

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Mory Mayer Gutman, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of patients, or any information that could identify the patients referred to orally or in the exhibits filed at the hearing 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.

This is also notice that the Discipline Committee ordered a ban on the publication of the name and any information that could disclose the identity of the witnesses whose testimony is in relation to allegations of misconduct of a sexual nature involving the witnesses, under subsection 47(1) 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. Gutman,
2017 ONCPSD 47**

**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. MORY MAYER GUTMAN

PANEL MEMBERS:

**DR. C. CLAPPERTON (CHAIR)
MS G. SPARROW
DR. E. STANTON
MR. P. GIROUX
DR. J. WATTERS**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF
ONTARIO:**

MS A. CRANKER

COUNSEL FOR DR. GUTMAN:

MS A. CHAISSON

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date:	August 24, 2017
Finding Decision Date:	August 24, 2017
Penalty Decision Date:	November 10, 2017
Release of Written Reasons:	November 10, 2017

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard together, on consent, the matters referred in the Notice of Hearing dated September 21, 2016 and the Notice of Hearing dated June 13, 2017. The hearing took place at Toronto on August 24, 2017. At the conclusion of the liability portion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct as alleged in the Notices of Hearing. After hearing evidence and submissions in the penalty hearing, the Committee reserved its decision on the matter of penalty.

ALLEGATIONS

The Notices of Hearing of September 21, 2016 and June 13, 2017 alleged that Dr. Mory Mayer Gutman committed acts 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 the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO ALLEGATIONS

Dr. Gutman admitted the allegations in the Notices of Hearing 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.

THE FACTS

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

Background

1. Dr. Gutman is a 65 year old family medicine physician practising in Toronto. Dr. Gutman received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on June 21, 1976.
2. In 2011, Dr. Gutman was found to have engaged in professional misconduct on the basis that he failed to maintain the standard of practice and 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. A copy of the decision and reasons of the Discipline Committee is attached at Tab A [to the Agreed Statement of Facts and Admission].
3. Further to the Order of the Discipline Committee, Dr. Gutman was among other things, prohibited from prescribing Narcotic Drugs/Preparations, Controlled Drugs, Benzodiazepines and other Targeted Substances (prescribing restriction) and prohibited from engaging in professional encounters with any female patients. A copy of the Order is attached at Tab B [to the Agreed Statement of Facts and Admission].

A. Prescribing contrary to the Discipline Committee’s restrictions

4. In January of 2013 the College received information from a pharmacist, that Dr. Gutman had prescribed Testosterone gel to a male patient in 2012 and 2013, contrary to the terms of his prescribing restriction and prohibited by the Order of the Discipline Committee. Testosterone gel is a controlled substance.
5. In May of 2014, the Inquiries, Complaints and Report Committee (ICRC) advised Dr. Gutman to be vigilant to ensure that he does not breach the terms of his certificate of registration. A copy of the ICRC’s decision is attached at Tab C [to the Agreed Statement of Facts and Admission].
6. In 2016 information from the Narcotics Monitoring System (NMS) for the time period of April 1, 2013 to August 13, 2015, was received by the College, raising concerns that Dr. Gutman had prescribed contrary to the Order of the Discipline

Committee and the terms of his certificate. The College commenced an investigation.

The Investigation

a) Testosterone

7. Dr. Gutman prescribed Testosterone gel to Patient 1 in October 2012; ten repeats were prescribed. Dr. Gutman was unaware that Testosterone was a controlled substance and therefore a medication he was prohibited from prescribing.

b) Sublinox

8. Sublinox is a controlled substance that Dr. Gutman is prohibited from prescribing.
9. Dr. Gutman prescribed Sublinox to Patient A on two occasions in October 2014.
10. Dr. Gutman prescribed Sublinox to Patient B on three occasions in September 2014.
11. Dr. Gutman prescribed Sublinox to Patient C on one occasion in October 2014, and on a second occasion in October 2014 with 8 refills.
12. Dr. Gutman prescribed Sublinox to Patient D in February 2014 and in April of 2016.
13. Dr. Gutman prescribed Sublinox to Patient E in October 2014 and April of 2016.
14. Dr. Gutman was unaware that Sublinox was a controlled substance and therefore a medication that he was prohibited from prescribing. The prescribing described in paragraphs 9-14 occurred prior to a pharmacist bringing to his attention that this substance was designated as a controlled drug.

c) Phenobarbital

15. Phenobarbital is a controlled substance that Dr. Gutman is prohibited from prescribing.
16. Dr. Gutman authorized eight refills of phenobarbital, to Patient F, an elderly patient who suffers from intellectual impairment and seizures, in March of 2014.
17. Dr. Gutman was aware that Phenobarbital is a controlled substance at the time he

prescribed it. The prescribing described in 16 above was an error that occurred when Dr. Gutman was renewing batch prescriptions of medication prescribed by Patient F's previous physician.

d) Clobazam

18. Clobazam is a benzodiazepine that Dr. Gutman is prohibited from prescribing.
19. Dr. Gutman prescribed Clobazam to Patient G, a young man with recurrent seizures, on one occasion in February 2016. Patient G is on a regimen of anti-convulsant medication. Dr. Gutman was asked to authorize a refill of his anti-convulsant medications. Dr. Gutman authorized a refill of Levetiracetam (an anti-convulsant, but not a controlled drug) and also authorized Clobazam (also used as an anti-convulsant, but which is a benzodiazepine which Dr. Gutman is prohibited from prescribing).
20. Dr. Gutman was not aware that Clobazam is a benzodiazepine at the time he prescribed it. The prescribing described in 19 above was an error by Dr. Gutman that occurred when renewing batch prescriptions for medication prescribed by Patient G's previous physician.

B. Assessing a Female Patient contrary to the Discipline Committee's Restriction

21. The College received information in November of 2016, that Dr. Gutman may have conducted an assessment of a female patient, contrary to the terms of the Discipline Committee restrictions. The College commenced an investigation.

The Investigation

22. Dr. Gutman was contacted by a member of Patient H's family, with a request that Dr. Gutman find a physician to assess Patient H. Dr. Gutman understood that there was a degree of urgency to the request made to him as the family was having difficulty finding a physician to conduct the assessment.
23. At issue was Patient H's capacity to vary her will and execute a new Power of Attorney. There was a dispute amongst family members about Patient H's

competence and whether she should be placed into a home for the elderly or remain living in the home of one of her children.

24. Dr. Gutman had conducted a prior assessment of Patient H in 2006, prior to his restriction from seeing female patients.
25. In October, 2016, Dr. Gutman conducted a capacity assessment of Patient H, who was in her 90's at the time of the assessment. A copy of the assessment is attached at Tab D [to the Agreed Statement of Facts and Admission].
26. Dr. Gutman did not retain a record of this encounter. He did not bill OHIP. Attached is a copy of Patient H's OHIP record at Tab E [to the Agreed Statement of Facts and Admission].
27. Dr. Gutman believed that given Patient H is in her 90s, "the CPSO would acknowledge that this was not what my restriction (against seeing female patients) was about."

Admission

28. Dr. Gutman admits that the conduct set out above constitutes professional misconduct, and admits specifically that his conduct 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, dishonorable, or unprofessional, contrary to paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991.

FINDING

The Committee accepts as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepts Dr. Gutman's admissions and finds that he committed an act of professional misconduct, in that he has engaged in acts or omissions in both matters relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

SUBMISSIONS ON PENALTY

The parties agree that an appropriate penalty order would include a period of suspension of Dr. Gutman's certificate of registration, a reprimand, successful completion of an approved course in understanding boundaries, and payment to the College of one day's hearing costs.

The College seeks a nine-month suspension, to take effect 15 days from the date of the order, as well as successful completion of one-on-one instruction in medical ethics.

Counsel for Dr. Gutman submits that a suspension in the range of three to six months is appropriate, and recommends a four-month suspension, effective 60 days from the date of the order.

EVIDENCE ON PENALTY

In arriving at its penalty decision, the Committee considered the documentary evidence and heard evidence from two witnesses called by counsel for Dr. Gutman: Mr. Dominic Stenka and Dr. Gutman. In addition, the Committee considered the submissions of the parties and considered prior decisions of the Discipline Committee provided by both counsel.

WITNESSES

Mr. Dominic Stenka

Mr. Stenka is Dr. Gutman's office manager and sole office employee. Mr. Stenka had worked previously as a pharmacy technician. He testified that many of Dr. Gutman's patients are disadvantaged and have challenges accessing health care. He outlined how requests for prescription renewals are managed and the measures that are now in place to minimize the possibility of a prescription for a controlled substance being given to a patient or filled by a pharmacy.

Dr. Gutman

Dr. Gutman testified that his prescribing of testosterone, Sublinox, and Clobazam was inadvertent and he had been unaware that they are controlled substances that he is prohibited from prescribing. Dr. Gutman stated that he immediately stopped prescribing Sublinox when a pharmacist friend made him aware it is a controlled substance.

Dr. Gutman testified that he was aware that phenobarbital is a controlled substance when he prescribed it. He stated that it was one of three to five medications for which he renewed prescriptions on behalf of a family member of a pharmacist who works in the same building. Dr. Gutman testified that he had not been careful enough in examining the batch request for prescription renewal. He characterized his actions as renewal of another physician's prescription, an oversight and error, and not that he himself prescribed phenobarbital.

Dr. Gutman described the measures instituted in his office after he became aware in 2016 that the existing processes to prevent inappropriate prescribing were insufficient.

Dr. Gutman testified that he has always cooperated fully with the College and has complied with all suggestions. He stated that an assessment of his practice in November 2012 identified some issues with documentation. This was shortly after he returned to practice and while he was transitioning from paper records to Electronic Medical Records (EMR). He stated that he then completed a record-keeping course, made changes in his practice, and had a fully satisfactory practice reassessment.

Dr. Gutman testified that he had done everything expected of him in the Physician Health Program (PHP) and has attended Caduceus group meetings for 7.5 years. A letter from the PHP Medical Director states that there were no concerns with Dr. Gutman's compliance or participation and describes him as interacting in a respectful and cooperative manner. Dr. Gutman confirmed the statements he made in a letter to the College investigator on June 24, 2016 to the effect that he regretted his errors, was very embarrassed, takes complete responsibility and sincerely apologizes.

Dr. Gutman testified that his practice includes many patients with complex needs related to advanced age, addiction, poverty, language barriers, and/or being a refugee. He expressed concern about the wellbeing of his patients if he were to be absent for a lengthy period of time from his medical practice. Dr. Gutman testified that it would definitely be helpful for him to have a two-month period prior to a suspension of his certificate of registration to make arrangements for his patients. He described some of his personal and financial circumstances and the anticipated impact of a suspension. He stated that he intends to keep his practice open during the period of his suspension.

With respect to his assessment of a female patient, Dr. Gutman testified that this was a lapse in judgement that he regrets. He had known the individual and her family for many years and continues to provide care for her male family members. Dr. Gutman described his experience with the elderly, including as a former nursing home director and providing palliative care. He described the circumstances that led to his doing the assessment of the elderly female patient's competency. He did not volunteer to do the assessment. The patient's relative, who accompanied her throughout, was aware that Dr. Gutman was prohibited from seeing female patients, but he was uncertain whether the patient herself was aware. Dr. Gutman described the patient as being terrified that she might be removed from her home and believed there was urgency to completing the assessment. The assessment took ten minutes. It did not include a physical exam. Dr. Gutman testified that he did not think to bill and that he did not keep an office record or notes because the letter he wrote served as the record.

With respect to his prescribing restriction, Dr. Gutman acknowledged that his appearance before the Committee in 2011 arose from incomplete and inadequate record-keeping and failure to appropriately manage prescription renewals and opiate prescribing. He testified that when he returned to practice in 2012 following a four-month suspension of his certificate of registration, he kept the list of the substances he was prohibited from prescribing on his desk, referring to it if he had a question, and there was a sign posted in his office. Dr. Gutman acknowledged that he received advice from the ICRC as a result of his prescribing testosterone to a patient in 2012, that he stated in his response to the

ICRC that he was extremely vigilant about complying with the terms on his certificate of registration, and that he could have learned that testosterone was a controlled substance if he had taken appropriate steps. More generally, Dr. Gutman acknowledged that he has an obligation to review a request for prescription renewal and conduct due diligence even if the original prescription was written by another physician.

Dr. Gutman acknowledged that he had deliberately violated the terms on his certificate of registration by conducting an assessment of a female patient and that he did so less than a month following the Notice of Hearing that alleged breaches of his prescribing restriction. He acknowledged receiving a clear written response from the College compliance monitor in 2012 to the effect that he was not permitted to see female patients. Dr. Gutman testified that he clearly understood that he was breaching the Committee's order, but he did not think that the intent of the order would apply in this circumstance.

Dr. Gutman did not attempt to contact the College compliance monitor, interview the patient's other relatives, request records from or discuss the situation with the patient's current family physician, or review prior competency assessments or his own previous clinical records. Dr. Gutman agreed that it is good practice to keep clinical records, but stated that it did not occur to him to record any details of his assessment. He stated that it did not enter his mind to bill for the assessment and that he often works *pro bono*. He testified that he has done three or four competency assessments in the last five years and that he usually keeps notes and bills for them. Dr. Gutman acknowledged that he did not want the College to find out that he had assessed a female patient. Dr. Gutman asserted that his assessment of this patient was not a medical encounter "because I was doing a very limited assessment that had nothing to do with her wellbeing in terms of her health."

DECISION ON PENALTY

For the reasons that follow, the Committee orders that Dr. Gutman's certificate of registration be suspended for a period of seven months, effective 30 days from the date of the order. In addition, the Committee orders that Dr. Gutman successfully complete one-

on-one instruction in Medical Ethics and a course in Understanding Boundaries at his own expense prior to resuming practice, that he appear before the panel to be reprimanded, and that he pay costs to the College for one day's hearing at the College tariff rate of \$5,500.00. The specific terms of the penalty and costs order are set out below.

REASONS FOR DECISION ON PENALTY

The principles which guide the imposition of penalty in College disciplinary proceedings are well established. The protection of the public is paramount. The penalty should serve as a specific deterrent to the member and as a general deterrent to the profession. The penalty should express the profession's denunciation of the member's misconduct. It should strive to maintain the public's confidence in the integrity of the profession and in the College's ability to govern the profession in the public interest. The penalty should serve to rehabilitate the member when appropriate. The penalty should be proportionate to the misconduct and be reasonably consistent with previous disciplinary decisions in similar cases.

It is for the Committee to weigh these principles in light of the specific facts and circumstances of the case, including both aggravating and mitigating factors, in order to arrive at a penalty which is just and appropriate.

Aggravating factors

The Committee is very troubled by Dr. Gutman's repeated breaches of his practice restrictions and by the fact that he has breached both the prescribing restriction and the prohibition on professional encounters with female patients. Dr. Gutman has previously breached the prescribing restriction, albeit inadvertently, calling into question his statement to the ICRC at that time that he is 'extremely vigilant' about complying with the terms on his certificate of registration. Further, Dr. Gutman deliberately breached the prohibition not to engage in professional encounters with female patients less than one

month after the Notice of Hearing alleging prescribing breaches, that is, at a time when he would be expected to be especially sensitive to the issue of compliance with his practice restrictions. There were alternatives to his proceeding to complete the assessment of a female patient that he should have been aware of, but either did not consider or chose not to pursue.

The expectation that a physician will be diligent in abiding by an order of the Discipline Committee and the seriousness of repeated breaches of an order were made clear in *CPSO v. Sweet*, 2012 ONCPSD 11. In that case, the physician had breached, for the third time, a 2002 order that included a prohibition on prescribing controlled substances. He had appeared before the Committee in 2004 for a breach of the prescribing restriction and again in 2008 for a second breach of the order in failing to have a proper sign in the waiting area of his office. The Committee commented that:

A reasonable physician would make absolutely certain that he knew the full and precise nature of any conditions imposed on their practice and they would ensure that they abided by those conditions. Repeatedly breaching the terms and conditions of an undertaking or order reflects a flagrant disregard for this College's responsibility to govern its members in the public interest. It is important that neither the public nor the profession be misled into thinking that even minor breaches of an Order of the Committee will be tolerated.

The Committee accepts that Dr. Gutman's breaches of his prescribing restriction represent lack of awareness, lack of knowledge, or oversights on his part. The Committee finds that they do not constitute a willful disregard of its order. Nonetheless, it is the Committee's view that they are unacceptable, were preventable, and reflect a striking lack of care and attention by Dr. Gutman when his responsibilities should have been very clear to him from his previous appearances before the Discipline Committee and the ICRC.

The seriousness of even inadvertent breaches was emphasized in *CPSO v. Maytham*, 2011 ONCPSD 18, where the physician breached an undertaking by failing to maintain a satisfactory narcotics register, although he had properly documented the prescriptions in his clinical notes. The physician had appeared before the Committee twice previously: once for a prescribing offence, and once for inadvertent breach of an undertaking. The Committee held that even if the physician's actions were not deliberate contraventions of the order, they nonetheless represented a clear lack of personal responsibility and "a disregard of the College's responsibility for professional governance. This disregard significantly exceeded carelessness or sloppiness, particularly given that it occurred after the Committee had reminded [the physician] at previous appearances of the seriousness with which the terms of the order should be viewed."

With respect to the restriction on professional encounters with female patients, the Committee was deeply concerned by the deliberate nature of Dr. Gutman's breach and by his rationalizations and attempted concealment. The Committee considers that his assertion, "Given that [Patient H] is in her 90s, I believe that the CPSO would acknowledge that she was not what my restriction was about" marks a serious disregard for the nature and substance of an order of the Discipline Committee. It suggests a presumption that he should be allowed to interpret the order, despite his having previously received an unambiguous confirmation of the prohibition against seeing female patients. Further, Dr. Gutman made his decision to proceed with the competency assessment of a female patient knowing that to do so was a breach of the Committee's order and knowing the potential consequences for himself and his practice of doing so.

The Committee accepts Dr. Gutman's description of events leading to the assessment, but finds disingenuous his explanation for neither billing for the assessment, nor recording any clinical details of it: in essence, he said it did not occur to him to do either and/or he felt that the letter he wrote was a sufficient record. Although Dr. Gutman may commonly not bill patients who are uninsured, his usual practice in doing competency assessments has been to keep notes and to bill OHIP. Dr. Gutman has acknowledged that he did not

want the College to learn of this encounter. The Committee concludes that the lack of billing and record-keeping were intended to conceal the encounter from the College.

The Committee does not accept Dr. Gutman's assertion that the competency assessment was not a medical encounter and considers this assertion an attempt either to avoid having the encounter considered a breach, or to minimize the severity of the breach. In any event, he has acknowledged the breach.

Counsel for Dr. Gutman submitted that Dr. Gutman's assessment of a female patient should be characterized as a momentary, one-time lapse in judgment which he very much regrets. The Committee accepts that Dr. Gutman breached this prohibition only once and that he very much regrets doing so, but finds his lapse in judgement very concerning for the reasons stated above.

Mitigating Factors

Counsel for the College and counsel for Dr. Gutman agreed that Dr. Gutman's admitting the allegations, with an agreed statement of facts, reduced hearing time and costs, and constituted a mitigating factor.

Dr. Gutman's counsel submitted that he has consistently acknowledged wrongdoing and that his behaviour has consistently been to do what the College has required of him. The Committee is impressed by Dr. Gutman's successful participation in the Physician Health Program. The Committee also acknowledges that Dr. Gutman had not prescribed any controlled medications once he learned they were controlled. This was recognized as a mitigating factor in *CPSO v. Maytham*, 2007 ONCPSD 25. Dr. Gutman put in place more robust measures to avoid inappropriate prescribing, but only after he became aware of the breaches, i.e. after the fact. The Committee does not view implementing such measures at that point as being significantly mitigating. Further, the Committee does not consider Dr. Gutman's deliberate breach of the restriction on encounters with female patients, albeit in relation to one patient, demonstrated that he consistently followed the College's direction.

Dr. Gutman's counsel submitted that the absence of harm to patients and that Dr. Gutman's actions were not for personal gain should be considered as mitigating factors. The Committee gives these factors limited weight. The apparent absence of harm is fortunate, but does not constitute a mitigating factor. The practice restrictions were put in place in 2011 for specific reasons to protect the public. At that time, the Committee found that Dr. Gutman had failed to maintain the standard of practice with respect to prescribing and he had committed boundary violations. At this time, the Committee can give little credit for the absence of harm, given Dr. Gutman's errors, lack of knowledge, and/or insufficient attention to detail in his prescribing, and his deliberate choice to flout the Committee's order by engaging in a professional encounter with a female patient. It is Dr. Gutman's breaches of his practice restrictions which are the subject of this hearing. The Committee accepts that Dr. Gutman's motivation was not personal gain, but does not view this as significantly mitigating: it is expected - as a fundamental value of the profession - that physicians strive to serve the needs of their patients individually, their patient's families, and their patient populations overall.

The Committee was impressed by Dr. Gutman's commitment to serving disadvantaged and vulnerable individuals and recognizes his willingness to provide such services to uninsured patients without compensation. It is clear that Dr. Gutman is attuned to the diverse needs and challenges faced by many of his patients. His counsel submitted that the potential harm to patients who may have difficulty accessing care were he to be suspended for an extended period of time should be considered by the Committee in determining the length of suspension. Dr. Gutman's counsel requested that any period of suspension be deferred for a period of two months to allow Dr. Gutman to put in place appropriate arrangements for his patients in his absence. Dr. Gutman testified that such a period of time would 'definitely' be helpful.

Case Law

Two other cases in which the physician worked in an under-serviced area were considered. Counsel for Dr. Gutman cited *CPSO v. Brand*, 2002 ONCPSD 17 in which

the physician breached an undertaking not to work emergency room shifts and charted inappropriate comments about a College medical inspector. The Committee accepted a joint submission on penalty that was sensitive to the needs of the underserved area. Counsel for the College referred to *CPSO v. Deluco*, 2005 ONCPSD 8 in which the physician examined two female patients without a chaperone present, breaching a section 37 order. The College had received a significant number of letters from the physician's patients expressing concern about the loss of his medical services. The Committee found that physician shortage "while an unfortunate state and serious problem in many parts of Ontario", could not be a mitigating factor. The Committee stated its view that physicians in under-served areas must be held to the same standard as all physicians in the province and that, most importantly, the patients in such areas cannot be subjected to lesser standards of physician conduct. The Committee supports the analysis in *Deluco*, and is of the view that the potential consequences of Dr. Gutman's absence during any suspension will be mitigated by allowing him time to make appropriate arrangements for coverage of his patients during the period of his suspension.

Counsel for Dr. Gutman submitted that the impact of a proposed order on the practitioner, his family, and his livelihood should be considered, citing Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act* (March 2017), 6:80.30(7). The Committee notes that the penalty of a seven-month suspension is not markedly greater than the upper limit of the range proposed by counsel for Dr. Gutman and slightly less than that proposed by the College counsel.

The Committee is aware that each case is unique, with a unique set of facts and mitigating and aggravating factors, and that an appropriate penalty that is fair and just must take these into account. The Committee finds that the facts in the prior cases differ significantly from those at issue here. For example, the misconduct in *CPSO v. Patel*, 2015 ONCPSD 22, *CPSO v. Noriega*, 2013 ONCPSD 26 and *CPSO v. Marcin*, 2016 ONCPSD 7, was so extreme as to not be of assistance to the Committee. The Committee found *CPSO v. Maytham*, 2011 ONCPSD 18, *CPSO v. Deluco*, 2005 ONCPSD 17, 2005 ONCPSD 24 and *CPSO v. Sweet*, 2012 ONCPSD 11 useful in its deliberations.

In *CPSO v. Maytham*, 2011 ONCPSD 18, the physician breached an undertaking related to prescribing controlled substances, having appeared twice before the Discipline Committee: once for a prescribing offence and once for an inadvertent breach of an undertaking. The penalty included a reprimand and a four-month suspension. Counsel for Dr. Gutman submitted that the facts of the physician's first appearance for breach of an undertaking (*CPSO v. Maytham*, 2007 ONCPSD 25) were closer to the present case. The Committee views the facts in *CPSO v. Maytham*, 2011 ONCPSD 18 as more comparable to Dr. Gutman's matter.

In *CPSO v. Sweet*, 2012 ONCPSD 11, the physician breached, for the third time, an order prohibiting him from prescribing controlled substances. The jointly proposed penalty included a four-month suspension and a reprimand. The misconduct pertains to a prescribing restriction and arose to some extent from insufficient diligence. However, it appears more serious than in the present case, in that the breaches were repeated more often. There is no parallel to the breach of Dr. Gutman's prohibition on seeing female patients in either *CPSO v. Maytham*, 2011 ONCPSD 18 or *CPSO v. Sweet*, 2012 ONCPSD 11.

In *Deluco*, 2005 ONCPSD 17, 2005 ONCPSD 24, the physician examined two female patients, each at one encounter, breaching a section 37 order prohibiting the examination of female patients without an acceptable chaperone. The penalty included a six-month suspension. The facts are similar insofar as both physicians deliberately breached a restriction on professional encounters with female patients. The Committee puts relatively less weight on differences in the clinical specifics of the encounters, and also notes that *Deluco*, 2005 ONCPSD 17, 2005 ONCPSD 24 has no equivalent to Dr. Gutman's prescribing breaches.

Conclusion

An order of the Discipline Committee is a serious matter and the College must be able to trust that a member will regard it with the utmost seriousness and abide by it with

diligence. Repeatedly breaching the terms and conditions of an order reflects a blatant disregard of the member for the College's responsibility to govern its members in the public interest. The Committee finds a serious penalty is warranted by the totality of the facts and is consistent with other similar cases. The penalty of a lengthy suspension will serve as a clear and necessary denunciation of the misconduct and will help maintain the confidence of the public in the integrity of the profession and in the College's ability to govern the profession in the public interest. The seven-month suspension and a reprimand will serve as a specific deterrent to Dr. Gutman and as a general deterrent to the membership, by highlighting the respect and diligence that must be accorded to orders of the Committee.

Deferring the suspension for thirty days will allow Dr. Gutman to put in place appropriate arrangements for his patients in his absence. He has given thought to how best to do so and, as both counsel proposed a period of suspension, he has been aware of the strong likelihood that suspension of his certificate of registration will be ordered and he has had ample additional time to prepare. Public protection will be served by the requirement for completion of instruction in ethics and a course on understanding boundaries. The public will be further protected in that the finding of professional misconduct and a summary of the facts is posted on the College Public Register.

Furthermore, the existing terms, conditions and limitations on Dr. Gutman's certificate of registration, ordered in 2011, will remain in place. The payment of costs to the College of one day's hearing at the College's tariff of \$5,500, as specified in the Rules of the Discipline Committee, is appropriate.

ORDER

Therefore, the Committee orders and directs that:

1. The Registrar suspend Dr. Gutman's Certificate of Registration for a period of seven (7) months, effective 30 days from the date of this Order.

2. The Registrar impose the following terms, conditions, and limitations on Dr. Gutman's Certificate of Registration:
 - (i) Dr. Gutman will successfully complete one-on-one instruction in medical ethics with an instructor approved by the College, at his own expense, and shall provide proof of completion to the College prior to his resumption of practice;
 - (ii) Dr. Gutman will successfully complete instruction in understanding boundaries through a course approved by the College, at his own expense, and shall provide proof of completion to the College prior to his resumption of practice;
3. Dr. Gutman appear before the Committee to be reprimanded within 90 days of the date of this Order.
4. Dr. Gutman pay to the College costs in the amount of \$5,500.00 within thirty (30) days of the date of this Order.