NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Gerald Paul Dempsey, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Dempsey, 2019 ONCPSD 51

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. GERALD PAUL DEMPSEY

PANEL MEMBERS:

DR. B. LENT
MS. G. SPARROW
DR. V. MOHR
MS. C. TEBBUTT
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. PENNY NG

COUNSEL FOR DR. DEMPSEY:

MR. MATTHEW GOURLAY

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. DAVID ROSENBAUM

Hearing Date:	**September 4, 2019**
Decision Date:	**September 4, 2019**
Release of Reasons Date:	**October 9, 2019**

PUBLICATION BAN

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 September 4, 2019. 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 its penalty and costs order with written reasons to follow.

THE ALLEGATION

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

1. Under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("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 circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO THE ALLEGATION

Dr. Dempsey admitted the allegation in the Notice of Hearing.

THE FACTS

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

BACKGROUND

1. Dr. Gerald Paul Dempsey ("Dr. Dempsey") is a 53 year-old paediatrician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") on February 21, 1996.

2. At the relevant time, Dr. Dempsey practised at a clinic in Belleville, Ontario. In 2007, Dr. Dempsey purchased a building located at 100 Station Street, Belleville, with the intention of establishing a multi-service pediatric and family facility with his pediatric clinic as the anchor. Dr. Dempsey has advised the College that he undertook significant renovation of the premises, which involved taking on significant debt. He operated his clinic until 2017. On March 20, 2017, his construction lender locked the doors at 100 Station Street and initiated foreclosure proceedings. Dr. Dempsey advised the College that he was unable to meet his financial obligations to his lender as two of his tenants had stopped paying rent.

DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

a) Closure of Office and Registrar's Investigation

3. In May 2017, the College began to receive complaints from the parents of Dr. Dempsey's patients, who were not able to contact Dr. Dempsey or access their children's medical records. The College also received information from the Chief of Staff at Quinte Health Care that the hospital was receiving calls from concerned patients regarding Dr. Dempsey's office closure. The College commenced a Registrar's Investigation regarding Dr. Dempsey closing his office without notice to his patients and without facilitating access to their medical records.

4. On May 4, 2017, in response to emails from the College's Patient and Physician Advisory Service regarding the information it had received about his office closure, Dr. Dempsey contacted the College and advised that his mortgage financier had locked him out of his building. Dr. Dempsey advised that he was working with the bank and that it appeared that he would be able to re-open his clinic soon. Dr. Dempsey advised the College that he had posted, on the clinic's Facebook page, the temporary closure. College staff advised Dr. Dempsey that he may wish to consider posting a sign on the clinic door, update his telephone greeting, and update any websites he may have regarding the closure. Dr. Dempsey advised that he would consider these options if he ran into a similar situation in the future. Dr. Dempsey advised that all patient records would be with the patients' family doctors, as he is a consulting paediatrician and he sends reports to patients' family physicians after every visit. Dr. Dempsey also advised that patients could email their medical record requests to him.

5. Dr. Dempsey obtained a new fax number sometime in May 2017.

6. Dr. Dempsey advised the College on June 21, 2017 that he was looking at ready-to-use clinic space in Belleville and expected to be back in practice "very quickly."

7. On August 28, 2017, Dr. Dempsey advised the College that he had resumed seeing patients at another physician's office in Belleville. Dr. Dempsey subsequently determined that the space was not suitable for his practice and stopped seeing patients at that location.

8. Dr. Dempsey did not re-open his clinic or secure a new practice location of his own in the Belleville area.

9. Dr. Dempsey provided a fax number to the investigator for patients to request their medical records. The fax number was posted on the College's public website in July 2017. Dr. Dempsey advised the College in November 2017 that he had received a number of faxed requests for medical records, to which he had responded.

10. In late 2017 and early 2018, Dr. Dempsey worked some shifts at a paediatric clinic network in Toronto. In early January 2018, Dr. Dempsey was offered a position at a Toronto clinic network, where he now practises.

b) DOCUdavit Solutions

11. On November 17, 2017, Dr. Dempsey advised the College that he was contracting with DOCUdavit Solutions for storage of his medical records and management of patient record requests. On November 29, 2017, the College requested permission from Dr. Dempsey to post the DOCUdavit service information on the College website. Dr. Dempsey replied on November 30, advising that he was waiting for the DOCUdavit portal to be ready before advising the College to post the information on its website.

12. On January 4, 2018, the College investigator received an email from a College staff member advising that staff had contacted DOCUdavit and that DOCUdavit advised that it had no records for Dr. Dempsey.

13. On January 5, 2018, the College emailed Dr. Dempsey and advised that DOCUdavit had told the College that they were not providing services on his behalf. Dr. Dempsey advised that he would be negotiating the contract with DOCUdavit on January 8, 2018.

14. On January 30, 2018, the College received a phone call from DOCUdavit Solutions indicating that it had received numerous calls regarding Dr. Dempsey's medical records, and confirming that DOCUdavit did not have a signed contract with Dr. Dempsey and was not currently storing any of Dr. Dempsey's medical records.

15. Dr. Dempsey ultimately retained DOCUdavit to process medical record requests in January 2019, after this matter had been referred to the Discipline Committee. As of August 6, 2019, six patients of Dr. Dempsey's had requested charts from DOCUdavit.

c) Patient Complaints

16. In the months following the closure of his office in May 2017, the College received seven public complaints from parents of Dr. Dempsey's patients who complained that Dr. Dempsey had closed his office without notice to them and that they were unable to obtain their children's medical records from Dr. Dempsey.

17. Throughout this time period, Dr. Dempsey corresponded frequently with the College investigator.

d) Ms A's Complaint

18. On May 29, 2017, the College received a complaint from Ms A regarding her inability to reach Dr. Dempsey and gain access to her daughter's medical record. Ms A advised that she had tried calling and attending Dr. Dempsey's office to obtain the records but had been unable to do so. Ms A advised that her daughter had been seeing Dr. Dempsey regularly for a year, and had

many tests and scans done, but her family physician was not copied on any reports, so she needed her daughter's file from Dr. Dempsey.

19. On June 1, 2017, the College investigator called Dr. Dempsey advising him of the complaint from Ms A. According to Dr. Dempsey, the only report that was not provided to Ms A's daughter's family physician was a Children's Treatment Centre Report which stated that there were no outstanding issues. Dr. Dempsey offered to email the report to Ms A. On June 2, 2017, Ms A advised the College that she did not require a copy of the Children's Treatment Centre Report, but that she wanted to keep the file open to see if Dr. Dempsey re-opened his practice, as she wanted her daughter to remain a patient of Dr. Dempsey.

20. On July 24, 2018, the College investigator called Ms A to follow up regarding whether she had received her daughter's medical record or if she had heard from Dr. Dempsey. Ms A advised that she was interested in obtaining the entire medical record and that she had not heard from Dr. Dempsey regarding the medical record or Dr. Dempsey's whereabouts. Ms A never received a complete medical record from Dr. Dempsey.

e) Ms B's Complaint

21. On August 3, 2017, the College received a complaint from Ms B, whose son was a patient of Dr. Dempsey's. Ms B was concerned that Dr. Dempsey closed his office without notice. Ms B's son has a unique medical condition. Ms B had requested her son's medical records on June 15 and July 7, 2017 for review by a new paediatrician. As she had not heard back from Dr. Dempsey, she complained to the College. Ms B advised that her request was urgent, as her son had not been able to see a paediatrician since January 2017.

22. On August 4, 2017, the College investigator notified Dr. Dempsey of Ms B's complaint. Dr. Dempsey responded to the investigator's email the same day, stating that he believed that the medical records had already been sent or if not, they would be mailed out.

23. By email dated August 28, 2017, Dr. Dempsey confirmed that he sent the medical records to Ms B by registered mail and that they were signed for. Ms B confirmed to the College that she received the medical records by mail.

f) Ms C's Complaint

24. On October 27, 2017, the College received a complaint from Ms C regarding her inability to reach Dr. Dempsey in order to obtain her daughter's medical records. Ms C expressed concern that Dr. Dempsey closed his office without notifying his patients. Ms C advised that she had called and emailed to request the records, but had been unable to obtain them from Dr. Dempsey. Ms C advised that her request for Dr. Dempsey's records for her daughter was urgent as her daughter had recently received a life-threatening diagnosis.

25. On November 7, 2017, Dr. Dempsey was notified of Ms C's complaint and the urgency of the request.

26. On November 21, 2017, Ms C followed up with the College, as she had not received the medical records or heard from Dr. Dempsey.

27. On November 27, 2017, Dr. Dempsey provided a tracking number for the medical records request. The investigator provided the tracking number to Ms C.

28. On November 30, 2017, Ms C contacted the College again, advising that she had received the electronic records provided by Dr. Dempsey, but that not all of her daughter's records were in the electronic record. Ms C requested the complete paper records from Dr. Dempsey. This was not provided by Dr. Dempsey.

29. On December 11, 2017, Dr. Dempsey responded by advising that he did not have a paper chart for Ms C's daughter, and advised that Ms C's daughter may have seen one of two other paediatricians who had previously practised in his office, and that if she had, then Dr. Dempsey did not have access to those records. Dr. Dempsey also advised that if he had seen Ms C's daughter at Quinte Health Care, then those records would have to be requested from the hospital.

30. On December 14, 2017, Ms C clarified that her daughter had not seen either of the two physicians identified by Dr. Dempsey.

g) Ms D's Complaint

31. On November 3, 2017, the College received a complaint from Ms D regarding her inability to schedule any appointments with Dr. Dempsey for her son. Ms D also indicated that she had sent a letter to a fax number that was provided to her to request her son's medical records, but the medical records had not been forwarded to her son's new paediatrician. Ms D advised that her son suffers from a heart condition and requires regular consultations with a paediatrician.

32. On November 13, 2017, Dr. Dempsey was notified of Ms D's complaint. The investigator also sent an email to Ms D, requesting that Ms D advise the College if Dr. Dempsey provided the medical records. Dr. Dempsey responded on November 17, 2017, advising that he would provide the registered mail tracking number for the records.

33. On November 20, 2017, the College received an email from Ms D confirming that her son's new paediatrician had not yet received the medical records from Dr. Dempsey.

34. On December 19, 2017, the College received an email from Ms D indicating that she had received the medical records on a USB stick in the mail from Dr. Dempsey.

h) Ms E's Complaint

35. On October 26, 2017, Ms E faxed Dr. Dempsey, using the fax number provided by Dr. Dempsey that was posted on the College's website, to request her son's medical records. No response was received from Dr. Dempsey, despite his having received the fax.

36. On December 7, 2017, the College received a complaint letter from Ms E, expressing her concern that Dr. Dempsey closed his office without letting anyone know and that she had been

unable to obtain her son's medical records from Dr. Dempsey despite calling, e- mailing and faxing Dr. Dempsey to request the records.

37. On January 9, 2018, the investigator called Ms E and advised that the College had notified Dr. Dempsey regarding the complaint and would be communicating with Dr. Dempsey to assist in the release of the medical record. Ms E explained that her son suffers from mild autism and that obtaining testing, such as blood work, was difficult for him. She wanted to obtain her son's medical records from Dr. Dempsey to avoid having repeat blood work done. The same day, the investigator sent an email to Dr. Dempsey regarding Ms E's request for records and requesting that he expedite the request. Dr. Dempsey responded to the email on January 12, 2018, advising that he would be couriering the medical records to Ms E and would provide the tracking number to the College.

38. On February 11, 2018, the College received an email from Ms E indicating that she still had not received the medical records from Dr. Dempsey and had not heard from Dr. Dempsey regarding her request.

39. On February 12, 2018, the investigator emailed Dr. Dempsey to advise that Ms E had not received the medical record and inquired whether Dr. Dempsey had sent the record as he had previously advised. Dr. Dempsey responded, requesting that the investigator "clarify this request" and provide him with information about Ms E. The investigator provided Ms E's contact information to Dr. Dempsey on February 15, 2018, and reiterated her request for the medical records. The investigator also provided Ms E's telephone number and suggested that Dr. Dempsey call Ms E regarding her request.

40. On March 15, 2018, Ms E advised the College by email that she had still not received her son's medical records. On March 15, 2018, the College also received a voicemail from Ms E expressing frustration with Dr. Dempsey as she still had not heard from him or received the records.

41. On March 15, 2018, the investigator attempted to contact Dr. Dempsey using the contact information provided by Dr. Dempsey to the College. The cell phone number on file provided a message that the customer could not be reached and Dr. Dempsey's home telephone number was no longer in service. The investigator sent a text message to Dr. Dempsey's dedicated text line regarding Ms E's request.

42. On March 20, 2018, Dr. Dempsey responded to the email exchange of March 15, 2018, which had been forwarded to him, advising that he had thought that the request was from a different patient with a similar name to Ms E, and had sent that patient their medical records. In order to rectify the error, Dr. Dempsey advised that he would courier Ms E's son's records to Ms E the following day.

43. On March 23, 2018, the College received a telephone call from Ms E indicating that she had received the medical record.

i) Ms F's Complaint

44. On April 16, 2018, the College received a complaint from Ms F, indicating that Dr. Dempsey had closed his office and retained her children's medical records. She advised that she had been unable to obtain the records by faxing a request to the number provided by Dr. Dempsey and posted on the College's website, as the fax did not transmit.

45. On April 30, 2018, the investigator called Ms F and indicated that she would email Dr. Dempsey to facilitate the transfer of records. The investigator emailed Dr. Dempsey the same day to notify him of Ms F's complaint and request that he provide the medical records to Ms F.

46. The investigator sent a follow-up email to Dr. Dempsey on May 10, 2018, inquiring about the status of Ms F's request. Dr. Dempsey never responded to either of the investigator's emails regarding Ms F's request.

47. On August 2, 2018, after the allegations had been referred to the Discipline Committee, the investigator called Ms F to obtain a mailing address to send the ICRC's Decision and

Reasons. During the call, Ms F confirmed that she still had not received the medical records of her four children from Dr. Dempsey.

j) Ms G's Complaint

48. On July 30, 2018, the College received a complaint from Ms G, expressing concerns that Dr. Dempsey had suddenly left town, and that she had been unable to obtain her son's medical records from Dr. Dempsey, despite her efforts, for over a year. Ms G advised that her son suffers from developmental delays, and that due to Dr. Dempsey's sudden absence, he had to start over with another paediatrician, which was made more difficult by the inability to obtain Dr. Dempsey's medical records. Ms G advised that her family physician had faxed the number provided by Dr. Dempsey several times, but had received no response. Ms G also tried calling a phone number provided by her family physician where Dr. Dempsey's records were supposed to be, but was told that they did not have the records.

49. The College notified Dr. Dempsey of Ms G's complaint on August 17, 2018. On September 25, 2018, Ms G contacted the investigator by telephone and advised that she had heard nothing to date from Dr. Dempsey and had not received a copy of her son's medical record.

50. On January 30, 2019, Counsel for Dr. Dempsey advised the College that Ms G's son's medical record had been provided to her through DOCUdavit.

ADMISSION

51. Dr. Dempsey admits the facts specified above and admits that, based on these facts, 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, contrary to paragraph 1(1)33 of O. Reg. 856/93.

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. Dempsey's admission and found that he committed an act of professional misconduct in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

AGREED STATEMENT OF FACTS RELEVANT TO PENALTY

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

Dr. Dempsey's History with the College

1. On May 10, 2007, the Discipline Committee of the College found that Dr. Dempsey had engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Dempsey admitted the allegation.

2. Dr. Dempsey admitted that between 1998 and 1999, and between 2001 and 2004, he entered into sexual and romantic relationships with the mothers of two of his patients while continuing to provide care and treatment to the patients.

3. The Discipline Committee ordered that Dr. Dempsey be reprimanded and that the results of the proceeding be recorded in the register. A copy of the decision of the Discipline Committee, dated June 18, 2007, is attached at Tab A [to the Agreed Statement of Facts Relevant to Penalty].

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Dempsey made a joint submission as to an appropriate penalty and costs, which consisted of: a two-month suspension, the imposition of terms, limitations and conditions on Dr. Dempsey's certificate of registration, and a reprimand. The proposed terms, conditions and limitations included that Dr. Dempsey: comply with the College Policy #2-07, "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation"; complete and pass a PROBE Ethics & Boundaries Program within six months of the date of the Order; provide proof to the College, within two weeks of the date of the Order, that he has contracted with a third-party provider to process patient medical record requests and for the next three years, provide proof to the College every six months that the arrangement remains in good standing; and maintain a log of requests for medical records, in an indicated form, and provide it to the College upon request. Counsel further proposed that Dr. Dempsey pay to the College costs in the amount of $6,000.

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

The Committee also took into consideration the well-recognized penalty principles of public protection, specific deterrence of the member, general deterrence of the profession, maintaining public confidence in the integrity of the profession, the College's ability to regulate the profession in the public interest, and rehabilitation. Other principles considered include denunciation of the misconduct and that the penalty must be proportionate to the misconduct. The Committee also took into account aggravating and mitigating factors.

Nature of the Misconduct

The College has an expectation that its members will notify patients of a pending closure of a practice in a timely fashion, so as to allow patients and their families time to make plans for

ongoing medical care (see College Policy Statement, “Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation”). The College also expects that physicians will put a management system in place to ensure that medical records are available on request.

Seven families made complaints to the College after repeated requests for medical records remained unanswered. Only five families finally received their records; the records were sent after a prolonged period of time, in one case greater than a year. One family never received the documents requested, and one family received only partial records.

Many of Dr. Dempsey’s patients were children with chronic medical illnesses who require ongoing medical care. Their new physicians also required timely access to their medical records to ascertain their medical history and ensure appropriate continuity of care. In failing to notify patients of his office closure in March 2017 and by not responding to patients’ requests for medical records in a timely fashion, Dr. Dempsey caused unnecessary stress and anxiety to his patients and their families. He may well have put his patients’ care at risk by failing to provide their records.

Although, as a consultant, Dr. Dempsey would be expected to send reports to patients’ family doctors, this does not always occur and therefore patients do not always have the option of obtaining consultants’ records from their family doctors. It was imperative that Dr. Dempsey be responsible for forwarding medical records in a timely manner once he received a request. The Committee found Dr. Dempsey’s lack of responsiveness and delays in this matter an affront to professional values and expectations.

Aggravating Factors

The Committee viewed the behaviour of Dr. Dempsey in failing to notify patients of his office closure as well as his failure to respond to patient requests for records in a timely fashion as serious. He displayed a lack of concern for the well-being of his young patients as well as insensitivity to the needs of his patients’ families. In the case of Patients E and G, it took almost

five months and over one year, respectively, to make the records available, which may have jeopardized their ongoing care. Patient A never received the records as requested. The number of patients, their young age and the impact on families are aggravating factors.

The Committee also noted that Dr. Dempsey had a prior finding of professional misconduct by the Discipline Committee in 2007. Although the matter considered in 2007 was for misconduct unrelated to the issues in this case, that Dr. Dempsey has a prior discipline finding is an aggravating factor.

Mitigating Factors

The Committee accepts as mitigating that Dr. Dempsey entered into an Agreed Statement of Facts and Admission regarding the misconduct, saving witnesses the stress of having to testify and the College the time and expense of a contested hearing.

The Committee also noted that Dr. Dempsey cooperated with College investigators, although he frequently failed to follow through on recommendations in a timely fashion.

Counsel for Dr. Dempsey submitted that the foreclosure proceedings in relation to Dr. Dempsey's office and the difficult financial circumstances that ensued should also be viewed as a mitigating factor. The Committee did not agree, as being in difficult financial circumstances is neither an excuse nor an explanation for a physician's multiple failures to respond to requests for medical records.

Counsel for Dr. Dempsey also pointed out that he signed a contract with DOCUdavit in January 2019 to provide ongoing access to medical records, which is a mitigating factor (although the Committee considered this to be of minimal weight, given that the initial requests for medical records were made in May 2017).

The Committee acknowledges that there is no allegation in this hearing about Dr. Dempsey's clinical care. However, this is not relevant given the misconduct found to have occurred and its potential to create risk to his young patients' care.

Case Law

Counsel for the College and counsel for Dr. Dempsey provided a Joint Book of Authorities which contained cases in which the misconduct was similar to that of Dr. Dempsey. The Committee reviewed the cases in the Joint Book of Authorities.

CPSO v. Otto 2018 – The Committee found that Dr. Otto had committed professional misconduct for failing to provide medical records in a timely manner. There were three complainants in this case. The Committee ordered a three-month suspension, the imposition of terms, conditions and limitations on his certificate of registration, a reprimand and costs. (There was a joint submission on penalty and costs, but the parties differed on the length of the suspension.) Dr. Otto's history at the College included three prior cautions by the Inquiries, Complaints and Reports Committee (ICRC), one in relation to his medical record-keeping, and the other two in respect of his failure to respond promptly and properly to requests for patient records. Dr. Otto also had a prior Discipline Committee finding related to deficiencies in medical record-keeping.

CPSO v. Romanescu 2015 – This case proceeded on the basis of an agreed statement of facts and joint submission on penalty. There were nine complaints about Dr. Romanescu's failure to notify patients of an office closure as well as her failure to provide medical records on request. The physician's health concerns were a mitigating factor in the case. An aggravating factor was that Dr. Romanescu had been cautioned once before by the ICRC for similar conduct. The Committee ordered a one month suspension, the imposition of terms, conditions and limitations on her certificate of registration, a reprimand and costs.

CPSO v. Tamari 2012 – This case involved multiple requests by an insurance company for medical records related to a patient for the purpose of resolving an outstanding claim. The

Complaints Committee had ordered that Dr. Tamari be cautioned on a similar matter; Dr. Tamari failed to attend for the caution. He also had a prior finding before the Discipline Committee for similar conduct. There was a joint submission on penalty. The Committee ordered a four-week suspension, a reprimand, terms, conditions and limitations and costs.

The Committee noted that the proposed suspension for Dr. Dempsey was shorter than that ordered in the case of Dr. Otto, but the physician in that case had received two prior cautions for similar concerns, which the Committee in that case considered to be "a significant aggravating factor". The proposed suspension was longer than in the cases of Dr. Romanescu and Dr. Tamari, but in the former case there was a significant mitigating factor, and in the latter, there was a single complaint. Overall, the Committee was satisfied that the proposed penalty in this case was within the range of the penalties imposed for similar misconduct.

Conclusion

The Committee found that Dr. Dempsey's behaviour demonstrated a blatant disregard for the care of many of his young patients, and created significant anxiety for their families. The Committee considered that the proposed two-month suspension could be viewed as lenient, in relation to the seriousness of Dr. Dempsey's behaviour. However, the fact that the proposed suspension was within the range of penalties in the prior cases it reviewed, and that the proposed penalty also included stringent terms, conditions and limitation on Dr. Dempsey's certificate of registration, satisfied the Committee that the jointly proposed penalty was appropriate in this case.

The Committee was satisfied that the two-month suspension and the reprimand would express the Committee's denunciation of the misconduct and would maintain the confidence of the public in the medical profession and in the College's ability to regulate it. It would serve as a specific deterrent to Dr. Dempsey and a general deterrent to the profession not to engage in this type of behaviour. The profession must respond to requests for medical records in a timely fashion; a failure to do so will be met with significant sanction.

Public protection is ensured by the requirement that Dr. Dempsey put in place a management system to respond appropriately to patient requests for records. The further requirement to attend the PROBE Ethics and Boundaries program will assist in rehabilitating Dr. Dempsey, with the hope that he will not repeat this behaviour.

The Committee also concluded that this was an appropriate case in which to require that Dr. Dempsey pay costs of the hearing.

ORDER

The Committee stated its finding in paragraph 1 of its written order of September 4, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

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

3. The Registrar suspend Dr. Dempsey's certificate of registration for a period of two (2) months, commencing from September 5, 2019, at 12:01 a.m.

4. The Registrar place the following terms, conditions and limitations on Dr. Dempsey's certificate of registration:

    a. Dr. Dempsey shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "B" to this Order;

    b. Dr. Dempsey 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. Dempsey will complete the PROBE program within 6 months of the date of this Order, 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;

c. Dr. Dempsey will, within two (2) weeks of the date of this Order, provide proof to the College that he has contracted with a third-party provider to process patient medical record requests and will for the next three (3) years, provide proof to the College every six (6) months that the arrangement remains in good standing;

d. Dr. Dempsey will maintain a log of requests for medical records, in the form attached hereto as Schedule "A", which will indicate when such requests were made and when they were fulfilled, and which will be provided to the College upon request;

5. Dr. Dempsey pay costs to the College in the amount of $6,000 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Dempsey waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND

September 4, 2019

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. GERALD PAUL DEMPSEY

Dr. Dempsey,

We are profoundly disturbed by your failure to notify patients' families of your office closure in an effective manner, and to ensure that families would be able to access their children's records in a timely manner.

The challenges the parents faced in retrieving records put patients at risk and added to their parents' worry and anxiety.

Members of the College are expected to abide by College policies. Your failure to provide easy access to patients' records reflect a lack of respect of such policies on your part.

The Committee is dismayed that this is your second appearance before the Discipline Committee.

The Committee hopes that in future, you will accept the significance of your professional obligations and will not appear before this Committee yet again.