

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Gutman*, 2021 ONPSDT 50

Date: December 16, 2021

Tribunal File No.: 21-007

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Mory Mayer Gutman

FINDING AND PENALTY REASONS

Heard: November 22, 2021, by videoconference

Panel:

Ms. Jennifer Scott (chair)

Dr. Michael Franklyn

Mr. Paul Malette, Q.C.

Dr. Joanne Nicholson

Ms. Shannon Weber

Appearances:

Ms. Emily Graham, for the College

Dr. Mory Mayer Gutman, self-represented

RESTRICTION ON PUBLICATION

The Tribunal ordered, under ss. 45-47 of the Health Professions Procedural Code, that no one may publish or broadcast the names or any information that would identify patients referred to during the Tribunal hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this order.

Introduction

- [1] The College of Physicians and Surgeons of Ontario referred allegations of professional misconduct about Dr. Gutman to the Tribunal. The College alleged Dr. Gutman had failed to maintain the standard of practice and/or had been incompetent in his care and treatment of Patient A and other patients, and that he had engaged in conduct with both Patient A and the College that would reasonably be regarded as disgraceful, dishonourable or unprofessional.
- [2] On April 14, 2021, the Inquiries, Complaints and Reports Committee (ICRC) imposed terms on Dr. Gutman's certificate of registration which required him to maintain a log of all prescriptions for antipsychotics and to practise under the guidance of a clinical supervisor acceptable to the College.
- [3] On November 8, 2021, Dr. Gutman signed an undertaking to resign from the College effective November 30, 2021 and not to reapply in Ontario or any other jurisdiction after this date. Dr. Gutman agreed to abide by the ICRC terms until his resignation.
- [4] During the hearing, the parties provided agreed statements of facts on liability and on penalty. In the agreed statement of facts on liability, Dr. Gutman admitted the allegations. We accepted his admissions.
- [5] Dr. Gutman and the College jointly submitted the penalty should be a reprimand and that Dr. Gutman pay costs of \$6,000 to the College. We found that Dr. Gutman had committed an act of professional misconduct and we accepted the joint submission on penalty and costs at the hearing. These are our reasons for that decision.

Misconduct

Patient A

- [6] Dr. Gutman was Patient A's physician between 2015 and 2019. In August 2019, Dr. Gutman prescribed Seroquel to Patient A without performing an adequate assessment, without explaining what he was prescribing and without regard to Patient A's history of addiction. Dr. Gutman did not spend sufficient time with

Patient A, rushed him out of the office and treated him with indifference as though he was a nuisance.

- [7] Patient A overdosed on Seroquel causing him to experience profound sedation and loss of consciousness. Patient A did not return to see Dr. Gutman after August 20, 2019.
- [8] The College retained Dr. Elise Venier to review Dr. Gutman's care and treatment of Patient A. Dr. Venier concluded Dr. Gutman failed to maintain the standard of practice of the profession, displayed a lack of skill and judgment and potentially exposed Patient A to harm or injury. More specifically, Dr. Venier concluded:
 - a. Dr. Gutman did not adequately maintain the Cumulative Patient Profile for Patient A.
 - b. Dr. Gutman's clinical entries for Patient A lacked detail and did not adequately reflect the subjective and objective findings and treatment plan.
 - c. Dr. Gutman did not adequately counsel Patient A regarding the potential adverse side effects and risks associated with Seroquel. Dr. Gutman was not aware that Seroquel had a potential risk of misuse and did not inform Patient A of this risk.
 - d. Dr. Gutman failed to recognize the potential risk of Seroquel misuse in a patient with a known history of substance misuse and failed to assess if Patient A was actively using or abusing drugs or alcohol.
 - e. Dr. Gutman failed to prescribe smaller doses of Seroquel which would have helped mitigate Patient A's risk of over-use.

Other Patients

- [9] After conducting the review of Dr. Gutman's care and treatment of Patient A, the College retained Dr. Venier to review 15 additional patient charts. Dr. Venier found that Dr. Gutman failed to meet the standard of practice and displayed a lack of knowledge, skill and/or judgment in 15 out of 15 charts. She also found that Dr. Gutman's clinical practice had the potential to expose his patients to harm or injury

in 14 out of 15 charts. Dr. Venier found there were problems with Dr. Gutman's record-keeping, in particular:

- a. The Cumulative Patient Profiles did not provide detailed accounts of family histories and high-risk factors.
- b. Dr. Gutman's documentation of clinical encounters did not provide a detailed account of the subjective and objective findings and the treatment plans were often omitted, as were the rationales for the plans.
- c. Dr. Gutman often omitted prescribed medications from the clinical encounter and failed to document that patients had provided informed consent regarding medications that were prescribed to them.
- d. Psychotherapy encounters were not adequately documented.
- e. Dr. Gutman failed to record immunizations.
- f. There was no cancer prevention flow sheet in the medical records to indicate when patients were screened for cancer.

[10] Dr. Venier found that Dr. Gutman failed to conduct routine colon cancer screening on his patients and failed to proactively screen for lung cancer in high-risk individuals. Dr. Venier also found that Dr. Gutman failed to complete chronic disease management for his patients.

Communications with the College investigator

[11] During the College's investigation of Patient A's complaint, Dr. Gutman used intemperate and profane language when describing Patient A and his complaint. He later apologized to the investigator for his response.

[12] When the investigator invited Dr. Gutman to consider literature on caring for diverse populations (Patient A is Black), Dr. Gutman responded with irrelevant comments.

Finding

[13] Based on the facts and Dr. Gutman's admission, we found that Dr. Gutman committed acts of professional misconduct that would reasonably be regarded by

members as disgraceful, dishonourable or unprofessional, that he failed to maintain the standard of practice of the profession in his care of patients and is incompetent.

Penalty

- [14] Dr. Gutman and the College made a joint submission on penalty. The question before us is whether the proposed penalty would bring the administration of justice into disrepute. A joint submission on penalty will be rejected only where it causes “reasonable and informed persons, aware of all of the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe the proper functioning of the justice system” has broken down. See *R. v. Anthony-Cook*, 2016 SCC 43 at para. 34 and *Bradley v. Ontario College of Teachers*, 2021 ONSC 2303 at para. 9.
- [15] It is not our role on a joint submission to consider whether we agree with the proposed penalty or whether it is a penalty that we would order following a contested hearing and a finding of misconduct. The question is not whether the proposed penalty is fit, but rather, whether it is contrary to the public interest in a way that would bring the administration of justice into disrepute.
- [16] We accept the joint submission and find that the proposed penalty would not lead reasonably informed persons to believe the proper functioning of the College’s professional discipline system has broken down. We make this finding having considered the circumstances of Dr. Gutman, the misconduct before us and the submissions on penalty, including the caselaw relied upon by the parties.
- [17] Dr. Gutman has a prior disciplinary history with the College. In February 2011, the Discipline Committee found that he had failed to maintain the standard of practice relating to his care and treatment of 18 patients and had committed boundary violations with another patient. The Discipline Committee ordered, among other things, that Dr. Gutman not engage in professional encounters with any female patients and not prescribe narcotic drugs, narcotic preparations, controlled drugs or benzodiazepines/other targeted substances. In November 2017, the Discipline Committee found that Dr. Gutman had breached the 2011 Discipline order and as a result, had again engaged in professional misconduct.

- [18] In addition to appearing before the Discipline Committee on two occasions between 2001 and 2020, Dr. Gutman was the subject of four complaints and one report at the ICRC. Over the years, the ICRC counselled Dr. Gutman, issued him advice, accepted a remedial agreement from him and required him to attend the College to be cautioned.
- [19] Dr. Gutman's current misconduct is multi-faceted and extensive. It involves a failure to maintain the standard of practice, disgraceful, dishonourable and unprofessional conduct and incompetence relating to the care and treatment of Patient A. It also involves a failure to meet the standard of practice and a lack of knowledge, skill and judgment relating to 15 other patients.
- [20] The joint submission on penalty, together with Dr. Gutman's undertaking, protects the public interest in two important ways. The public is protected from any further incidents of professional misconduct or incompetence by Dr. Gutman because he has undertaken to resign from the profession and not reapply, and the reprimand delivered by the Tribunal maintains public confidence in the College's ability to regulate the profession.
- [21] The parties rely on three cases where members have received a reprimand in the context of an undertaking to resign from the College and not reapply. The facts of these cases are very different from the facts of this case. The case that is most applicable is *College of Physicians and Surgeons of Ontario v. Reavely-Diaz*, 2021 ONCPSD 2.
- [22] The misconduct in *Reavely-Diaz* is similar, at least in part, to the misconduct here in terms of its nature and its scope. The misconduct involved deficiencies in knowledge, skill and judgment that affected many patients and included a lack of professionalism when dealing with the College. These behaviours persisted despite the College issuing prior cautions and giving opportunities for remediation. The misconduct was significant and widespread. Dr. Reavely-Diaz undertook to resign her certificate of registration and never reapply in Ontario or any other jurisdiction. The Discipline Committee ordered a reprimand. While this case is not binding, it provides support for the penalty proposed in this case.
- [23] Having considered the circumstances of Dr. Gutman including his undertaking to resign and not reapply, his misconduct and the Tribunal's caselaw, we find the

proposed penalty does not bring the administration of justice into disrepute and we accept it for this reason.

Costs

[24] The Tribunal is satisfied that the parties' joint submission on costs is appropriate for a half-day hearing.

Order

[25] At the conclusion of the hearing, we ordered:

- a. Dr. Gutman to attend before the panel to be reprimanded.
- b. Dr. Gutman to pay costs to the College of \$6,000 by December 22, 2021.

[26] Dr. Gutman waived his right of appeal at the hearing and we delivered the reprimand.

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- and -

Dr. Mory Mayer Gutman

The Tribunal delivered the following Reprimand
by videoconference on Monday, November 22, 2021.

*****NOT AN OFFICIAL TRANSCRIPT*****

Dr. Gutman,

Your resignation, accompanied by an undertaking not to apply for registration to practice as a physician in any jurisdiction brings to an end a career as a flawed physician.

The facts admitted in today's hearing encapsulate the issues you have encountered during your career.

You prescribed Seroquel to Patient A because he was having difficulty sleeping. You did so:

- a) without performing an adequate assessment,
- b) without describing what you were prescribing,
- c) without regard to the patient's history of addiction and,
- d) your clinical record keeping for Patient A was grossly deficient.

A review of 15 additional patient charts, revealed fundamental issues with your record keeping and care of patients.

And not for the first time you have used abusive language.

Given your history with the Inquiries, Complaints and Reports Committee and the Discipline Tribunal you have shown yourself to be ungovernable and incapable of remediation.

Your admission of incompetence is entirely appropriate. There is no need to prolong this reprimand. Your career as a physician is now ended.