months, ordered he pay a $10,000 fine and imposed a number of other terms. The Committee noted that Dr. Otto had since completed the medical record-keeping course in accordance with his previous undertaking, and ordered that he also complete an educational program in ethics. [Tab 4 to the Agreed Statement of Facts regarding Penalty].

PENALTY AND REASONS FOR PENALTY

Submissions

Counsel for the College and counsel for the member made a joint submission with respect to an appropriate penalty and costs order, except in relation to the length of suspension.

The parties jointly proposed that the penalty include a suspension, a reprimand and the imposition of terms, conditions and limitations on Dr. Otto’s certificate of registration, including the requirements to maintain a log of all requests for release of Personal Health Information, complete a prescribed preceptorship, undergo practice re-assessment, and successfully complete a physician practice management course. They also submitted that Dr. Otto should pay hearing costs to the College, in the amount of $6,000.00, within 30 days of the date of the order.

However, regarding the length of suspension to be served by Dr. Otto, counsel for the College submitted that a two month suspension was appropriate, while counsel for Dr. Otto submitted that a suspension of between two and four weeks was appropriate.

The Law and Legal Principles

In considering the proposed penalty, the Committee was mindful of the well-established penalty principles. The overarching principle and primary consideration is protection of the public. In this matter, the principles that the Committee considered to be of additional importance included denunciation of the misconduct, specific deterrence of the member, general deterrence of the profession, and maintenance of public confidence in the profession and in the College's ability to regulate the profession in the public interest.

The Committee was also aware of the Supreme Court of Canada's decision in *R. v.-Anthony-Cook*, 2016 SCC 43, which states that a joint submission on penalty should be accepted, unless the proposed penalty would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

The Committee accepted the jointly proposed aspects of the penalty as components of an appropriate sanction in this matter. However, the Committee had to decide the appropriate length of suspension of Dr. Otto's certificate of registration, which was contested. The Committee has discretion to determine the appropriate length of suspension as an issue separate and apart from the agreed upon aspects of the penalty order proposed by the parties.

The Committee took guidance from the discussion in *CPSO v. Minnes* (2015) regarding the use of prior cases:

> It is not disputed that similar cases should, in general, result in similar sanctions. In this regard, the Committee referred to the ruling of the Divisional Court of Ontario in the case of *Stevens v. the Law Society of Upper Canada (1979)*, 55 O.R. (2d) 405 (Div. Ct.), which states:

> *"A conscious comparison should be made between the case under consideration and similar cases wherein sentences were imposed. If the comparison with other cases is not undertaken, there may well be such a wide variation in the results so as to constitute not simply unfairness but injustice. Considerations of such a nature should have as great a significance for professional discipline bodies with the power to impose onerous penalties as they do for Courts of Appeal and of first instance dealing with sentences upon conviction of criminal offences."*

Although Committee decisions are not binding as precedent, the Committee accepts as a principle of fairness that like cases should be treated alike. Accordingly, the Committee thoroughly reviewed the similar cases which were provided by counsel for both the College and Dr. Minnes. Each case is, however, unique. While a review of similar decisions can often disclose some commonality between the facts of the case under consideration and previous factual situations, there will be differences reflecting the individual circumstances of the cases. The challenge for the Committee is to carefully consider all of the facts and circumstances of the case and, by weighing the accepted principles of penalty in a fashion that takes into account the unique features of the case, to arrive at a fair and just decision.

In addition, the Committee considered the Supreme Court of Canada's decision in *R. v. Lacasse* 2015 SCC 64, regarding sentencing:

> Where sentencing ranges are concerned, although they are used mainly to ensure the parity of sentences, they reflect all the principles and objectives of sentencing. Sentencing ranges are nothing more than summaries of the minimum and maximum sentences imposed in the past, which serve in any given case as guides for the application of all the relevant principles and objectives. However, they should not be considered "averages", let alone straitjackets, but should instead be seen as historical portraits for the use of sentencing judges, who must still exercise their discretion in each case (see *Lacasse*, at para. 57).

And further:

> There will always be situations that call for a sentence outside a particular range: although ensuring parity in sentencing is in itself a desirable objective, the fact that each crime is committed in unique circumstances by an offender with a unique profile cannot be disregarded. The determination of a just and appropriate sentence is a highly individualized exercise that goes beyond a purely mathematical calculation. It involves a variety of factors that are difficult to define with precision. This is why it may happen that a sentence that, on its face, falls outside a particular range, and that may never have been imposed in the past for a similar crime, is not demonstrably unfit. Once again, everything depends on the gravity of the offence, the offender's degree of responsibility and the specific circumstances of each case. (see *Lacasse*, at para. 58)

The Committee applied these principles in its analysis and reasoning, set out below.

ANALYSIS

Aggravating Factors

Nature of the Misconduct

The Committee found Dr. Otto's failure to respond to patients' requests for medical records to be a serious matter. Providing the requested patients' records in a timely fashion is an important aspect of a physician's ongoing care of the patients. That these requests came from the patients' legal representatives does not diminish the importance of providing these records as part of the ongoing care of the patients. Failure to obtain the requested records from a physician in a timely fashion has the potential to create difficulties in the treatment of patients, as well as cause frustration and anxiety for patients. The repeated attempts by legal counsel for patients to request the medical records may also result in added expense and needless delay in relation to the purpose for which the records are being requested. The Committee notes in the case before it that

letters from the legal counsel for two of Dr. Otto's patients indicated that "the matter had become urgent" and that "time was of the essence."

The Committee noted that in respect of the requests for records for each of Patients A, B, and C, significant time had elapsed from the patient's legal counsel's initial request to the date when the medical records were provided. In addition, legal counsel had to make repeated requests to obtain the requested records. In the case of Patient C, the delay amounted to three years, while for Patient B the delay was eleven months, and for Patient A, the delay was five months. In the case of Patient A, the legal representative made two unsuccessful requests to Dr. Otto before contacting the College. In the case of Patient B, legal counsel made three requests before contacting the College. In the case of Patient C, legal counsel made four requests to Dr. Otto before contacting the College.

In all of these cases, intervention by the College was required before Dr. Otto provided the medical records. The Committee views such behaviour as serious and disrespectful of the time and effort required by the patients' legal counsel and the College, as well as being potentially harmful to the patients themselves.

Finally, the Committee found that Dr. Otto's explanation - that he was misled by the inconsistent spelling of Patient C's first name - was feeble, as the combination of the patient's surname and date of birth should have led Dr. Otto to take steps to clarify the request and the spelling of the patient's first name with the patient's legal representative directly. The Committee finds that Dr. Otto's failure to provide the patients' medical records in a timely fashion constitutes a serious breach of his professional responsibilities as a physician.

Prior History with the College

The Committee noted that Dr. Otto has had several relatively recent cases before the Inquiries, Complaints and Reports Committee (the "ICRC") as well as a prior appearance before the Discipline Committee.

College investigations concerning Dr. Otto first began in September 2010.

On November 19, 2012 the ICRC cautioned Dr. Otto in person regarding his improper use of a physician assistant and his inadequate medical record-keeping. There were instances in which Dr. Otto had lost the hand-written notes intended for a patient's medical record. Also, Dr. Otto's medical records were generally lacking adequate documentation of assessments. Dr. Otto undertook to complete a medical record-keeping course. He also agreed to a period of clinical supervision, practice reassessment and unannounced inspections of his practice location.

On May 1, 2013 the ICRC issued a written caution to Dr. Otto regarding his failure to respond to a patient's request for medical records over a period of two-and-a-half years. The ICRC did not accept Dr. Otto's claim that he believed that the patient had withdrawn his consent for the release of the records. The ICRC also noted that the College had received a number of previous complaints about Dr. Otto's failure to respond to requests for medical records.

The Committee considers Dr. Otto's prior ICRC caution for similar concerns of failing to respond promptly to requests for patient records a significant aggravating factor. Indeed, Dr. Otto's failure to respond to requests for records for Patient C began less than one year after the May 1, 2013 ICRC caution. Dr. Otto's failures to respond to patients' requests for records continued in November 2015 (Patient B) and April 2016 (Patient A). This was despite Dr. Otto's assurance at the time of the 2013 matter that he had since set up a binder to record patient record requests, which he said he reviewed weekly.

In response to the College's investigation regarding the complaints made on behalf of Patients A and C, Dr. Otto indicated to the College investigator on December 8, 2016, that he had set up a journal that uses an accounting-style form to record patient name, file number, date of request, deadline for sending, the date mailed and the date received, and payment submitted for patient information. Dr. Otto stated, "I am confident that the system now implemented at my office will assist us in responding to patient record requests in a timely and appropriate manner." The Committee notes that this is substantially similar to Dr. Otto's response to the 2013 ICRC case.

Dr. Otto has also a prior finding before the Discipline Committee. On October 29, 2015 the Discipline Committee found that Dr. Otto had committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession, and in that he had engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would be reasonably regarded by members as disgraceful, dishonourable or unprofessional. That matter involved Dr. Otto's failure to include information to support patient claims in the completion of Special Diet Allowance forms. Dr. Otto admitted his professional misconduct, including that his record-keeping for children and adult patients failed to maintain the standard of practice of the profession. The Discipline Committee ordered a two-month suspension, a fine to be paid by Dr. Otto to the Minister of Finance in the amount of $10,000.00, a reprimand and the imposition of terms conditions and limitations on Dr. Otto's certificate of registration, including the requirement for another physician to approve and co-sign his Special Diet Allowance forms prior to Dr. Otto providing the form to his patient(s). He was also required to successfully complete an educational program in Ethics, with reporting to the College of his progress and compliance.

Mitigating Factors

The Committee accepts that Dr. Otto's agreement to the statements of facts on liability and penalty and his admission to the professional misconduct allegation is a mitigating factor. This saved witnesses the stress of having to testify and saved the College the time and expense of a contested hearing.

Case Law

Counsel for the College and counsel for Dr. Otto provided the Committee with separate books of authorities, including cases in support of their respective positions as to the appropriate length of suspension in this case.

The College referred to several previous decisions of the Discipline Committee in support of its position that a two-month suspension is appropriate, given the range of penalties ordered for similar misconduct in those cases.

In *CPSO v. Kozner* (2001), the member was found to have committed professional misconduct for failing to provide written reports regarding four pediatric patients to the children's parents. The time lag to provide the requested reports ranged from two to 22 months. Intervention by the College was required in two cases to prompt the release of the records. Dr. Kozner provided records following the College's intervention to Patient 1 and Patient 4. Although the College intervened regarding Patient 2, Dr. Kozner never provided the records to Patient 2's parents. There was no College intervention regarding Patient 3. It was put forward as a reason, not a justification, that Dr. Kozner's assistant had left her employment with Dr. Kozner, which resulted in a work backlog in the office. The Committee confirmed that this was not a justification for the delays. The Committee accepted the parties' joint submission on penalty and ordered: a six-month suspension, with three months of the suspension to be suspended if Dr. Kozner, among other things, retained an assessor at her own expense, successfully completed any remediation and reassessment required by the assessor at her own expense, as well as fund and cooperate with the annual inspection of her practice for a period of three years; and a reprimand.

In *CPSO v. Faulkner* (2001), the member failed to respond to a solicitor's request for the medical records and a report for a pediatric patient who had been injured. Dr. Faulkner responded to the request only after the College intervened. The Committee noted that Dr. Faulkner had been found to have committed professional misconduct in 1991, in that he had failed to respond to requests for information related to a patient's condition. The Committee accepted the parties' jointly proposed penalty and ordered: a one-month suspension; the requirement to undergo a peer assessment of her office practice and an office inspection; and a reprimand.

In *CPSO v. Stewart* (2007), the member repeatedly failed to respond at all or in a timely manner to patients' requests for their medical records. In addition, Dr. Stewart failed to fill out forms and failed to make appropriate referrals. The Committee accepted the jointly proposed penalty and

ordered: a twelve-week suspension of Dr. Stewart's certificate of registration, as well as the imposition of terms, conditions and limitations, including limiting his practice time, the requirement to practise under clinical supervision, timelines to complete charts, and the requirement for continued enrolment in the Physician Health Program for a major depressive illness.

In *CPSO v. Tamari* (2012), the member failed to respond to an insurance company's request for one patient's medical records. The Committee heard evidence that the insurance company had made over two dozen calls to Dr. Tamari's office between April and September 2009. Dr. Tamari ultimately provided the records in November 2009, after the insurance company filed a complaint with the College. In his response to the College, Dr. Tamari made reference to problems with "professional capacity and behaviour" of a medical assistant/secretary, stating that she was responsible for handling such requests. It was also noted that Dr. Tamari had a previous finding of professional misconduct before the Discipline Committee in 2000; he had failed to respond to an inquiry from the College and he had failed to provide information to the insurance company about a patient. The Committee accepted the jointly proposed penalty and ordered: a four-week suspension; the imposition of terms, conditions and limitations on Dr. Tamari's certificate of registration, including the requirement to maintain a log of patients' requests for records, complete an educational program in practice management with a preceptor, and undergo a re-assessment with regard to practice management; and a reprimand.

Counsel for Dr. Otto submitted that in both the *Tamari* (2012) and *Faulkner* (2001) cases, the Discipline Committee had ordered a one-month suspension and referred to further cases in support of his position that a two to four week suspension is appropriate in this case.

In *CPSO v. Portugal* (2010), the patient's authorized representative sent approximately thirteen requests to Dr. Portugal for the patient's medical record between June 2007 and June 2009. The agreed facts indicated that the delay in response was because Dr. Portugal office did not respond to the requests or bring the requests to his attention. The College had received prior similar complaints in relation to Dr. Portugal. Dr. Portugal had been counselled by the Complaints Committee in 1998 and had received two cautions in 2007 for similar concerns about failing to

provide timely reports. The Committee accepted the parties' jointly submitted penalty and ordered: a one-month suspension, to be suspended if Dr. Portugal retained the services of an organization expert to evaluate his current administrative practices and implement the expert's recommendations regarding the management and administration of his practice; the imposition of terms, conditions and limitations on his certificate of registration to provide a report from the efficiency expert and to successfully complete the Medical Ethics and Informed Consent course; and a reprimand. In its decision, the Committee noted that a significant penalty was warranted in order to satisfy the principles of both specific and general deterrence.

In *CPSO v. Romanescu* (2015), the member admitted to having engaged in unprofessional conduct when she did not follow College policies regarding *Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence, or Close Their Practice Due to Relocation.* Dr. Romanescu had health problems that resulted in a failure to respond to numerous patients' requests for medical records. In May 2010, the ICRC cautioned her for similar concerns; failing to provide proper notice, and to have in place a plan to ensure provision of care for her patients, when she had to take a sudden leave of absence. The Committee accepted the parties' jointly submitted penalty and ordered: a one-month suspension; the imposition of terms conditions and limitations on her certificate of registration, including the requirement that Dr. Romanescu undergo a practice assessment and only practise in a group setting acceptable to the College; and a reprimand. In its decision, the Discipline Committee noted that a one-month suspension was "a serious sanction". The Committee further noted, "It also sends a message to the profession that such conduct will not be tolerated".

Length of Suspension

The Committee reviewed the length of suspension ordered by the Committee in the cases presented by the parties. The cases ranged in time from 2001 to 2015 and the length of suspension ranged from one month (*Faulkner* (2001); *Portugal* (2010); *Tamari* (2012); *Romanescu* (2015)) to three months (*Kozner* (2001) six-month suspension, three months to be suspended if certain conditions are fulfilled; *Stewart* (2007)). In all of these cases, the parties had made joint submissions on penalty, while in the present case, the issue of the length of

suspension was contested and was not part of a joint submission. In two cases, the member had a discipline history with the College (*Faulkner*; *Tamari*).

The Committee considered all of the cases that included a one-month suspension, noting that those cases were decided in 2001, 2010, 2012 and 2015. The Committee noted that in these earlier decisions, the Discipline Committee had commented that a one-month suspension was "a significant penalty" (*Portugal* (2010)) or "a serious sanction" (*Romanescu* (2015)). Furthermore, the Discipline Committee in *Romanescu* (2015) concluded that its decision "also sends a message to the profession that such conduct will not be tolerated."

A suspension of one month had been considered an appropriate period of suspension at that time and in those joint submission cases. However, the Committee concluded that a three- month suspension was appropriate in Dr. Otto's case.

Two of the key penalty principles are specific deterrence of the member, and general deterrence of the profession, from engaging in similar professional misconduct. The Committee decided that a one-month suspension was insufficient to deter Dr. Otto and other members of the profession from misconduct related to failing to provide medical records. A one month suspension is easily within the range of what could be perceived as vacation time for a member of the profession. The Committee concluded that a one-month suspension would not serve specific or general deterrence, or maintain and ensure public confidence that the College is regulating the profession in the public interest.

In deciding that a three-month suspension of Dr. Otto's certificate of registration is appropriate in this case, the Committee considered the specific aggravating factors of Dr. Otto's serious and repetitive conduct of failing to provide medical records when requested, which shows a disregard for the care of his patients. The Committee noted that over a relatively short period of time, from 2012 to 2018, Dr. Otto was before the ICRC or the Discipline Committee on three occasions. Each of those appearances was preceded by College investigations that were specific to the individual concerns outlined in each matter. Given that Dr. Otto's prior history with the College in all three previous matters involved concerns about some aspect of his office practice

management, either medical record-keeping or timely production of medical records, Dr. Otto is expected to have an enhanced awareness and vigilance of office practice management issues. That Dr. Otto completed a course on medical record-keeping in 2012, and committed in 2013 to create an office log system for tracking requests for patient records, did not remediate the concerns, despite his expressed confidence in the log system he had created in 2013. Indeed, Dr. Otto's failure to respond to requests for records, despite creating the log system, occurred less than one year after the May 1, 2013 caution from the ICRC. The Committee considered that in 2014 to 2016, Dr. Otto's log system had missed nine requests in regard to three patients.

Counsel for Dr. Otto submitted that the *Dr. Kozner* (2001) case was distinguishable from the current matter, because Dr. Kozner had personally promised to provide the reports to her patients' parents, while Dr. Otto was not personally aware from his staff of the requests for medical records from the patients' legal counsel. The Committee rejected this argument. Physicians are accountable for the conduct of their administrative staff in dealing with processes that have been created by the physician. This is especially relevant in a case like this where the physician has been previously cautioned about the failures in the administrative processes in his practice. It is also important to recognize that this failure to provide records despite repeated requests over time is not merely an administrative failure; it engages the care and well-being of patients upon whose behalf the requests are made, for purposes of importance and consequence to them.

Conclusion

Having regard to the nature of Dr. Otto's misconduct and his prior history with the College, the Committee concluded that a three-month suspension of Dr. Otto's certificate of registration was appropriate in this case. It serves as an appropriate specific and general deterrent and serves to denounce the misconduct and demonstrate to the public and to the profession that patients' requests for their medical records must be dealt with by physicians in a timely fashion, and that failure to do so will not be tolerated. The Committee considered the College's submission on penalty, but concluded that a two-month suspension was not a sufficient penalty in the circumstances of this case.

Public protection is ensured not only by the length of the suspension, but also by the imposition of the terms, conditions and limitations on Dr. Otto's certificate of registration, requiring a records log, a preceptorship, a practice reassessment and for Dr. Otto to successfully complete a physician office practice management course. The Committee believes that the penalty in this case will serve to protect the public and maintain public confidence in the College's ability to regulate the profession in the public interest.

The terms, conditions and limitations also serve as a further attempt to rehabilitate Dr. Otto.

The reprimand in this matter will allow the Committee to directly express to Dr. Otto its denunciation of his neglect of his professional responsibilities.

Costs

Ordering the partial recovery of the costs of hearing in the amount of $6,000.00 is appropriate, fair, and reasonable in the circumstances, as this matter was scheduled as a half-day discipline hearing, and required consideration in advance of the hearing of the Agreed Statement of Facts and appended documentation.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of April 23, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Otto attend before the panel to be reprimanded;

3. the Registrar suspend Dr. Otto's Certificate of Registration for period of three (3) months, to commence on May 7, 2018;

4. the Registrar to impose the following terms, conditions and limitations on Dr. Otto's Certificate of Registration:

Records Log

(a) Dr. Otto shall maintain a log of all requests for the release of Personal Health Information ("PHI"), which shall include a copy of the requests received, the date such requests were received, and the date of Dr. Otto's response (the "Log"). Dr. Otto shall also include a copy of the request and his response in the relevant patient's clinical record;

(b) Dr. Otto shall submit a copy of the Log to the College thirty (30), sixty (60) and ninety (90) days following the date of this Order, and every two (2) months thereafter, for a total period of twenty-four (24) months;

Education

(c) Dr. Otto shall complete a physician practice management course acceptable to the College within six (6) months of the date of this Order;

Preceptorship

(d) Within thirty (30) days of the conclusion of the suspension of his Certificate of Registration described above in paragraph 3, Dr. Otto shall retain, at his own expense, a College-approved clinical supervisor or supervisors (the "Preceptor") with respect to effective office administration, and in particular the timely response to requests for PHI. The Preceptor will sign an undertaking in the form attached as Schedule "A" to the Order dated April 23, 2018;

(e) Dr. Otto shall meet with the Preceptor a total of six (6) times over a period of twelve (12) months (the "Preceptorship"): an initial meeting, then once after one (1) month, once after a further two (2) months; and once every three (3) months thereafter until the conclusion of the Preceptorship;

(f) The meetings shall include a review of the Log and related correspondence, including the requests received, the responses by Dr. Otto and the associated records and patient charts to ensure appropriate documentation. The Preceptor

may conduct an additional review of any records or documents deemed necessary for the purposes of the Preceptorship. The Preceptor may also make inquiries of relevant individuals, including staff or colleagues;

(g) Dr. Otto shall cooperate fully with the Preceptor and shall abide by the recommendations of the Preceptor, including but not limited to, any recommended practice improvements and professional development;

(h) The Preceptor shall submit quarterly reports to the College;

(i) If a person who has given an undertaking in Schedule "A" to the Order dated April 23, 2018 is unable or unwilling to continue to fulfill its provisions, Dr. Otto 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;

(j) If Dr. Otto is unable to obtain a Preceptor in accordance with this Order, he shall cease to practice until such time as he has obtained a Preceptor acceptable to the College;

(k) If Dr. Otto is required to cease practice as a result of paragraph (4)(j) above, this will constitute a term, condition or limitation on his Certificate of Registration and that term, condition or limitation will be included on the public register;

(l) Dr. Otto shall consent to the disclosure by his Preceptor to the College, and by the College to his Preceptor, of all information the Preceptor or the College deems necessary or desirable in order to fulfill the Preceptor's undertaking and Dr. Otto's compliance with this Order

Reassessment

(m) Within six (6) months of completing the Preceptorship required above, Dr. Otto shall undergo a reassessment with regard to effective office administration by a College-appointed Assessor;

(n) The reassessment may include (at the College's discretion) a review of Dr. Otto's Log and related documentation; an interview with Dr. Otto, interviews

with colleagues and staff, and any other tools deemed necessary by the College;

(o) The results of this assessment shall be reported to the College;

(p) Dr. Otto shall abide by all recommendations with regard to practice management made by the College-appointed Assessor;

(q) If Dr. Otto is of the view that any of the Assessor's recommendations are unreasonable, he shall have thirty (30) days following receipt of the recommendation within which to provide the College with his submissions in this regard. Thereafter, the Inquiries, Complaints and Reports Committee (the "ICRC") will consider his submissions and make a determination regarding whether or not the recommendations, or any of them, are reasonable and if so, whether they, or any of them, constitute limitations or restrictions on his practice, and that decision will be provided to Dr. Otto;

(r) Following the decision referenced in paragraph (4)(q) above, Dr. Otto shall abide by those recommendations of the Assessor that the ICRC has determined are reasonable.

Other

(s) Dr. Otto shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen 15 days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;

(t) Dr. Otto shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient records for the purposes of monitoring and enforcing his compliance with the terms of this Order;

(u) Dr. Otto shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with this Order.

(v) Dr. Otto shall consent to the sharing of information among the Preceptor, the Assessor and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations;

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

5. Dr. Otto pay costs to the College for one half-day hearing in the amount of $6,000 within sixty (60) days from the date of this Order.