Court of Appeal File No.: C63644

COURT OF APPEAL FOR ONTARIO

B E T W E E N :

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Appellant (Respondent)

\- and -

DR. JAVAD PEIROVY

Respondent (Appellant)

Publication Ban Notification:

The Discipline Committee of the College of Physicians and Surgeons of Ontario ordered that no person shall publish or broadcast the identity of any information that could identify the complainants 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. The Order was lifted in respect of one complainant, T.D., at her request.

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PART I – OVERVIEW OF THE CASE

1. Sexual abuse is an extreme form of misconduct by a physician towards his patients. It represents an egregious breach of the physician's role and duty to patients. It is fundamentally contrary to the conduct reasonably expected by patients, the public, the profession, the regulator and the legislature in 2017 in Ontario.

2. The Appellant seeks to sustain a penalty imposed by the Discipline Committee of a six-month suspension of his certificate of registration. The wholly insufficient penalty was imposed to address three separate findings of professional misconduct, none of which were appealed by the Appellant. First, the Appellant sexually abused four female patients at a walk-in clinic in Toronto, between November 2009 and July 2010. The Appellant deliberately cupped his patients' breasts, touching their nipples and, in one instance, "tweaking" a patient's nipples. Second, the Appellant asked a fifth patient out on a date immediately following his medical examination of her, during which her breasts were fully exposed. Third, the Appellant, who had been charged with sexual assault in respect of the above patients, pleaded and was found guilty of common assault in respect of two of these patients.

3. The Divisional Court quashed the penalty decision of the Discipline Committee for two reasons. First, the penalty decision contained multiple errors in principle which fatally undermined the reasonableness of the Committee's decision. The Committee made findings on penalty that were inconsistent with its findings on liability. It drew inadmissible inferences from the psychiatric evidence to conclude that the Appellant had no sexual motivation. It incorrectly held that revocation is reserved for only the most egregious offenders. The Divisional Court correctly concluded that, taken as a whole, and without subjecting the reasons to painstaking scrutiny, the Committee's decision was unreasonable and wrong in law.

4. Second, the Divisional Court held that the Discipline Committee's penalty decision is significantly out of step with community values regarding physician-patient sexual abuse. A six-month suspension is wholly inadequate to address the Appellant's repeated sexual abuse of patients under the guise of a medical examination.

5. The fact that prior penalty decisions, described by the Court as unfit, had not been appealed is irrelevant. The Divisional Court did not "overturn" prior decisions. Rather, the Court held that the penalty in this case was clearly unfit and that earlier decisions did not fulfill the public protection mandate of the College and should not be relied on in this case.

6. The community's intolerance for sexual abuse of patients by physicians has been recognized by the legislature, the courts and the regulatory bodies since at least 1991.

7. While the Divisional Court commented that it would expect the Discipline Committee to be debating a suspension measured in years as opposed to months,[1] legislative change has overtaken the Court's comments. On May 30, 2017, the *Protecting Patients* Act, 2017, was enacted. Revocation is now statutorily mandated for any physician who engages in touching of a sexual nature of a patient's breasts, as the Appellant did to four of his patients.[2]

8. Penalties for physicians who engage in sexually abusive behaviour towards their patients are expected to reflect the zero tolerance regime that has been in place in this province since January 1, 1994, and that has been re-affirmed with the enactment of the *Protecting Patients Act*, 2017.[3] The penalty imposed in this case does not reflect zero tolerance. It does not protect the public. It undermines public confidence in the ability of the profession and the

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[1] *College of Physicians and Surgeons v. Peirovy*, 2017 ONSC 136, at para. 39 (Div. Ct.) [*Peirovy* (Div. Ct.)], Respondent's Book of Authorities [Respondent's BOA], Tab 1

[2] *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act*, 1991, S.O. 1991, C-18, ss. 51(5) 3(vi)

[3] *Protecting Patients Act*, 2017, S.O. 2017, C.11 (Bill 87)

regulator to eradicate sexual abuse of patients by physicians. The Discipline Committee relied on a flawed reasoning process to arrive at a penalty that is manifestly unfit. The Discipline Committee's failure is particularly acute in light of the overwhelming public protection aspect of all penalty decisions made under the *Regulated Health Professions Act*.

PART II - THE FACTS

A. OVERVIEW

9. During the liability phase of the hearing, the Discipline Committee found the Appellant liable under three heads of professional misconduct, in respect of a total of five patients. The Appellant did not appeal from these findings:

- He engaged in sexual abuse of four patients;
- He engaged in disgraceful, dishonourable or unprofessional conduct, with respect to five patients;
- He had been found guilty of an offence (assault) that is relevant to his suitability to practise, with respect to two patients.[4]

10. In the penalty phase of the hearing, the College sought revocation of the Appellant's certificate of registration. The Appellant submitted that a suspension of four months was appropriate. The Discipline Committee imposed a six-month suspension of the Appellant's certificate of registration, and various other terms and conditions. The College successfully appealed on the issue of penalty to the Divisional Court. The Divisional Court sent the matter of penalty back to the Discipline Committee for determination.

B. THE APPELLANT SEXUALLY ABUSED FOUR OF HIS FEMALE PATIENTS

11. The Discipline Committee accepted the four patients' evidence as credible and reliable and found that the Appellant's conduct with these patients amounted to sexual abuse and

[4] Decision and Reasons for Decisions of Discipline Committee, July 17, 2015, Appellant's Appeal Book and Compendium (Appellant's Compendium), Tab 6, pp. 46-87

conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.[5] Each patient's evidence was also accepted as similar fact for the others.[6]

(i) Sexual Abuse of Patient "V" (A.C.C.)

12. This patient was 18 years old when she saw the Appellant at a walk-in clinic in Toronto on November 17, 2009. She had a sore throat and was unable to reach her family doctor.[7]

13. The Appellant instructed the patient to lie on the examination table and look at the wall. During his examination of her, the Appellant placed his hand, holding his stethoscope, under her clothing and touched her breasts. He placed his hand under her bra while she was lying down on the examination table, and placed his stethoscope directly on her nipples on both her breasts, one after the other. The patient felt slight pressure on her nipples for approximately 5 seconds. The Appellant said nothing while he was conducting this examination.[8]

14. The patient felt shocked and violated. No prior medical examination of her chest had occurred in this way.[9]

(ii) Sexual Abuse of Patient "X" (T.D.)

15. This 28-year-old patient saw the Appellant on February 24, 2010 at a walk-in clinic in Toronto. She was having issues with her sinuses/ears and believed she needed medication.[10]

16. This patient was lying on the examination table when the Appellant placed his hand, holding his stethoscope, under her bra. He touched her breasts with his hand. He cupped her breasts and used his fingers to put pressure on her nipples. The patient described the touching as "tweaking", meaning that he grasped or pinched her nipples between two of his fingers. The

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[5] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 72-76
[6] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 82-86
[7] Evidence of A.C.C., Respondent's Compendium, Tab 2, p. 13, l. 18 to p. 15, l. 20
[8] Evidence of A.C.C., Respondent's Compendium, Tab 2, p.16, l. 6 to p. 24, l. 15
[9] Evidence of A.C.C., Respondent's Compendium, Tab 2, p. 23, l. 4 to p. 25, l. 18
[10] Evidence of T.D., Respondent's Compendium, Tab 4, p. 39, l. 20 to p. 40, l. 20

examination was different from any other chest examination conducted by other physicians.[11]

17. The patient was in shock and felt frozen. She knew that what was happening was wrong. She kept thinking, “He’s a pervert. He’s a pervert. You’ve got to get out of here”.[12]

(iii) Sexual Abuse of Patient “U” (D.A)

18. This patient was 23 when she went to a walk-in clinic in Toronto on March 24, 2010, for medical attention for a sinus infection.[13]

19. The Appellant stated that he needed to lift her clothing to listen to her chest. He instructed the patient to lie down and face the wall. He lifted her clothing and her bra over her breasts. He placed his stethoscope on various locations on her breasts, including directly on top of her nipples. The Appellant cupped each of her breasts with his hand.[14]

20. The patient immediately felt that the touch was inappropriate. No physician had examined her in this manner before. She felt frightened and angry and left the clinic crying. She spoke to her boyfriend, who was waiting outside, and they both went in to speak to the Appellant, who apologized for making her uncomfortable.[15]

(iv) Sexual Abuse of Patient “W” (P.F.)

21. This patient saw the Appellant at a walk-in clinic in Toronto on July 31, 2010, when she was 32 years old. The patient felt unwell and believed she might need antibiotics.[16] By the time he saw this patient, the Appellant knew that Patient “U” had complained to the College.

22. The Appellant listened to her chest using his stethoscope while she lay on her back. He

[11] Evidence of T.D., Respondent’s Compendium, Tab 4, p. 40, l. 15 to p. 48, l. 22
[12] Evidence of T.D., Respondent’s Compendium, Tab 4, p. 49, l. 1 to p. 53, l. 20
[13] Evidence of D.A., Respondent’s Compendium, Tab 1, p. 2 , l. 1 to p. 4, l. 20
[14] Evidence of D.A , Respondent’s Compendium, Tab 1, p. 5, l. 1 to p. 9, l. 24
[15] Evidence of D.A., Respondent’s Compendium, Tab 1, p. 8, l. 18 to p. 11, l. 20
[16] Evidence of P.F., Respondent’s Compendium, Tab 3, p. 29, l. 21 to p. 30, l. 18

slid his hands under her clothes and bra and touched her nipples with his fingers. He examined her left breast first. The patient was very uncomfortable and when he started to move to her right breast, she tried to make it difficult for him by pulling her shoulders back to tighten her clothes over her chest. The Appellant persisted and inserted his hand under bra, touching her right nipple. The patient had never been examined in this way before by any other physician conducting a chest examination.[17]

C. PROFESSIONAL MISCONDUCT IN RELATION TO PATIENT "Z" (D.B.)

23. This 22-year-old patient was examined by the Appellant on March 17, 2010, at a walk-in clinic in Toronto.[18]. The Appellant asked the patient to undo her bra and lift her clothing. The patient's breasts were fully exposed and the Appellant did not explain what he was doing nor did he offer her a gown or any covering for her breasts.[19]

24. Immediately after the examination, the Appellant asked his patient out on a date. The Appellant told her that if they saw each other socially, he could not be her doctor. He asked her to sign a note on the chart terminating the doctor-patient relationship. The patient was extremely uncomfortable and gladly signed the document terminating the doctor-patient relationship. Her intention was to terminate the appointment as quickly as possible and leave. The Appellant told her he would call her, although he never did.[20]

25. The Committee found that a physician asking his patient out during a medical appointment and viewing her as a "legitimate future object of his social, romantic and/or sexual interests" was disgraceful, dishonourable or unprofessional conduct, particularly given the

[17] Evidence of P.F. Respondent's Compendium, Tab 3, p. 31, l. 1 to p. 36, l. 25
[18] Evidence of D.B., Respondent's Compendium, Tab 5, p. 55, l .6 to p. 58, l. 20
[19] Evidence of D.B., Respondent's Compendium, Tab 5, p. 59, l. 1 to p. 69, l. 15; p.75, ll. 2-23
[20] Evidence of D.B., Respondent's Compendium, Tab 5, p. 69, l. 20 to p. 74, l. 5

manner in which the examination had been conducted with her breasts fully bared.[21] The Committee also found that the Appellant lacked credibility when he denied any sexual interest in asking to see his patient socially.[22]

D. CRIMINAL CONVICTIONS FOR ASSAULT

26. The Respondent was criminally charged with six counts of sexual assault in relation to six patients, including the five described above. Ultimately, he pleaded guilty and was found guilty of two counts of assault in respect of Patients "U" and "W". The remaining charges were withdrawn by the Crown. The Respondent received a conditional discharge and eighteen months' probation with conditions.[23]

27. The Respondent's position in the hearing was that a finding of guilt for simple assault was not relevant to his suitability to practise. The Committee disagreed, stating:

> It is in fact difficult for the Committee to imagine a clearer example of an offence relevant to a physician's suitability to practise than a finding, as in this case, that he has assaulted his patients in his office during the course of a medical examination.[24]

E. EXPERT EVIDENCE IN LIABILITY HEARING

28. The College and the Appellant each called an expert to provide an opinion on the appropriateness of the chest examinations. The College's expert, Dr. Goldstein, testified that there would be no reason to reach under a patient's bra with a stethoscope. It would never be necessary for a physician to place a stethoscope on a patient's nipple, and there is no medical reason for cupping a patient's breast during a chest examination for respiratory issues.[25]

29. The Appellant's expert, Dr. Weston, acknowledged that he would not examine a female

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[21] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 80-81
[22] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 67
[23] Criminal Finding of Guilt Brief, Exhibit 10, Exhibit Book, Tab 10, pp. 105-127
[24] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 86-87
[25] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 58-60

patient under her bra or deliberately place a stethoscope on a patient's nipple. He agreed the Appellant's actions could not be characterized as simple failures of communication.[26]

F. THE DISCIPLINE COMMITTEE REJECTED THE APPELLANT'S EVIDENCE AND HIS DEFENCE

30. The Appellant denied that he cupped his patients' breasts, that he placed his stethoscope directly on his patient's nipples and that he tweaked one patient's nipples.[27] The Committee rejected the Appellant's evidence and found that he had done all those things, that the touching was deliberate and that there was no consent and no clinical reason for him to have touched his patients in that manner. The Committee found that the Appellant's explanation for his examination methods was disingenuous.[28]

31. The Committee unequivocally dismissed the Appellant's position that the patients had misunderstood what had occurred. The Committee noted as follows:

> As will be stated below, however, **the Committee finds that the precise and detailed evidence of four of the complainants with respect to how Dr. Peirovy touched their breasts is not consistent with misunderstanding as the explanation for their complaints.**[29]

G. EVIDENCE ON PENALTY

(i) College Evidence on Penalty – Victim Impact Statements

32. The Committee received victim impact statements detailing the profound and lasting impact of the Appellant's conduct. A common thread in each victim's statement is a profound loss of trust in men, in the profession and in male doctors in particular.[30]

(ii) Defence Evidence on Penalty – Dr. Jonathan Rootenberg

33. Dr. Rootenberg, a forensic psychiatrist, was qualified to give an opinion on the

[26] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 60-63
[27] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 67-68
[28] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 67
[29] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 71 [emphasis added]
[30] Brief of Victim Impact Statements, Exhibit 35, Exhibit Book, Vol. I, Tab 35, p. 414 – 426

assessment and treatment of persons who have committed sexual offences and on the risk of re-offence of such persons generally.[31]

34. The Appellant, who did not testify on penalty, provided Dr. Rootenberg with the same explanation that had been rejected by the Committee: that he lacked communication skills and was clumsy and awkward in dealing with female patients. The Appellant told Dr. Rootenberg that he was conducting normal chest examinations and the patients had misunderstood and misinterpreted his actions. The Appellant maintained that he had no sexual motivation. As Dr. Rootenberg put it: "he certainly doesn't believe that he touched anybody for a sexual reason".[32] With respect to trying to date a patient, Dr. Rootenberg suggested that the Appellant's explanation, which had been rejected by the Committee, could be accurate, testifying that, "it may simply be that he misunderstood the context in which that conversation arose".[33]

35. Dr. Rootenberg testified that even though the Appellant sexually abused one patient despite knowing another had complained, the risk of re-offence was nonetheless low because the Appellant had gained insight into his lack of "sensitivity" and become more cognizant of patient consent issues.[34] In Dr. Rootenberg's opinion, because the Appellant did not think that what he was doing was sexual abuse, his conduct in sexually abusing multiple patients, even after one had complained, was not risk-taking behaviour and not predatory.[35]

(iii) Defence Evidence on Penalty – Dr. Dawn Martin (PhD)

36. Dr. Martin is a communication coach who frequently works with physicians. She was qualified by the Committee to give expert evidence in assessing, treating, training and

[31] Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p. 77, ll. 9- 20
[32] Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p. 84, ll. 13-19
[33] Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p. 83, l. 17 to p. 84, l. 4
[34] Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p. 79, l. 8 to p. 80, l. 16
[35] Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p. 81, l. 14 to p. 82, l. 6

remediating physicians in "communication, interviewing skills, collaboration and professionalism, including the maintenance of boundaries".[36]

37. The Appellant told Ms. Martin that his patients had misinterpreted his conduct due to his communication deficits, a position Ms. Martin accepted in her work with the Appellant. Ms. Martin agreed that she had no expertise in assessing an individual's motivations and that her opinion regarding the Appellant's motivation was irrelevant.[37]

PART III – ISSUES AND THE LAW

38. The Respondent responds to the Appellant's issues as follows:

A. The Divisional Court applied the correct standard of review and exercised appropriate deference.

B. The errors in principle identified by the Divisional Court were glaring. The Court did not subject the Discipline Committee's decision to painstaking scrutiny.

C. The Divisional Court correctly concluded that the penalty imposed was clearly unfit. It did not err in in its treatment of proportionality or in holding that the prior penalty decisions advanced by the Appellant were no longer appropriate and should not have been relied on in this case.

A. The Divisional Court Applied the Correct Standard of Review

39. The Divisional Court identified and applied the correct standard of review for a "specialized administrative tribunal of a self-regulating profession". The Court correctly held that a penalty decision is due great deference, and may only be overturned where the decision-maker has made an error of principle or where the penalty is clearly unfit.[38]

B. The Divisional Court Correctly Found that the Discipline Committee's Penalty Decision Discloses Significant Errors in Principle [Appellant's Factum, paras. 76-89]

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[36] Evidence of Dr. Martin, Respondent's Compendium, Tab 7, p. 87, ll. 2-7; p. 88, ll. 12-18
[37] Evidence of Dr. Martin, Respondent's Compendium, Tab 7, p. 89, l. 10 to p. 90, l. 20
[38] *Peirovy* (Div. Ct.), *supra,* at paras. 24-26, Respondent's BOA, Tab 1; *Reid v College of Chiropractors of Ontario*, 2016 ONSC 1041, at paras. 98-99, Respondent's BOA, Tab 2

40. The Divisional Court identified three errors in principle in the Committee's decision:

i. **Inconsistent findings of fact:** The Discipline Committee made inconsistent findings of fact. In particular, it was unreasonable for the Committee to have found that the Appellant deliberately touched his patients in a sexual manner, but to impose a penalty based on "poor communication" and "awkward manner";

ii. **Error in use of opinion evidence:** The Committee used the opinion evidence improperly on the issue of sexual motivation;

iii. **Error in applicability of revocation:** The Committee was wrong in holding that revocation is reserved for the most egregious cases.

i) The Discipline Committee made inconsistent findings of fact on liability and penalty

41. The Discipline Committee may make additional findings of fact at the penalty stage of a hearing, but only if these findings are not inconsistent with its earlier findings on liability. Where, as here, a penalty decision relies on additional facts inconsistent with those found on liability, the decision is unreasonable.[39]

42. The Discipline Committee reached the following key conclusions in its decision on liability:

- The Committee accepted the patients' description of the Appellant's conduct as "blatantly sexual" and expressly dismissed the Appellant's contention that he did not touch the patients in the specific manner they allege; i.e. cupping their breasts and nipples, including tweaking one patient's nipples, and placing the stethoscope directly on other patients' nipples;[40]
- The Committee held that the Appellant's touching of his patients' nipples and breasts was deliberate;[41]
- Based on the expert evidence offered by both parties, the Committee rejected the

[39] *College of Physicians and Surgeons of Ontario v. McIntyre,* 2017 ONSC 116, at para. 44 (Div. Ct.) [*McIntyre* (Div. Ct.)], Respondent's BOA, Tab 3A (leave to appeal to Ont. C.A. dismissed July 17, 2017)
[40] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 72-76
[41] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 72, 74-76

Appellant's contention that the touching could be explained as inadvertent/incidental touching during a legitimate and clinically appropriate examination. The Committee held there was no clinical necessity for the cupping and touching of breasts and nipples, or for the placement of the stethoscope directly on the nipple;[42]

- The Committee expressly dismissed the Appellant's contention that patients misunderstood the touching as sexual or that miscommunication was to blame. The Committee expressly found that the patients did not misunderstand what happened;[43]
- The Committee concluded that, viewed objectively, the Appellant's behaviour was of a sexual nature;[44]
- The Committee held that the Appellant's testimony that he had no sexual interest in Ms. Z when he asked her out on a date was "evasive" and "lacking in credibility".[45]

43. Notwithstanding its findings of deliberate, sexual touching without patient consent or medical justification, in its decision on penalty the Committee resiled from these clear conclusions and proceeded to explain the Appellant's conduct on the basis of poor communication and awkward manner. The Committee found that the Appellant's "serious deficits in his communication skills, his sensitivity to the extent of his patients' vulnerability and his understanding of boundaries and consent" were "antecedents to the Appellant's sexual misconduct", and his "awkward, unskilled and non-empathic manner with his female patients was a factor in understanding his abusive behaviour".[46]

44. Poor communication, awkward manner, and a misunderstanding of consent and boundaries had been expressly dismissed by the Committee in making its finding of sexual abuse. Moreover, they could only be relevant to the Appellant's tweaking of nipples and cupping of breasts if there were some legitimate explanation for this touching. The Committee

[42] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 57, 59, 60-61
[43] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 71
[44] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 69-70; 72-76
[45] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, p. 67
[46] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 96-98

explicitly found there was no legitimate or appropriate medical reason for him to have touched his patients in this manner. Nor was there any evidence of another, non-abusive purpose for engaging in this conduct. The Appellant did not claim to have any legitimate purpose for touching his patients as they described; rather, he said that he had not done so. At the penalty stage, he continued to deny that the touching was deliberate, as the Committee had found. He continued to insist, through his expert, that it was incidental or inadvertent during an appropriate medical examination.[47] Aside from the Appellant's denial of the conduct itself, there was no other direct or admissible evidence regarding motivation.

45. Despite its finding of deliberate, sexual touching without medical justification, the Committee imposed a penalty that was based on a different set of facts, now accepting for the purposes of penalty that the misconduct could be explained by miscommunication, an awkward manner and the Appellant's lack of awareness that he was being abusive. In short, the patients misperceived the touching as "blatantly sexual", a complete reversal from the Committee's finding on liability. Not surprisingly, the Committee imposed a lower penalty than would have been appropriate had it maintained its findings that the conduct was deliberate and sexual.

46. The absence of an explicit finding in the liability decision that the Appellant's sexual abuse of patients was sexually motivated is beside the point. The Committee had rejected the defence theory of miscommunications and it rejected the Appellant's account of what had happened. His actions, viewed objectively, constituted a violation of the sexual integrity of his patients, as defined by the Supreme Court of Canada in *Chase*.[48] Further, the Committee accepted that the assault convictions (which required proof the touching was intentional) were

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[47] As confirmed by Dr. Rootenberg: Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p 78, ll. 2-13; p. 84, l. 13 to p. 85, l. 20. Dr. Peirovy did not testify at the penalty hearing and provided no direct evidence on penalty regarding his motivation.

[48] *R. v. Chase,* [1987] 2 S.C.R. 293, at pp. 302, Respondent's BOA, Tab 4

relevant to his suitability to practice. Finally, there was no admissible evidence of a non-sexual explanation for the Appellant's conduct consistent with the facts the Committee had found. In the absence of such evidence, the Divisional Court correctly concluded that, having found the touching was "blatantly sexual", it was unreasonable for the Committee, on penalty, to attribute the conduct to the Appellant's "awkward, unskilled and non-empathic manner":

> [I]n view of the finding on the liability phase that the Respondent deliberately touched the four complainants in a way that an objective observer would find to be sexual and in accepting the complainants' evidence that the touching was, to them, "blatantly sexual" there is no line of analysis that could reasonably lead the tribunal to conclude that the Respondent's awkward, unskilled and non-empathic manner was a factor in understanding his abusive behaviour or that it could reasonably infer that he was genuinely and completely unaware of the ways in which his behaviour in relation to his patients was in fact abusive.
>
> …
>
> The Respondent cupped breasts, tweaked nipples and placed a stethoscope on breasts and nipples. The Committee found that he had no legitimate medical purpose for doing so. The Respondent did not claim any legitimate purpose for doing so. He said that he had not done so. His motivation can have been nothing but sexual…
>
> …
>
> It was also unreasonable for the Committee to find that the conduct vis-à-vis the four complainants would be seen by the objective observer as a violation of their sexual integrity, but that a highly trained professional with no significant mental health issues would not necessarily appreciate the same thing.[49]

47. The Divisional Court did not subject the Committee's reasons to painstaking scrutiny. The stark differences between the Committee's findings on liability and penalty were overwhelmingly apparent and constituted a significant error that rendered the Committee's decision unreasonable.

ii) The Discipline Committee erred in using opinion evidence on the issue of sexual motivation

48. The Divisional Court correctly held that the Discipline Committee had erred in its use of opinion evidence. In particular, the Committee used the opinion evidence to change its

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[49] *Peirovy* (Div. Ct.), *supra*, at paras. 32-35, Respondent's BOA, Tab 1

finding that the Appellant deliberately touched his patients in a sexual manner, finding instead that the Appellant had no sexual motivation. The Committee's findings on this issue are as follows:

> In Dr. Peirovy's case, the Committee does not fully accept the College's submission that his sexual actions with the four victims are unexplained. What does remain unclear is a full understanding of Dr. Peirovy's motivations**. The expert evidence, however, now effectively rules out psychopathy or sexual deviance, and this is an important finding with respect to the issue of Dr. Peirovy's motivation.**
>
> …
>
> The fact that Dr. Peirovy's sexual misconduct with these four patients occurred in fairly close succession, over a time frame of several months, and continued to occur even after he was aware that a complaint had been made, was considered by the Committee. **The Committee did not, however, infer that this pattern is indicative of predatory intent or uncontrollable deviant urges on Dr. Peirovy's part, and thus a serious aggravating factor. In fact, the expert evidence appears to rule out motivation of this nature.** Another possible inference is that this pattern reflects a physician who was genuinely and completely unaware of the ways in which his behaviour in relation to his patients was, in fact, abusive.[50]

49. There was no evidence before the Committee to support a conclusion that the absence of an identifiable psychiatric disorder rules out a sexual or predatory motivation. Sexual assault and sexual abuse are committed by a wide range of individuals, notwithstanding that they exhibit no medically or psychiatrically recognized illness. Courts have long recognized that rape is a crime "assumed to be committed by normal persons."[51]

50. This is equally true of physicians. As the Supreme Court has observed, "there is no acceptable body of evidence that doctors who commit sexual assaults fall into a distinctive class with identifiable characteristics."[52]

51. The Discipline Committee unreasonably used the opinion evidence to conclude that the Appellant was not the sort of person who would intentionally sexually abuse his patients. Not

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[50] Decision and Reasons for Decision, Appellant's Compendium, Tab 6, pp. 96-98 [emphasis added]

[51] *R. v. McMillan*, 1975 CanLII 43, at p. 21 (Ont. C.A.), Respondent's BOA, Tab 5 (aff'd by S.C.C. at [1977] 2 S.C.R. 824, Respondent's BOA, Tab 5)

[52] *R. v. Mohan,* [1994] 2 S.C.R. 9, at pp. 37-38, Respondent's BOA, Tab 6

only was this finding inconsistent with the Committee's conclusion on liability, as described above, but this error led it to accept the defence theory that the Appellant had *no* sexual motivation when he sexually abused his patients. The inference that sexual (and predatory) intent was "ruled out" was an error in logic that renders the penalty decision unreasonable.

52. This error in the use of opinion evidence is the same error identified by this Court in *R. v. Suarez-Noa*.[53] In that case, similar to this one, the psychiatrist testified that the accused had no mental disorder and did not fall within "any psychiatrically identifiable group". The psychiatrist then provided his opinion regarding how the accused was likely to respond to the provocation at issue in that case. This Court confirmed that psychiatric opinion evidence about what might have motivated the accused and whether he is "the sort of person" to commit an offence of this nature, is inadmissible:

> [80] I first consider whether Dr. Gojer's opinion fell within the proper ambit of expert psychiatric opinion. Dr. Gojer did not testify that Mr. Suarez-Noa suffered from any identifiable mental disorder, or that he fell within any psychiatrically identifiable group. Instead, he described Mr. Suarez-Noa as "passive" and "non-aggressive… from a physical point of view". **Stripped to its essential core, Dr. Gojer's testimony came down to the assertion that if one believed what Mr. Suarez-Noa told Dr. Gojer, Mr. Suarez-Noa was not the sort of person who would do what he did** to Ms. Cowell unless some "significant event" caused him to lose control and react with extreme and uncharacteristic violence. In short, Dr. Gojer gave evidence of Mr. Suarez-Noa's disposition, and more specifically, his disposition not to act violently in the absence of a "significant triggering event".
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> …
>
> [83] Dr. Gojer did not suggest that Mr. Suarez-Noa fell into any "distinctive group" from a psychiatric point of view. […]Dr. Gojer's opinion was not based on a diagnosis or characterization of Mr. Suarez-Noa's mental state as reflecting some recognized psychiatric disorder or condition. Instead, **Dr. Gojer's evidence reflected his personal opinion on what may have been in Mr. Suarez-Noa's mind, based on Dr. Gojer's assessment of Mr. Suarez-Noa's mental makeup**.[54]

[53] *R. v. Suarez-Noa*, 2017 ONCA 624, at paras. 83-86, Respondent's BOA, Tab 7
[54] *Ibid.*, at paras. 80, 83 [emphasis added], Respondent's BOA, Tab 7

53. In this case, Dr. Rootenberg excluded mental disorder, the issue on which he had been qualified to testify. The bulk of his evidence attempted to explain what may have driven the Appellant's conduct, based on what the Appellant had told him about his lack of sexual motivation. Psychiatric opinion evidence is not admissible to explain what motivates the behaviour of "normal" people or what "normal" people would or would not do. Contrary to the Appellant's assertion that "motivation" is properly the subject of opinion evidence,[55] opinion evidence is not admissible to explain an individual's motivation for conduct, absent a specific psychiatric disorder or membership in a psychiatrically identifiable group.[56]

54. The only admissible use to which the Discipline Committee could put Dr. Rootenberg's evidence was regarding the Appellant's risk of re-offence (the other area in which it had qualified this expert). Dr. Rootenberg's evidence could <u>not</u> be used to explain the Appellant's intention, motivation or disposition when he engaged in sexual abuse of his patients. Indeed, Dr. Rootenberg could provide no insight whatsoever into the Appellant's intent, given the Appellant's continued insistence during their conversations that the sexually abusive contact "was inadvertent," an explanation the Discipline Committee had already dismissed.[57]

55. Based on its improper use of this opinion evidence, the Discipline Committee ruled out sexual and predatory intent and concluded there were no aggravating factors to be drawn from the repeated nature of the sexual abuse. As the Divisional Court stated:

> [32] There are two problems with this reasoning. First, the number of offences was itself aggravating, without predatory intent and deviant sexual urges. Second, in view of the finding on the liability phase that the Respondent deliberately touched the four

[55] Appellant's factum, at paras. 4, 13, 80-82

[56] *R. v. McMillan*, *supra*, at pp. 20-21, Respondent's BOA, Tab 5. It is clear that College counsel did not anticipate that the Committee would use Dr. Rootenberg's evidence to improperly change its findings on liability or to draw inadmissible inferences about his motivation. See Closing Submissions, Respondent's Compendium, Tab 8, pp. 91-100.

[57] Evidence of Dr. Rootenberg, Respondent's Compendium, Tab 6, p. 78, l. 2-13; p. 85, ll. 13-20

> complainants in a way that an objective observer would find to be sexual and in accepting the complainants' evidence that the touching was, to them, "blatantly sexual" there is no line of analysis that could reasonably lead the tribunal to conclude that the Respondent's awkward, unskilled and non-empathic manner was a factor in understanding his abusive behaviour or that it could reasonably infer that he was genuinely and completely unaware of the ways in which his behaviour in relation to his patients was in fact abusive.
>
> [33] Moreover in the case of Patients U and W such an inference was inconsistent with the finding of guilt for criminal assault.
>
> [34] Psychopathy and deviant sexual urges were beside the point. The Respondent cupped breasts, tweaked nipples and placed a stethoscope on breasts and nipples. The Committee found that he had no legitimate medical purpose for doing so. The Respondent did not claim any legitimate purpose for doing so. He said that he had not done so. His motivation can have been nothing but sexual. The Committee proceeded as if they had only ascribed to the Respondent the misconduct that they found in the case of Patient Z. The Committee based the penalty on a hypothetical set of facts that was inconsistent with facts that they themselves had found in the liability hearing.[58]

56. By relying on the psychiatric opinion evidence that the Appellant was psychiatrically "normal" to conclude that he had no sexual or predatory intent and was simply "awkward", the Discipline Committee abdicated its fact-finding role to the expert witness. The error critically undermined many of the Committee's key conclusions on penalty. As found by the Divisional Court, the Committee's use of opinion evidence is a fundamental error in principle that renders the Committee's decision unreasonable.

iii) The Discipline Committee wrongly concluded that revocation is reserved for only the most egregious conduct or offenders with a high risk to re-offend

57. Revocation of a member's certificate of registration is not limited to cases involving the "most egregious" conduct or circumstances in which the member is at a high risk to re-offend. The practice of medicine is a privilege, not a right.[59] Discipline proceedings are regulatory in

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[58] *Peirovy* (Div. Ct.), *supra,* at paras. 32-34, Respondent's BOA, Tab 1

[59] *Sazant v. College of Physicians and Surgeons of Ontario*, 2012 ONCA 727, at para. 175 [*Sazant* (Ont. C.A.)], Respondent's BOA, Tab 8C

nature, not criminal or quasi-criminal.[60] The principle of "least restrictive sanction" is a criminal sentencing principle that has no place in the professional regulatory context.[61] Penalties under the *RHPA* are intended to protect the public, not to punish the offender.[62]

58. The Discipline Committee's error in holding that revocation is reserved for the most egregious cases was discussed by the Divisional Court as follows:

> In my view it was an error for the Committee to proceed on the basis that revocation of registration is reserved for egregious conduct or offenders with a high risk to re-offend. Most egregious conduct would involve sexual contact that makes revocation mandatory.[63]

59. As the Alberta Court of Appeal stated in *Adams*, in reasons recently adopted by the Divisional Court, the assessment of a disciplinary sanction:

> [M]ust be undertaken with due respect to contemporary values in Canadian society. In this regard, we observe that in the past, there has sometimes been a tendency to minimize and excuse misconduct of a sexual nature between the members of some professions and their clients… **[W]e do not accept the proposition still often invoked in criminal cases, that the most serious disciplinary sanction, disbarment, should be reserved for the most serious misconduct by the most serious offender**.[64]

C. Penalty Imposed by Discipline Committee was Clearly Unfit [Appellant's Factum, paras. 56-75]

60. In concluding that the penalty imposed was clearly unfit, the Divisional Court did not err in law in describing other penalty decisions, put forward by the Appellant, as "a litany of clearly unfit penalties." Proportionality is always a necessary consideration but, as noted by the

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[60] *R. v. Wigglesworth*, [1987] 2 S.C.R. 541, at p. 560, Respondent's BOA, Tab 9; *Sazant v. College of Physicians and Surgeons of Ontario*, 2011 ONSC 323, at paras. 146-153 (Div. Ct.), Respondent's BOA, Tab 8B (aff'd at *Sazant* (Ont. C.A.), *supra*, Respondent's BOA, Tab 8C)

[61] *Ontario (College of Physicians and Surgeons of Ontario) v. McIntyre*, 2015 ONCPSD 25, at pp. 42-43 [*McIntyre* (D.C.)], Tab 3B (aff'd *McIntyre* (Div. Ct.), *supra,* Respondent's BOA, Tab 3A); *Iacovelli v. College of Nurses of Ontario*, 2014 ONSC 7267, at paras. 50-53 (Div. Ct.) [*Iacovelli*], Respondent's BOA, Tab 10.

[62] *Sazant* (Ont. C.A.), *supra*, at para. 94, Respondent's BOA, Tab 8C; *McIntyre* (Div. Ct.), *supra,* at para. 48, Respondent's BOA, Tab 3A; *Pharmascience Inc. v. Binet,* 2006 SCC 48, [2006] 2 S.C.R. 513, at para. 36 [*Pharmascience*], Respondent's BOA, Tab 11; Health Professions Procedural Code, s. 1.1

[63] *Peirovy* (Div. Ct.), *supra,* at para. 36, Respondent's BOA, Tab 1

[64] *Adams v. Law Society (Alberta)*, 2000 ABCA 240, cited in *McIntyre* (Div. Ct.)*, supra,* at para. 51, Respondent's BOA, Tab 3A [emphasis in *McIntyre*].

Divisional Court, it cannot be used to justify an otherwise unfit penalty.[65]

i) Penalty principles governing discipline proceedings

61. Professional discipline proceedings undertaken by the College under the *Act* are neither criminal nor quasi-criminal and are primarily directed to public protection.[66] The Supreme Court of Canada, in *Pharmascience,* confirmed that regulatory bodies have an overarching mandate to protect the public in the execution of all their functions:

> 36 This Court has on many occasions noted the crucial role that professional orders play in protecting the public interest. As McLachlin J. stated in *Rocket v. Royal College of Dental Surgeons of Ontario*, "[i]t is difficult to overstate the importance in our society of the proper regulation of our learned professions". The importance of monitoring competence and supervising the conduct of professionals stems from the extent to which the public places trust in them…. I have no hesitation in applying the comments I wrote for this Court in *Finney*, at para. 16, generally to the health field to emphasize the importance of the obligations imposed by the state on the professional orders that are responsible for overseeing the competence and honesty of their members:
>
>> The primary objective of those orders is not to provide services to their members or represent their collective interests. They are created to protect the public, as s. 23 of the *Professional Code* makes clear.[67]

62. The Code is also clear: the primary purpose of the sexual abuse provisions is, and always has been, protection of the public by eradicating sexual abuse of patients by members:

> **Statement of purpose, sexual abuse provisions**
>
> 1.1 The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members.[68]

63. In imposing any penalty, including revocation in respect of sexual abuse, the paramount consideration for the Discipline Committee is public protection, as recently confirmed by the Divisional Court in *McIntyre:*

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[65] *Peirovy* (Div. Ct.), at para. 38, Respondent's BOA, Tab 1
[66] See footnotes to paragraph 58, above.
[67] *Pharmascience*, *supra,* at para. 36 [citations omitted], Respondent's BOA, Tab 11
[68] Health Professions Procedural Code, s. 1.1

> Penalties imposed by a self-regulating professional body are not the same as punishments imposed for criminal wrong-doing. While the discipline tribunal is required to be fair and even-handed in dealing with its members, it is guided first and foremost by its duty to protect the public.[69]

ii) The Divisional Court correctly concluded that a six month suspension was clearly unfit

64. Short suspensions for deliberate acts of sexual abuse have been found to be inadequate by differently constituted panels of the Discipline Committee, the courts and the Ontario legislature.

65. The legislature's recent amendments to the *Regulated Health Professions Act*, and in particular the amendments strengthening penalty provisions for sexual abuse of patients, are a clear signal that lenient penalties for sexual abuse are out of step with society's current values and are inadequate to protect the public. The recent amendments:

- Expand the application of mandatory revocation to include touching of a sexual nature of the patient's genitals, anus, breasts or buttocks (this would include the conduct engaged in by the Appellant);[70]
- Require the Discipline Committee to make an interim order suspending a member's certificate of registration, immediately upon making a finding of sexual abuse that would attract mandatory revocation;[71] and
- Remove the ability of panels of the Discipline Committee to impose any gender-based restrictions on a member (such as restricting a member to seeing only male patients, or requiring a chaperone for only female patients), a condition imposed on the Appellant in this case.[72]

66. The 2017 amendments follow in the footsteps of the 1991 *Task Force on the Sexual*

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[69] *McIntyre* (Div. Ct.), *supra*, at para. 50, Respondent's BOA, Tab 3A, See also: *Iacovelli, supra,* at paras. 50-53, Respondent's BOA, Tab 10.
[70] Protecting Patients Act, Schedule 5, s. 19(3)
[71] Protecting Patients Act, Schedule 5, s. 19(2)
[72] Protecting Patients Act, Schedule 5, s. 19(2)

Abuse of Patients and the 1993 legislative response, which introduced the zero tolerance/mandatory revocation scheme for specified sexual acts between health professionals and their patients.[73]

67. In arguing for an expanded application of revocation for acts of sexual abuse by physicians, the 1991 Task Force Report noted:

- the general vulnerability of patients in such relationships;
- the power imbalance that almost invariably exists in favour of the practitioner, thus facilitating easy invasion of the patient's sexual boundaries;
- the serious, long-term injury to the victim, both physical and emotional, that results from sexual abuse, including the harmful effects on future care caused by the victim's inability to place her trust in other doctors and caregivers;
- the fact that sexual abuse tarnishes public trust in the entire profession; and
- the results of an historical review by the Task Force of sanctioning decisions by the College's Discipline Committee and the Divisional Court, which demonstrated a leniency that reflected “a profound non-appreciation of the harm done to victims.”[74]

68. The legislative history, up to and including the enactment of the *Protecting Patient Act,* 2017, shows that over the past twenty-five years, the legislature has consistently indicated that Ontario society has zero tolerance for sexual abuse of patients by health professionals and that the problem of physician-patient sexual abuse is ongoing.

69. Discipline Committee panels at various Colleges have noted that these legislative amendments were adopted following the receipt of recommendations from the *2016 Minister's Task Force on the Prevention of Sexual Abuse*. The 2016 Task Force recommended

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[73] *Mussani v. College of Physicians and Surgeons of Ontario*, 2004 CanLII 48653 (Ont. C.A.), at para. 2 [*Mussani*] Respondent's BOA, Tab 14

[74] *Mussani*, *supra*, at para. 21, Respondent's BOA, Tab 14

strengthening legislation dealing with sexual abuse of patients to better protect the public.[75]

70. Recently, panels have imposed penalties which include:

- Revocation for acts of professional misconduct, including sexual abuse by kissing a patient, for which revocation was not mandatory. This penalty was upheld as reasonable by the Divisional Court;[76]
- Revocation for acts of disgraceful, dishonourable or unprofessional conduct involving sexual activity with former patients, where revocation was not mandatory;[77]
- Revocation for acts of disgraceful, dishonourable or unprofessional conduct involving sexual misconduct with non-patients, where revocation was not mandatory.[78]

71. In imposing these penalties, panels of the Discipline Committee have explicitly recognized that societal values regarding sexual misconduct by physicians require increased penalties to reflect the community's abhorrence of these actions. As the Committee stated in *Horri*, a case where a physician commenced a sexual relationship with his patient two weeks after terminating the doctor-patient relationship:

> Although revocation is not mandatory for this misconduct, it is within the jurisdiction of the Committee to order revocation and it is the opinion of the Committee that revocation is necessary to protect the public in the circumstances of this case. Even though revocation is outside the range of the typical penalties imposed in past cases, the Committee concluded that this is a case that calls for revocation, because of the seriousness of the misconduct…
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> …

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[75] *Ontario (College of Physicians and Surgeons of Ontario) v. Ghabbour*, 2017 ONCPSD 38, at pp. 13-14 [*Ghabbour*], Respondent's BOA, Tab 15; *College of Nurses of Ontario v. Kwan*, 2015 CanLII 102549, at paras 52-53 (College of Nurses Discipline Committee), Respondent's BOA, Tab 16.

[76] *McIntyre* (D.C.), *supra*, Respondent's BOA, Tab 3B. See also *Ontario (College of Physicians and Surgeons of Ontario) v. Noriega*, 2015 ONCPSD 29 [*Noriega*], Respondent's BOA, Tab 13, (aff'd Div. Ct: *Noriega v. The College of Physicians and Surgeons of Ontario*, 2016 ONSC 924); *Ontario (College of Physicians and Surgeons of Ontario) v. Sazant,* 2009 ONCPSD 26 [*Sazant* (D.C.)], Respondent's BOA, Tab 8A, (aff'd Div. Ct and Ont. C.A., Respondent's BOA Tabs 8C and 8B)

[77] *Ontario (College of Physicians and Surgeons of Ontario) v. Horri*, 2017 ONCPSD 12 [*Horri*], Respondent's BOA, Tab 17; *Ghabbour, supra*, Respondent's BOA, Tab 15

[78] *Minnes, Ontario (College of Physicians and Surgeons of Ontario) v. Minnes*, 2015 ONCPSD 3 [*Minnes*] (aff'd by Div. Ct.: *The College of Physicians and Surgeons of Ontario v Minnes*, 2016 ONSC 1186), Respondent's BOA, Tab 13; *Ontario (College of Physicians and Surgeons of Ontario) v. Marshall*, 2016 ONCPSD 3, Respondent's BOA, Tab 18

> The Committee was also mindful that societal values are changing and that penalties likewise may need to change to reflect and protect these changing values.[79]

72. Similarly, in *Ghabbour*, a case where a psychiatrist commenced a sexual relationship with a patient very soon after termination, the Committee stated:

> [I]t is the view of the Committee that a lengthy suspension rather than revocation of certificate of registration would not address the public's, or the Committee's concerns regarding this type of physician misconduct.
>
> The public expects and deserves professionalism and integrity from Ontario doctors and that the College will regulate the profession in the public interest. The Committee is very aware of the shift in societal values that is highlighted by the Ontario government's amendments to the *Regulated Health Professions Act* (Bill 87), which came out of recommendations of the recent 2016 *Minister's Task Force on the Prevention of Sexual Abuse*.[80]

73. In *Noriega*, a case that pre-dates the Appellant's case, the Discipline Committee imposed revocation for a historical act of "sexual impropriety" (now called sexual abuse) by the member, although this penalty was not mandatory under the applicable legislative regime. The Committee expressly referred to the need to increase penalties in the specific context of sexual abuse of patients:

> In the context of professional self-regulation, the nature of the penalty required to maintain public confidence in effective self-governance might well evolve over time. Societal standards shift, as the public becomes more aware of the problems associated with physician sexual misconduct and its potential impact on patients…
>
> Changing perceptions regarding sexual abuse of patients by some physicians has resulted in the legislative changes now contained in the *Regulated Health Professions Act*. If Dr. Noriega's conduct with respect to Ms. X had been governed by this Act, revocation of his certificate of registration would have been mandatory. Although the Committee is aware that in determining a penalty for misconduct which occurred many years in the past, it is doing so in the present. The Committee must impose a penalty which is consistent with the judicious application of the relevant principles, in light of all the facts of the case.[81]

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[79] *Horri*, *supra,* at p. 20, Respondent's BOA, Tab 17
[80] *Ghabbour, supra*, at p. 13, Respondent's BOA, Tab 15
[81] *Noriega*, *supra*, at p. 12, Respondent's BOA, Tab 13

74. These observations have been consistently echoed by the courts, including the Divisional Court and the Court of Appeal. As early as 2003, the Court of Appeal acknowledged in *Mussani* that the purpose of legislative interventions regarding sexual abuse is to respond to the ongoing problem of physician-patient sexual abuse:

> However, the Mandatory Revocation Provisions were enacted in response to a recognized and growing problem of sexual abuse in the medical profession. Indeed, they were enacted specifically to rectify a situation where discretionary sanctioning on the part of professional disciplinary committees and the courts had been found to be wanting.[82]

75. In *McIntyre*, the Divisional Court noted with approval the approach the Discipline Committee took to imposing a penalty for sexual abuse of a patient, describing the approach as:

> A broad policy-based view of its own mandate: to protect the public; to recognize the devastating impact on patients when the trust they place in doctors has been violated, particularly through sexual abuse; and to maintain public confidence in the ability of the medical profession to regulate itself in the public interest.[83]

76. In the Appellant's case, the Discipline Committee failed to recognize that societal values and the ongoing recognition of the harm caused by physician sexual abuse require increased penalties. As the Divisional Court concluded:

> In the space of a few months the Respondent sexually abused four young women. The misconduct had significant consequences for each of them, which are documented in their impact statements. These statements also document the serious effect the offences had for the profession. These women have lost much of their trust in doctors, especially male doctors. A short suspension is clearly inadequate to deter others and to contribute meaningfully to the eradication of sexual abuse in the profession.[84]

iii) No error in concluding that prior penalty decisions are unfit

77. Having concluded that a six-month suspension in this case was clearly inadequate, the Divisional Court next addressed the Appellant's argument (advanced again before this court) that the penalty of six months was reasonable because it fell within a range established by prior

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[82] *Mussani*, *supra,* at para. 73, Respondent's BOA, Tab 14
[83] *McIntyre* (Div. Ct.), *supra,* at para. 62, Respondent's BOA, Tab 3A
[84] Decision and Reasons, at para. 37

Discipline Committee decisions imposed in respect of similar misconduct.[85]

78. The Divisional Court correctly rejected the Appellant's argument, noting that while consistency in the imposition of penalty is a necessary consideration, a penalty in the regulatory context will only be "fit" if it is adequate to protect the public and upholds the related principle of general deterrence.[86] The Divisional Court reviewed the cases put forward by the Appellant in support of his penalty. These cases included suspensions of between four to eight months for acts of sexual abuse, including repeated acts of sexual abuse against extremely vulnerable patients.[87] The Divisional Court reached the same conclusion with respect to the adequacy of these penalties as it did for the case before it:

> The facts of these cases are base. It is depressing to review them. They do little to encourage confidence in the Committee's approach to eradicating sexual abuse in the profession.[88]

79. A court or a tribunal is entitled to look critically at penalties imposed in prior cases and to conclude that the penalties are no longer appropriate. Areas where courts have done this include penalties for drunk driving, "domestic" homicide and sexual abuse of children.[89] In rejecting the appropriateness of short suspensions for intentional acts of sexual abuse against patients, the Divisional Court applied settled law that a court or tribunal - whether at first instance or on appeal - can find that penalties imposed in the past in respect of similar misconduct are no longer appropriate without the necessity of those other cases being appealed.

80. Even in the criminal context, the Supreme Court of Canada has held that sentencing

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[85] Factum of Appellant, at para. 62

[86] *Peirovy* (Div. Ct.), *supra,* at paras. 36-38, Respondent's BOA, Tab 1

[87] The Appellant and the Discipline Committee also relied on cases which did not involve findings of sexual abuse, where a penalty of two to three months was imposed, to further justify the minimal penalty in this case: *Le (Re),* [2010] O.C.P.S.D. No. 10, Appellant's BOA, Tab 2; *Li (Re),* [1996] O.C.P.S.D. No. 12, Appellant's BOA, Tab 4

[88] *Peirovy* (Div. Ct.), at para. 38, Respondent's BOA, Tab 1

[89] *R. v. Lacasse,* 2015 SCC 64, Appellant's BOA, Tab 16; *R. v. Klimovich*, 2013 ONSC 2888, Respondent's BOA, Tab 19; *R. v. D. (D.)*, 2002 CanLII 44915 (Ont. C.A.), at paras. 21-40, Respondent's BOA, Tab 20

ranges are not to be viewed as straitjackets and can evolve over time and in response to specific cases and social circumstances. For regulatory tribunals, which impose penalties for the purpose of public protection and not to punish offenders,[90] this principle holds even greater weight. In *R. v. Lacasse,* the Court confirmed that ranges are not static:

> 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.[91]

81. Similarly, in *R. v. Klimovich*, a case addressing sentencing for domestic manslaughter, the Ontario Superior Court declined to follow sentencing precedents from the Court of Appeal noting that prior law, though never appealed, was out of step with social values and that domestic assault is the type of offence where penalties must be increased to bring sentencing into line with changing social values.[92]

82. In *R. v. D. D.*, this Court approved a penitentiary sentence that was higher than previous cases involving the sexual assault of children, noting, "while there may have been a time, years ago, when offenders like the appellant could take refuge in the fact that little was known about the nature or extent of the damage caused by sexual abuse, that time has long since passed."[93]

83. The Appellant argues that the Divisional Court erred in commenting on the appropriateness of prior penalty decisions because it did not have an "evidentiary or

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[90] See section B(i) above
[91] *R. v. Lacasse, supra,* at paras. 7, 57-58, Appellant's BOA, Tab 16
[92] *R. v. Klimovich*, *supra*, at paras. 63-65, Respondent's BOA, Tab 19
[93] *R. v. D.D.*, *supra,* at para. 36, Respondent's BOA, Tab 20

jurisprudential basis in relation to the conduct of physicians in practice in 2009 and 2010."[94] This argument is misplaced:

i. In the leading case on the treatment of sentencing ranges, the Supreme Court recognized that appellate courts, as well as trial courts, are presumed to be well-placed to know the particular circumstances in their jurisdictions.[95] The Divisional Court, which hears appeals from all regulated health colleges in Ontario, is in a unique position to assess the fitness of penalties for sexual abuse by regulated health professionals.

ii. There is no authority requiring a "robust evidentiary record" to depart from a penalty range. This may be relevant, as it was in *Smith,* but is not a condition precedent. In *Lacasse,* the Court rejected the argument that evidence is required as to "local reality", noting that "trial judges and provincial courts of appeal are in the best position to know the particulars circumstances in their jurisdictions"[96]

iii. In any event, the legislative history of sexual abuse provisions and jurisprudence from the courts and the Discipline Committee provide ample support to confirm society's decreased tolerance for physician sexual abuse and the need for increased penalties to protect the public. There is no need for additional evidence on this issue.

iv. Retrospectivity is not at issue in this case. Revocation has always been an available penalty for the Appellant's misconduct. Penalty ranges are guidelines. They are not binding and are not "applied" by the Discipline Committee; rather, proportionality is considered alongside other penalty principles, including public protection.

v. Finally, the prevalence of physician sexual abuse in 2009 and 2010, when Dr. Peirovy committed the acts of sexual abuse, is irrelevant. A penalty must be appropriate at the

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[94] Appellant's factum, at para. 67
[95] *R. v. Lacasse*, *supra*, at para. 95, Appellant's BOA, Tab 16
[96] *R. v. Lacasse, supra,* at paras. 95, Appellant's BOA, Tab 16

time it is imposed; the Discipline Committee and the Divisional Court must consider what penalty upholds the relevant penalty principles in the present, not at the time the misconduct was committed.[97]

PART IV – NO ADDITIONAL ISSUES RAISED BY THE RESPONDENT

84. The Respondent raised no additional issues

PART V – ORDER REQUESTED

85. The Respondent respectfully requests that the appeal be dismissed with costs.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 15th day of September, 2017.

Elisabeth Widner
Counsel for the Respondent

Ruth Ainsworth
Counsel for the Respondent

[97] *R. v. H.S.*, 2014 ONCA 323, at paras. 53-55, Respondent's BOA, Tab 21.

CERTIFICATE

I, Elisabeth Widner, counsel for the Respondent, certify that:

(i) An order under subrule 61.09(2) is not required; and

(ii) That the estimated time for the Appellant's oral argument is 40 minutes.

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Elisabeth Widner
Counsel for the Respondent

SCHEDULE "A"

TAB

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5 *R. v. McMillan*, 1975 CanLII 43 (Ont. C.A.) (aff'd [1977] 2 S.C.R. 824)

6 *R. v. Mohan,* [1994] 2 S.C.R. 9

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9 *R. v. Wigglesworth*, [1987] 2 S.C.R. 541

10 *Iacovelli v. College of Nurses of Ontario*, 2014 ONSC 7267 (Div. Ct.)

11 *Pharmascience Inc. v. Binet,* 2006 SCC 48*,* [2006] 2 S.C.R. 513

12 *Ontario (College of Physicians and Surgeons of Ontario) v. Minnes*, ONCPSD 3 (aff'd Div. Ct.: *The College of Physicians and Surgeons of Ontario v Minnes*, 2016 ONSC 1186

13 *Ontario (College of Physicians and Surgeons of Ontario) v. Noriega*, 2015 ONCPSD 29, (aff'd Div. Ct: *Noriega v. The College of Physicians and Surgeons of Ontario*, 2016 ONSC 924

14 *Mussani v. College of Physicians and Surgeons of Ontario,* 2004 CanLII 48653 (Ont. C.A)

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17 *Ontario (College of Physicians and Surgeons of Ontario) v. Horri*, 2017 ONCPSD 12

18 *Ontario (College of Physicians and Surgeons of Ontario) v. Marshall*, 2016 ONCPSD 31

19 *R. v. Klimovich*, 2013 ONSC 2888

20 *R. v. D. (D.)*, 2002 CanLII 44915 (Ont. C.A.)

21 *R. v. H.S.*, 2014 ONCA 323

SCHEDULE "B"
RELEVANT STATUTES

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act,* 1991, S.O. 1991, c. 18, as amended, ss. 1(3)-(6); 1.1; 3(1)-(2); 51(5); 72(3)

Note: On a day to be named by proclamation of the Lieutenant Governor, section 1.1 of Schedule 2 to the Act is repealed and the following substituted: (See: 2017, c. 11, Sched. 5, s. 7)

Statement of purpose, sexual abuse provisions

1.1 The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling in connection with allegations of sexual abuse by members and, ultimately, to eradicate the sexual abuse of patients by members. 2017, c. 11, Sched. 5, s. 7.

Orders relating to sexual abuse

51 (5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Suspend the member's certificate of registration if the sexual abuse does not consist of or include conduct listed in paragraph 3 and the panel has not otherwise made an order revoking the member's certificate of registration under subsection (2).
3. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:
    i. Sexual intercourse.
    ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
    iii. Masturbation of the member by, or in the presence of, the patient.
    iv. Masturbation of the patient by the member.
    v. Encouraging the patient to masturbate in the presence of the member.
    vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.
    vii. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 19 (3).

Protecting Patients Act, 2017, S.O. 2017, c. 11 - Bill 87

SCHEDULE 5
REGULATED HEALTH PROFESSIONS ACT, 1991

19 (1) Clause 51 (1) (b) of Schedule 2 to the Act is repealed and the following substituted

(2) Section 51 of Schedule 2 to the Act is amended by adding the following subsections:

(a) No gender-based terms, conditions, limitations

(4.1) In making an order under paragraph 3 of subsection (2), a panel shall not make any order directing the Registrar to impose any gender-based terms, conditions or limitations on a member's certificate of registration.

(b) Interim suspension of certificate

(4.2) The panel shall immediately make an interim order suspending a member's certificate of registration until such time as the panel makes an order under subsection (5) or (5.2) if the panel finds that the member has committed an act of professional misconduct,

(a) under clause (1) (a) and the offence is prescribed for the purposes of clause (5.2) (a) in a regulation made under clause 43 (1) (v) of the *Regulated Health Professions Act, 1991*;

(b) under clause (1) (b) and the misconduct includes or consists of any of the conduct listed in paragraph 3 of subsection (5); or

(c) by sexually abusing a patient and the sexual abuse involves conduct listed under subparagraphs 3 i to vii of subsection (5).

(c) Non-application to mandatory orders

(4.3) For greater certainty, subsection (4) does not apply to a mandatory order made under subsection (5) or a mandatory order made under subsection (5.2).

(3) Subsection 51 (5) of Schedule 2 to the Act is repealed and the following substituted:

(d) Orders relating to sexual abuse

(5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Suspend the member's certificate of registration if the sexual abuse does not consist of or include conduct listed in paragraph 3 and the panel has not otherwise made an order revoking the member's certificate of registration under subsection (2).

3. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:

   i . Sexual intercourse.
   ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
   iii. Masturbation of the member by, or in the presence of, the patient.

iv. Masturbation of the patient by the member.
v. Encouraging the patient to masturbate in the presence of the member.
vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.

a. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991*.

(e) Interpretation

(5.1) For greater certainty, for the purposes of subsection (5),
"sexual nature" does not include touching or conduct of a clinical nature appropriate to the service provided.

(f) Mandatory revocation

(5.2) The panel shall, in addition to anything else the panel may do under subsection (2), reprimand the member and revoke the member's certificate of registration if,

(a) the member has been found guilty of professional misconduct under clause (1) (a) and the offence is prescribed in a regulation made under clause 43 (1) (v) of the *Regulated Health Professions Act, 1991*; or

(b) the member has been found guilty of professional misconduct under clause (1) (b) and the misconduct includes or consists of any of the conduct listed in paragraph 3 of subsection (5).

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO -and- **DR. JAVAD PEIROVY**

Appellant (Respondent) **Respondent (Appellant)**

Court of Appeal File No. C63644

COURT OF APPEAL FOR ONTARIO

Proceeding commenced at Toronto

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