

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Tariq Iqbal, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity or any information that could identify any of the complainants or patients 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, in relevant part:

Every person who contravenes an order made under ... section 45 or 47... 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.
Iqbal, 2015 ONCPSD 41**

**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. TARIQ IQBAL

PANEL MEMBERS:

**DR. E. STANTON (CHAIR)
P. PIELSTICKER
DR. M. DAVIE
P. GIROUX
DR. P. CHART**

Penalty Hearing Date:	October 20, 2015
Penalty Decision Date:	October 20, 2015
Release of Written Reasons:	December 14, 2015

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on May 19 to 22, June 1 to 5 and June 16, 2015. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

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

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has failed to maintain the standard of practice of the profession;
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;
3. under clause 51(1)(b.1) of the *Health Professions Procedural Code* which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (“the Code”) in that he engaged in the sexual abuse of a patient.

RESPONSE TO ALLEGATIONS

Dr. Iqbal denied the allegations in the Notice of Hearing.

BACKGROUND

The allegations against Dr. Iqbal arose following an investigation into the complaints of four patients, who came forward independently, relating to visits to Dr. Iqbal’s office(s) between May and June of 2011. The four complainants did not know each other or each

other's complaints. The allegations in this matter are serious and include sexual abuse in the context of rheumatology consults and follow up care.

At the time of the complaints, Dr. Iqbal was a newly qualified rheumatologist having received his Royal College of Canada certification in October 2010. His practice locations were in Brockville and Manotick.

Dr. Iqbal

Dr. Iqbal was born in Zaida, Pakistan in December 1965. He is married and has two sons. His first language is Pashto however he is fluent in English. Dr. Iqbal graduated from medical school in Pakistan in 1989. He held positions of junior and senior house officer, research medical officer and primary care medical officer in a rural area in Pakistan.

From 1992 to 1994, he served as an emergency room (ER) physician and held an infectious diseases position at a children's hospital in Pakistan. Dr. Iqbal then entered an internal medicine residency program in Peshawar (1994 to 1996). He did not obtain certification but had the necessary training. He took qualifying exams to practise in the United States and for a brief time came to America; he tried, but was unsuccessful in obtaining a residency position in internal medicine there.

Dr. Iqbal returned to Pakistan and worked in various in-patient and outpatient settings. In 2000, he started a gastroenterology training program in Peshawar. This field was of particular interest to him. In 2001, he was unable to finish the training program due to financial problems. From 2001 to 2002, he practised as an ER physician in Saudi Arabia.

Dr. Iqbal applied for immigration to Canada, then returned to Pakistan and worked as an internal medicine and gastroenterology physician.

Dr. Iqbal and his family immigrated to Canada in 2003. He started working in voluntary positions. He worked as a security guard to support his family. He was determined to be a gastroenterologist and completed all the necessary examinations to qualify to practise medicine in Ontario. He was accepted into the Internal Medicine Residency Program at the University of Ottawa. During his residency from 2005 to 2008, his focus of interest

remained gastroenterology. However, he was unable to get a position for subspecialty training in gastroenterology in Ontario where he was funded. He accepted a position for subspecialty training in rheumatology, which he successfully completed from 2008 to 2010. He was successful in obtaining Royal College of Canada certification in Internal Medicine (May 2010) and in Rheumatology (October 2010) and also a Diplomate, American Board of Rheumatology.

Dr. Iqbal subsequently accepted a full-time position at the Queensway-Carleton Hospital (October 2010) and took internal medicine call once a week, along with 24/7 call for rheumatology. He stopped internal medicine call in November 2013 and his rheumatology call in April 2014 and resigned from the Hospital.

From December 2010, Dr. Iqbal has maintained offices in Brockville and Manotick. At both sites, he offers a consultant-based practice in rheumatology. He also does a monthly clinic at the Pembroke Hospital.

FACTS AND EVIDENCE

The Committee received a number of documents in evidence including: patient medical records, various Curriculum Vitae, letters, diagrams, sketches and emails, published and unpublished papers authored by Dr. Iqbal, photographs of both offices, day sheets, and the College's Policy on Maintaining Appropriate Boundaries and Preventing Sexual Abuse.

In addition, the following facts were set out in an Agreed Statement of Facts that was filed as an exhibit and presented to the Committee:

1. The Ontario Physicians Human Resources Data Center reports that as of December 31, 2011, there were 14 gastroenterologists practising in the South East Local Health Integration Network ("LHIN"), which includes Gananoque, Brockville and Kingston. As of December 31, 2010, there were 12 gastroenterologists practising in the South East LHIN and as of December 31, 2012, there were 13 gastroenterologists practising in the South East LHIN.

2. The Ontario Physicians Human Resources Data Center reports that as of December 31, 2011, that there were 6 rheumatologists practising in the South East LHIN, which includes Gananoque, Brockville and Kingston. In 2010, there were 6 rheumatologists practising in the South East LHIN and in 2012, there were 7 rheumatologists practising in the South East LHIN.

The Committee heard the testimony of each of the four patients whose complaints are central to this matter and of Dr. Iqbal in regard to these complaints. Dr. Iqbal's evidence is included in the review of each of the patient complaints. A summary of this evidence in narrative form follows.

Ms A

Ms A testified that she was in her forties in 2011. She retired in 2009 from her job. She is currently married with children. She testified that in 2011, she had been experiencing health problems for approximately fifteen years.

She was admitted to hospital in April 2011 with abdominal pain, which was found to be due to a bowel perforation. At that time, she was under the care of a surgeon (Dr. Q) and a gastroenterologist (Dr. R). The differential diagnosis was either Crohn's disease or Wegener's granulomatosis (an uncommon disorder that causes inflammation of blood vessels that restricts blood flow to various organs).

Dr. R requested a rheumatology consult from Dr. Iqbal. Ms A testified that she first encountered Dr. Iqbal when he saw her, reviewed her history and did a physical examination on her while she was in hospital. He requested that she come and see him at his office clinic after discharge.

Dr. Iqbal testified that he saw Ms A in April 2011, while she was in hospital, at the request of Dr. R. He reviewed her records, examined her and made a consult note. He testified he did not do a rectal or genital examination as she was quite sick and there was no history of rectal bleeding. There were no complaints related to the rectum or genitalia

at that time. Dr. Iqbal agreed that he was aware that she had a colonoscopy, a digital rectal examination (DRE) and a perianal examination performed by Dr. R during admission and that the DRE and perianal examination showed no evidence of disease. Dr. Iqbal noted chronic anaemia, which he attributed to chronic gastrointestinal blood loss and menorrhagia leading to a hysterectomy in 2008. He ordered a number of tests including an MRI of the sacroiliac joint area as noted in the medical record. The plan was to treat her conservatively with intravenous antibiotics and then to consider Prednisone and Imuran. He saw her again in April 2011 and told her he would follow her after discharge as set out in the medical record. Ms A testified she recalled seeing him only once during admission.

Ms A testified she saw Dr. Iqbal at his office in City 1 in May 2011. She testified her health was not good at that time. She was scheduled to go back to the hospital for a bowel resection, she was weak and had lost weight. She had returned to the emergency department since discharge in April 2011 with severe abdominal pain and also had seen Dr. R. She understood that her visit to Dr. Iqbal was to investigate the possibility of Wegener's granulomatosis. She attended alone. This accords with Dr. Iqbal's electronic medical record (EMR), which notes an 11:00 am appointment and an entry made at 11:57.

Both Ms A and Dr. Iqbal testified that the visit started with an interview and questions as to how she was doing. He was seated at his desk and she was seated in a chair in front of him. Ms A testified that Dr. Iqbal asked her about her symptoms. Dr. Iqbal testified he asked how she was doing and she volunteered that she had been back to the ER after discharge for symptoms of bowel obstruction and was currently on a low residue diet. Ms A testified that he asked her if she had any fissures of the vagina or rectum. She responded that she had previously had vaginal sores (thirteen years ago) but had none currently; she never had rectal fissures but had haemorrhoids in the past. She testified that he asked her if there was rectal bleeding. She responded that there was none that she noticed but that her stools always tested positive for blood. Dr. Iqbal noted in the medical record that she was complaining of abdominal pain and occasional rectal bleeding. He

also recorded that she had haemorrhoids before. Dr. Iqbal testified he recalled her mentioning red in colour. He said that to him rectal bleeding was a new finding. Dr. Iqbal testified that he told her that a rectal and perianal examination would be done in the context of rectal bleeding but that her bigger problem was to see if there were other things related to her disease such as fistulas or other perianal diseases. Ms A testified that he asked for consent to do a rectal and vaginal examination saying that fissures could be present that were unknown to the patient. She consented. Dr. Iqbal testified that if he found abnormalities, he would maybe get some tissue and refer back to her gastroenterologist.

She then proceeded to the examination table. Ms A testified that Dr. Iqbal asked her to lay face down on her stomach and pull down her jeans to below her buttocks. She did so pulling her underwear down with her jeans. She testified he stayed “right there” while she changed (Vol. 1A, pgs. 16-17)¹ and did not offer her a gown. There was no drape to offer her privacy. She testified that he did not offer a chaperone and she did not ask for one. Dr. Iqbal testified that he offered her a gown and the opportunity for a chaperone and she declined.

Dr. Iqbal testified that he performed a general physical examination including blood pressure (BP), head, eyes, ears, nose and throat (HEENT), thyroid, chest, heart, lungs and joints (MSK) while she was sitting. Ms A agreed on cross examination that there were aspects of the physical examination that she could not specifically recall, such as whether her BP was taken, whether a HEENT exam was done or checking for lymph nodes. She did not recollect a chest or heart examination or an examination of her joints.

Dr. Iqbal testified that he asked her to lay flat and felt her abdomen. He testified that up to this time, she was fully dressed. He testified that he told her to turn towards the wall and that she rolled over onto her belly (Vol. 5, pg. 118). He testified he let her remain in that position. He asked her to slide her pants down to below her buttocks so he could do a

¹ Refers to testimony in the hardcopy version of the hearing transcripts and will be noted throughout in this fashion - Vol. 1A, p.16.

rectal and perianal exam. He did not leave the room but moved to get gloves and lubricant and so had his back to her and she could not see him.

Ms A testified that he proceeded to do the rectal exam by inserting his fingers; she was not sure how many but said more than one. She testified that the rectal examination started normally with him feeling in a circular motion and then it changed to a back and forth motion, which she described as sexual in nature and quite forceful, to the extent that it moved her on the table. She described the bones of his hand “bottoming out” on the bones of her buttock and his fingers were all the way in. He made grunting and groaning sounds, which she likened to the sounds of foreplay or sex with her husband. She testified that he used gloves and lubricant and that the probing lasted three to four minutes. She testified that she wondered what was going on, whether she could fight back and thinking, because he is a doctor, he knows what he is doing. She further testified that when he was finished in the rectum, he went straight to the vaginal exam and he did not change gloves. She found this “quite disgusting” (Vol. 1A, pg. 25). She could not clearly recall whether she was still face down during the vaginal probing. The motion, when his fingers were in her vagina, was in and out and again, sexual in nature; there was no pretext of palpation or a circular motion. She did not know how many fingers were in her vagina but testified at least two. Ms A testified that the vaginal probing lasted two to three minutes; he made the same kind of guttural noises, which she described as sexual, and he touched her clitoris right at the end before he took his hand out. At this time, she felt ashamed, dirty, violated and stressed.

Dr. Iqbal testified that he performed a perianal examination by spreading her buttocks with both hands. He admitted that part of the lower external genitalia was also visible as her legs were straight and spread a little apart. He noted a couple of haemorrhoids and he felt with his thumb what he described as a sentinel pile. He then performed a digital rectal examination (DRE) using one finger. He testified the examination lasted only a few seconds and, he did not touch any part of her genitalia. He denied making moaning sounds. He testified that he was not jerking and then said “Well, I mean, there could have been a little bit of shake or whatnot, but no in and out movements” (Vol. 5, pg. 136). He

testified that he always does a DRE using his left index finger even though he has an intention tremor in this hand. He further pointed out his right index finger is missing beyond the distal phalangeal joint as a result of a childhood accident.

Ms A testified that the examination performed by Dr. Iqbal was unlike any other exam she had had previously. There was no privacy when changing and the positioning of her body was different. Dr. Iqbal testified that a DRE is preferably done in the lateral position but that he has done this in the prone position and the bent forward position though this is uncommon.

Ms A testified that when he had finished, he told her to get dressed and gave her a tissue to wipe herself. She looked to see if he had an erection but by the time she looked, he was back seated at his desk. Dr. Iqbal testified that he made an electronic medical record (EMR) note after the patient left and created a letter to Dr. R, later at the end of the day. In both of the documents, he noted that no oral or genital ulcers were present and that the abdominal examination was negative except for haemorrhoids (Ex. 2). He agreed he did not document a DRE, and said that this was an oversight.

Dr. Iqbal asked her to book another appointment, which she did. Ms A then testified that she walked to her car and bawled for about ten to fifteen minutes, debating whether to go back in and tell the receptionist or call the police. She felt so shocked that she just waited until she was calm enough to drive home. She went on to have bowel surgery at the end of June 2011 and eventually the diagnosis of Crohn's disease was established.

She spoke to her husband about what had happened and then decided to make a complaint to the College. She testified that she does not know any other patients of Dr. Iqbal and specifically, does not know the other complainants in this proceeding.

Ms B

Ms B was in her forties when she was referred to Dr. Iqbal by her family doctor, Dr. S, for possible fibromyalgia. Ms B testified she is married with children and is currently

employed. She testified that in 2011, she hurt all over her body from her head to her toes, as if she was ill with the flu. She had been waiting for a rheumatology consult in City 2, but she had heard about Dr. Iqbal from her case worker at Workman's Comp and asked if she could be referred.

She testified that she was uncertain about the date she saw Dr. Iqbal but the medical record establishes it in May 2011, and she recalls a warm day. She saw him in the City 3 office, which she describes as a big building (closed factory) with a pharmacy that she needed to walk through to get to his office.

Dr. Iqbal called her into his office and asked how she was feeling. She testified "Everything hurt". She testified that her shoulders, legs, groin, feet, every part of her body hurt. She testified he told her he had to check pressure points to diagnose fibromyalgia. Dr. Iqbal testified that he initially went over her past medical history and he particularly recalled her because of her significant social history, which is noted in the medical record. He stated that during the interview, she was sitting across the desk from him. Ms B testified that she was sitting on the examination table and had her clothes on. He testified that he told her fibromyalgia can have these symptoms and that he wanted to examine her to rule out other possibilities. He testified he gave her a gown and asked her to undress leaving her undergarments and the top on. He testified that he left the room for a moment. Ms B testified that she could not recall being offered a gown or blanket and he did not offer her a chaperone.

Dr. Iqbal testified that while she was sitting he started with a BP, head and neck including the thyroid examination and listened to the chest and lungs. He looked for the tender points that you would see with fibromyalgia. Ms B testified that he pushed on her neck, shoulders and back and asked if it hurt. She testified he had her lay down on her back on the examination table and he checked out her stomach and legs. Dr. Iqbal concurs and testified that he did an abdominal examination through the gown and felt her groin area, which he clarified as the inguinal structures. Ms B testified until this time, she remained dressed (Vol. 2, pgs. 17-19). Ms B testified that he then had her take her pants off. She

testified that she said “Do you want me to take them off now?” (Vol. 1A, pg. 151) He said yes. She testified that she lifted her butt up and scooted her pants and underwear down. While she was doing this, he took her shoes off and grabbed the bottom of her pants and helped her take her pants off. She testified he was standing at the bottom of the examination table at the time. Dr. Iqbal denied helping her undress.

Dr. Iqbal testified that he asked her to turn toward the wall so he could examine her lower back. He stated she had a gown on all the time. He testified that he examined the sacrum, ischial spine and lateral hip. He testified she had 18/18 tender points and had a lot of tenderness in the area of the ischial and trochanteric bursa. He testified that he could deal with bursitis with cortisone shots and offered these to her.

Ms B gave a different description of the examination. She testified that he told her that he had to check pressure points in the vagina and then proceeded to stick his finger inside of her vagina. She thought there was one finger and it felt pretty normal at first, like he was checking around and then it went on too long and he started “wiggling his finger up towards the top of my vagina” (Vol. 1A, pg. 153). She testified it was “like he was trying to stimulate me”. She testified that she thought he was trying to touch her G-spot. She testified that it felt like a long time, like ten minutes. He did not say anything just asked if it hurt. Dr. Iqbal denied doing a vaginal examination on this patient (Vol. 5, pg. 182).

She testified she was scared and in shock and did not know what was happening. She testified that she felt “dirty and gross” (Vol. 1A, pg. 155). Her legs were spread apart and she tried to close them but Dr. Iqbal pushed them back open. After he pulled his finger out, she testified that he told her to sit up. She testified that he told her it would be good to have cortisone shots. She testified that he said that a shot would help the pain in the groin area. She agreed to the cortisone shot.

Dr. Iqbal testified that he then asked her to remove her underwear but to leave the gown on; he left the room to get the cortisone shots. Dr. Iqbal testified he told her to lay on her left side for the injections. Ms B testified he had her lying on her stomach with her legs

apart. She testified she was embarrassed, and she had her face buried. He gave her a needle, which she described as being between her vagina and “bum hole” and as he was giving her the needle, he had a finger inside her vagina. Right after the injection, he started massaging the area, saying it would help the cortisone work faster. As he was massaging the spot, she testified that he was making weird noises, like moaning noises, like “Mmmmmmmm” (Vol. 1A, pg. 159).

Dr. Iqbal testified that he first injected her hip or trochanteric bursa and that she stayed in the same position for the ischial bursa injection. He testified he never had a finger in her vagina either during examination or while he was doing the injection.

She did not recall whether he offered her a gown or blanket but he did not offer a chaperone. She testified that he did not use gloves or lubricant. She was clear that he wore no gloves for the vaginal examination when cross examined on this point. Dr. Iqbal testified that he always wears gloves when he does injections.

When he was done, she testified that he told her to get dressed and then sit in the chair in front of his desk. She testified, “And, I remember at the time thinking like he had just had his hands in my vagina and near my vagina and he never washed his hands. It grossed me out horribly” (Vol. 1A, pg. 160). She testified he never left the room while she dressed. He went and sat at his desk (Vol. 2, pg. 47). She testified that he talked to her about treatment with Lyrica and that he wanted her to come back for further testing. Dr. Iqbal testified after the injections, he removed his gloves and stepped out of the room. They then discussed fibromyalgia and bursitis, the use of Lyrica and side effects and then she left. He ordered no tests.

Ms B testified she left Dr. Iqbal’s office, paid for the cortisone shot, went to her car and sat there and just cried. She testified she never went back because he made her feel dirty and gross and she never wanted to see him again. She testified he called her twice but she made excuses not to return.

She subsequently went to see her doctor and also a psychologist she was seeing at the time. She testified she told them everything that Dr. Iqbal had done. She testified that she was told they needed to report it and she asked them not to use her name. Her family doctor came back to her several times to ask her to give her name and again she refused, however, when informed that her doctor's license was at risk, she called the College herself (Vol. 1A, pgs. 169-170).

Ms B testified that she does not know any other patients of Dr. Iqbal, and specifically, she did not know the other three complainants.

Ms C

Ms C is a woman in her thirties who is married with a young child. For medical and personal reasons, her evidence was received electronically by secure video link.

Ms C testified she saw Dr. Iqbal on two occasions. Her problems started after the birth of her child in October 2010. She began experiencing pain all through her body causing her problems walking and pain so bad that when she picked up a glass, she would drop it. She was referred to Dr. Iqbal by her family doctor (Dr. S) for consultation for possible arthritis.

June 2011 visit

Ms C testified she saw Dr. Iqbal at his City 3 office. She attended alone. She was able to describe his office with reasonable accuracy compared with the office sketch and photos.

Ms C testified the first visit began with her sitting at his desk and she discussed her past history and family history with him. She told him that she had epilepsy and psoriasis. Ms C testified that since October 2010, her body had been filled with pain. She had no stomach or abdominal pain at the time of her visit. Dr. Iqbal testified that he took an extensive history. This included whether she had ever had oral or genital ulcers. He said this is a standard line of questioning for him. Ms C testified he asked about rectal fissures and whether she had ever had sores in her genital area. She informed him that she never

had genital sores but that she had bleeding from the rectum time and again. She was checked by her family doctor years ago for this and nothing was found. At the time of her visit to Dr. Iqbal, she denied rectal bleeding and indicated that it was not a concern for her.

Dr. Iqbal testified that he did a perianal examination on Ms C based on her history to see if there is rectal bleeding and to see if there were any localized abnormalities such as sinuses, fistulas or abscesses as inflammatory bowel disease can be associated with psoriatic arthritis and other seronegative arthritides. He was also concerned that she was taking a lot of non-steroidal anti-inflammatory drugs and could have peptic or colonic ulcers, which could give rise to rectal bleeding.

Ms C testified that when he wanted to examine her, he held a gown up in front of her and told her to remove her clothes from the waist down. After a brief hesitation, she removed her pants and socks while he was standing about two feet in front of her. She put on the gown. Ms C testified she believed he helped slide the gown around her and then she tied it. Ms C said he assisted her by holding her arm and helped her get on the examining table as her knee and foot were very painful. Dr. Iqbal testified he offered her a gown and told her to undress including her undergarments. He informed her he would be doing a perianal examination. He testified he stepped out of the room but he could not recall whether a chaperone was offered. When he returned, she was still in her chair with the gown on and he helped her onto the examination table.

She was sitting on the examination table when the examination began. Dr. Iqbal examined her joints. She lay down flat on her back and he checked her hips, knees and foot again. Dr. Iqbal testified he started his usual examination including BP, HEENT, chest, heart, thyroid and lymph nodes. Some of her joints were swollen and tender. He asked her to lay flat on her back and examined her belly and then the hip and lower limb joints. He testified that he asked her to turn on to her left side toward the wall and she rolled over on to her belly. He testified that, for him, the prone position was not wrong. Since Ms C had a hard time mobilizing, he thought the prone position would be enough.

Ms C testified he asked her to roll over on her stomach and he assisted her so she would not roll off the table. He checked her spine and pushed on her hips from the back. Ms C testified that he then grabbed her underwear on each side and slid them down to her ankles.

Ms C testified she was unable to see him but she heard him in the background. He took both hands and spread her bum cheeks open and pushed around with his finger like he was searching for something. She testified she thought this lasted about five minutes. His fingers did not enter her anus. Ms C described her legs spread open enough that he could see. Ms C testified that using his index and middle finger, he slid them down to her vagina and started to wiggle them and he made his way higher to where the clitoris is. She did not see what fingers he used as she was face down but if felt just like two fingers. There was no break, he moved right along from the anal area to the vaginal area. She testified it lasted about the same time (five minutes) or a couple of minutes less. He then slid her underwear up, told her to roll over and talked about cortisone shots. Dr. Iqbal testified that he never moved his fingers into the vaginal area and did not wiggle his fingers. He testified he did not touch her clitoris. He said he never assisted any patient with dressing or undressing. (Vol. 7, pg. 34)

Ms C testified it felt like he was trying to turn her on (Vol. 3, pg. 30) and she likened it to what she experienced when younger when she and her husband started doing sexual things. She did not know whether he wore gloves, or not, but testified that before she rolled over, he had nothing on his hands. She was sure he used lubricant as it was cold and wet.

Ms C testified that the examination with Dr. Iqbal was unlike any prior vaginal exam she had. She thought at the time that he might be checking for vaginal sores even though she told him she never had them.

Following the examination, he left the room to get the shots. On his return, she testified that he drew fluid from her knee and followed that with a cortisone shot and then he gave

her a shot in her foot. She testified that she got off the table and put her pants back on. She reported he said she did a good job. He ordered a CAT scan and asked her to return in a month. Dr. Iqbal testified he drew fluid from the right ankle and then injected depo-medrol into the ankle following which he injected the bursa around the knee. The medical record confirms the aspiration recorded as coming from the right ankle.

Dr. Iqbal testified that he ordered further blood work including an anti-CCP (a test he knew was not covered by health insurance). He testified he makes a point to tell every patient and in this case, she probably misunderstood. He also ordered a CAT scan.

Even though it all felt very wrong to her, Ms C testified she returned to see him as she had so much pain she could not hold her new baby and that rheumatologists were hard to get in to see. (Vol. 3, pg. 39)

July 2011 visit

Ms C testified that at the second visit, Dr. Iqbal again stood in front of her holding a gown while she changed removing her pants and socks. He examined her joints again. They discussed her test results. She testified that he thought she had psoriatic arthritis brought on by the trauma of childbirth. He did further injections (hips, wrists). It hurt so bad she was crying. He encouraged her and persuaded her to have the thumb done as well. She testified it hurt even more and she left the office crying. There was no examination of the anus or vagina on that occasion. She did not return to see him.

Dr. Iqbal testified that when Ms C was seen in July 2011, she was quite upset that he had not received the CAT scan report though this had just been done that morning. She was still having pain and he planned more injections. There was no perianal examination to be done and he did not give her a gown. He did a musculoskeletal examination. He then gave her a gown as she needed to take her underwear down to expose the site for injection of the trochanteric bursa. He testified he injected the trochanteric bursa, then the wrists and thumb. He testified she was crying, he tried to convince her to have the thumb injected but did not force her. He testified that after the injections were done he left the

room giving her the opportunity for privacy to pull her pants up. He added a brief course of prednisone and naproxen (NSAID), to the methotrexate that he had given her before. He planned on seeing her in a month.

He testified that a few days after the appointment, Ms M (a part-time employee) brought an email to his attention regarding payment for the anti-CCP test. Ms C was upset and refused to pay and said she was not informed that it would cost her anything.

Ms C testified that she went back to her family doctor and asked whether she was supposed to get an examination “down on your privates” at a rheumatology consult (3-49). Her doctor said no and that she was not the only one. Ms C hesitated to make a complaint but decided to do so, because she did not want it to happen to anyone else. Ms C denied knowing any of the other complainants in this matter.

Ms D

Ms D testified that she is currently in her twenties, living in a common-law relationship and has children. She has been diagnosed with lupus and fibromyalgia. In 2011, she was referred to Dr. Iqbal by her family doctor (Dr. T) for joint pain, headaches and rashes when she was in the sun. Ms D recalls seeing Dr. Iqbal on three occasions.

May 2011 visit

The first visit in May 2011, she attended Dr. Iqbal’s City 3 office with her mother. She testified they first talked about her current symptoms, which included bloody diarrhoea. Dr. Iqbal testified that Ms D had a significant history of anxiety and panic attacks for which she was on treatment. Over the past six months, she had diffuse joint pain and headaches and lupus was of concern. He saw her in his City 3 office, which was located in a decommissioned Nortel building. He reviewed her history including the medications she was taking. He noted a history of irritable bowel syndrome (IBS) in the past. He documented her joint pain. He testified that he asked about genital ulcers and she volunteered bloody diarrhoea. He inquired about genital ulcers, to be complete and get as much information as he could. He testified that oral and genital ulcers can be associated

with inflammatory bowel disease and Behcet's vasculitis. Ms D stated she never had vaginal or genital ulcers.

Ms D testified Dr. Iqbal then said he wanted to do a physical examination and asked her to remove her clothing from the bottom half. She believed he gave her a paper sheet. Dr. Iqbal said he provided her with a gown. He testified that he stepped out of the room for a moment. Ms D testified that she was by the examination table and he was in the opposite corner of the room while she was undressing. Her mother was seated in the room but could not see her.

Dr. Iqbal then carried out a full physical examination, first in the sitting position and then on her back for the abdomen and lower extremities. This included looking for fibromyalgia tender points.

Dr. Iqbal testified that he had her assume the left lateral position with her knees bent and he performed a perirectal visual exam. He used gloves but no lubricant used as there was no penetration of the rectum. He remembered that part of the lower genitalia (vulva) was exposed (Vol. 6, pg. 62). Ms D testified he first examined her joints and then asked her to lie down on her left side. She described being in the foetal position facing the wall. She said she felt him separate her bum cheeks and then he inserted two fingers in the rectum and felt around in a circular way and then in and out. The rectal examination lasted a few seconds. She testified he was using gloves and lubricant. She testified when he finished the rectum, he separated the labia and just looked; he did not insert his fingers. Dr. Iqbal testified he did not touch her vulva or open the flaps of the vagina. Her mother remained in the room seated at the desk.

Ms D testified she believed in doing the rectal exam, he was checking out the bloody diarrhoea and that he was looking for ulcers in the vaginal area. Dr. Iqbal testified that there were a few reasons he wanted to do the perianal exam; first was whether there were any pathologies (ulcers, rashes or blood), then he noted she was on NSAID's and it was possible that ulcerations of the upper GI tract could cause bleeding, and lupus itself,

which can affect any part of the bowel including the rectum and be a source of the bleeding.

Ms D testified she then got dressed and again Dr. Iqbal remained in the room over in the corner by his shelf. Dr. Iqbal testified that he left the room while she dressed. She returned to the desk and they discussed treatment and when he would see her again. Ms D had no concerns about the way he examined her at this appointment. Ms D's mother remained in the examination room seated at Dr. Iqbal's desk throughout the appointment.

June 2011 visit

Ms D testified she returned to see Dr. Iqbal again in June 2011. She attended alone. She said she was feeling better but still had sun sensitivity and joint pain. She had no abdominal symptoms but noted some black stool. Dr. Iqbal testified that she continued to have headaches and reported a visit to the ER for abdominal pain. An ultrasound and barium follow-through examination had been done but he did not have the reports. A colonoscopy was planned. He notes the ER visit as June 2011 in his letter to her physician. He testified that she volunteered her stool was now black in colour and this condition had started the day before he saw her. He testified that he was genuinely concerned about melena.

Ms D testified he asked her to undress, gave her a paper sheet and he remained in the room over by the shelf while she was undressing. He did not offer her a chaperone. He testified that he gave her a gown and stepped out of the room.

Ms D testified he did a physical examination, checking her hands, knees, ankles, "normal stuff like that" (Vol. 2, pg. 70). Dr. Iqbal's evidence is consistent with this. He asked her to turn on her left side. While she was lying on her left side with her legs bent towards the wall, she testified that he inserted two fingers in her rectum. She could not see his fingers but from the sensation it was two fingers. He was wearing gloves and using lubricant. She testified the movement was circular and in and out many times. He inserted his fingers really deep and it was very uncomfortable. She testified it felt like a while, "probably

about ten seconds”. He said nothing other than telling her to relax. She testified she felt violated. He then asked her to lift her leg and inserted his fingers into her vagina, she felt like it was two fingers. She testified this shocked her as it was a “no-no”.... “You don’t put the bad bacteria into your vagina” (Vol. 2, pg. 73). She testified he did not change gloves or wash his hands. She knew this as he did not move from where he was standing. She testified he used the same circular and in and out movement in her vagina lasting a few seconds and then he reinserted fingers back into her rectum using the same motion for a few seconds.

Dr. Iqbal’s version differs. He testified that he never uses two fingers and always uses his left index finger to do a DRE. He lifted the buttock, inserted his finger in the rectum looking for stool but found none. He testified that if you are obtaining a history of ongoing bloody diarrhoea, a fecal occult blood test (FOBT) could be ordered but he did not. He would have sent her for endoscopy to diagnose and treat the cause of the bleeding (Vol. 6, pg. 77). He testified it was a quick exam and he did not do a vaginal examination. Dr. Iqbal was taken to his report (Ex. 2, Tab D, page 47) and he agreed that he did not mention a rectal examination in his letter to Dr. T regarding the June 2011 appointment and said that was an oversight.

Ms D testified that he asked her to get dressed during which time he remained in the room. Dr. Iqbal testified he gave her tissue, took off his gloves, told her to get dressed and he left the room. He said they discussed treatment with Lyrica and further follow up.

Ms D testified that she found the examination done at the first visit at least a little more professionally done; in June, she felt something was not right. She had not had a rectal examination before this time but the vaginal exam was different than with other doctors. She thought Dr. Iqbal was looking for ulcers but she did not know what to expect as she had never been to a rheumatologist before. After this visit, she told her mother, boyfriend and talked to her family doctor.

Ms D testified she returned to see Dr. Iqbal in August 2011 because she had no other doctor to go to. She testified she lied to him saying she had her period so that she would not be examined again. No rectal or vaginal examination was done. She testified that she did not recall a fourth visit.

Ms D testified she subsequently requested a new rheumatologist from her family doctor and is currently on treatment for lupus and fibromyalgia. She did not contact the College until 2014, after a discussion with her new rheumatologist. Until then, her life was busy with her children. She testified she does not know any of the other complainants in this matter. She does know other patients of Dr. Iqbal but they are male.

Expert Evidence

The Committee heard expert evidence from two rheumatologists, Dr. X and Dr. Y.

Dr. X

Dr. X is a rheumatologist who received her Royal College of Canada certification in internal medicine in 1998 and in rheumatology in 1999. She is currently Division Head of Rheumatology at Women's College Hospital. Most of her time is spent doing clinical work. Dr. X has an academic appointment at the University of Toronto and teaches at the medical student and resident level.

The Committee accepted Dr. X as an expert in this proceeding to give opinion evidence in rheumatology including, but not limited to, the indications and manner of performing examinations in a rheumatology practice.

Dr. X testified as to the scope of practice for a rheumatologist, which would include primarily musculoskeletal, inflammatory and immune conditions; by way of example she identified rheumatoid arthritis, lupus, gout and other inflammatory arthritides or joint conditions. She stated the field is broad and may overlap with other diseases.

Dr. X described a perianal examination as a primarily visual examination looking for abnormalities in the area such as rashes, lumps, fistulas or abscesses. If something abnormal is noted, there may be some palpation involved. This is not a common examination in rheumatology practice and is usually related to skin rashes or bowel problems. Sometimes clues are looked for in other systems to characterize the arthritic problem. If a patient had symptoms consistent with inflammatory bowel disease (IBD) but the diagnosis was not established, that may trigger a perianal examination. If there were no complaints, it would not be part of a rheumatology examination. In a rheumatology practice, a perianal examination would be exceedingly rare. If there was a true concern for IBD, steps to make the diagnosis are needed. The diagnosis will not be made on visual inspection. It is uncomfortable for the patient and it is best done in the hands of someone who can make the diagnosis, unless there is an acute issue.

Dr. X testified as to how a perianal examination is done. The patient is asked to remove their underwear and a gown is provided. The patient needs to understand the purpose of the examination. The examination is carried out in the left lateral position with the knees bent upward; that is the standard position and how it is taught. With gloves on, the top buttock is moved to expose the area. If anything abnormal is seen, a decision whether or not to palpate would be made. The examination should last a matter of seconds. Dr. X testified there is no reason to examine the patient in other than the standard position and that to examine a patient lying on her stomach would be much more awkward and difficult.

Dr. X described a DRE as palpation of the inner part of the rectum by the finger of the physician. She testified that it is not done in rheumatology outside of three situations: (i) a suspicion of IBD and where examination may help the diagnosis - in her setting, she would refer to a gastroenterologist for a definitive diagnosis; (ii) suspicion of a GI bleed and if necessary to confirm, stool could be tested for blood; and (iii) where there is a concern regarding spinal cord compression to check for anal tone.

Dr. X described the appropriate manner of performing a DRE as follows: the undergarments need to be removed and the patient draped, the patient should be in the left lateral position with their legs pulled up toward their chest such that their buttocks can be exposed (easiest and most comfortable for the patient). After applying lubricant, a finger is placed in the rectum usually at the 6 o'clock position and is swept up one side and then the other so that 360 degrees are felt. The finger is then removed, unless there is something that needs to be felt such as a mass. The depth is one to two inches generally. The examination lasts a matter of seconds, unless there is some concern.

Dr. X testified that a rheumatologist would never do an internal vaginal examination. She stated that visual inspection of the perineum is not part of a routine rheumatologic examination. In circumstances where an inflammatory condition (Behcet's disease) where genital ulcers are a manifestation of disease or when the patient is complaining of genital ulcers, she said it would be reasonable to do an inspection to look for these ulcers.

An appropriate visual exam would be carried out with the patient supine (after removing their underwear and using draping) with the legs bent and apart, so the area can be fully exposed. There may be some palpation to move the vulva aside. A proper visual inspection cannot be done with the patient lying face down.

Dr. X opined on the individual care received by each of the complainants and this will be addressed later in our reasons.

Dr. Y

Dr. Y completed his medical training in the United Kingdom (UK). He is a fellow of the Royal College of Physicians in Canada. He received his certification through recognition of his UK training and not by examination. His Ontario certificate of registration to practice is restricted to rheumatology. He came to Canada in 2006 and had an academic appointment at Queen's University. His time was dedicated 60% clinical and 40% teaching. He had significant responsibilities in teaching clinical skills (including rectal

examination) to medical students in their first two years as well as training residents who were in rheumatology and internal medicine. He left his academic appointment at Queen's at the end of 2013 to set up an independent practice.

The Committee accepted Dr. Y to be qualified to give opinion evidence in rheumatology, including but not limited to the indications and manner of performing examinations in a rheumatology practice.

Dr. Y was questioned as to the scope of rheumatology. He testified that he regarded rheumatology as a sub-specialty of internal medicine. He testified there is a huge overlap with other specialists citing respirologists, nephrologists and gastroenterologists. Rheumatic disease is not focused just on the joints but also other diseases of the immune system.

In respect of the standard of practice, Dr. Y testified that a physician would wear gloves when touching a patient in the rectal or perianal area, provide for patient privacy while a patient is undressing by leaving the room or creating a barrier and also by providing appropriate draping.

Dr. Y testified that both DRE and perianal examinations are not routine in rheumatology practice and would not be done, unless clinically indicated. He further testified that "if a rheumatologist feels it is within his skill base to do a rectal exam or perianal exam, it may be reasonable" (Vol. 9, pg. 134). There will be some instances where it is personal judgment. Dr. Y understood that Dr. Iqbal had experience in gastroenterology.

Dr. Y agreed that if a patient denied any genital ulceration or vulvovaginal symptoms, he would not expect a rheumatologist to visually examine the vulva (Vol. 9, pgs. 142-143). He testified that that he has become aware in the last few months of new CanVasc Guidelines, which awarded scoring points for visual examination of the genitals. He testified that to do a full examination of the genitals, the patient would be supine. A proper visual examination could not be done with the patient face down.

Dr. Y was questioned as to the specific examination of each of the complainants and this will be addressed later in our reasons.

The Committee also heard testimony from two additional witnesses.

Dr. N

Dr. N is a Ph.D. student in classics and religious studies (Vol. 8, pg. 113) at the University of Ottawa. He testified that he has been an Imam and the spiritual leader of the South Nepean Muslim Community since August 2011. He leads the prayer and provides spiritual guidance, education, marriage/family counselling and networking services as well as being a day-to-day mentor.

Dr. N has known Dr. Iqbal since 2009/2010 from educational and fundraising activities for the Muslim community. Dr. Iqbal was a regular member of the community and would join for prayers when he was in the Ottawa region, especially during the month of Ramadan. He testified that all of the people showed respect for Dr. Iqbal.

Dr. Iqbal asked to meet him. When they met Dr. Iqbal gave him the Notice of Hearing to read and told him that he had some issues.

The Committee accepts his evidence as credible and reliable but limited as to its relevance to matters in issue.

Ms M

Ms M testified that she was born in 1990 and currently lives in Toronto. She has a part-time job in retail. In the spring and summer of 2011, she worked as a receptionist part-time for Dr. Iqbal. She worked three days per week in his City 3 office. She left to return to school.

Ms M testified as to the layout of the office and that the door to his office had a window about half way up. While she worked there, the glass was not covered. She noted that she could not see a patient on the examination table by looking through the door but could see his desk. She recalled interrupting him maybe once or twice for something very minimal and she would knock first.

Ms M testified she did not know whether Dr. Iqbal offered chaperones to every female patient. She recalled two occasions when he asked her to be in the examination room, one was for a cortisone shot and the other for an examination of painful areas (knees, legs, lower thighs); she assumed that was because the patient wanted a female companion in the office.

Ms M was questioned as to a conversation she had with Ms C in July 2011 regarding an invoice for an anti-CCP test. Ms M testified that Ms C was angry, and stern that she would not pay for the test. She further testified that Ms C was frustrated and bitter, wanting immediate resolution. Ms C said she was going to invoice Dr. Iqbal.

The Committee accepts her evidence to be credible and reliable.

Credibility Assessment

The Committee is aware of the importance of assessing the credibility of witnesses and the reliability of their evidence. In cases of alleged sexual abuse, the conduct generally takes place in private, without witnesses present.

There are general principles which need to be considered. Credibility speaks to honesty, the ability to speak the truth. Reliability relates to the ability to observe, recall and describe events accurately.

Further, just because there is no apparent motive to lie, the Committee understands it does not mean a witness is necessarily telling the truth. Inconsistencies in a witness's evidence and prior inconsistent statements can be important and need to be examined

with care. If there are material inconsistencies without a reasonable explanation for them, this is important in assessing the testimony of witnesses.

The Committee understands that it can accept all of what a witness said, some of it, or reject it entirely. In weighing the testimony of witnesses, it is the force of their testimony given the circumstances that is important, in the context of all the evidence admitted at the hearing.

In this matter, the following factors were of particular importance:

- Plausibility or improbability of a witness' story;
- Exaggeration;
- Motive or lack thereof;
- Inconsistent evidence, including prior inconsistent statements; and
- Manner or demeanour, though the Committee is alive to the limitations of demeanour in assessing credibility.

The Committee considered the evidence of each of the complainants individually and sets out its assessment of their credibility and the reliability of their evidence and then does the same for the evidence of Dr. Iqbal.

Ms A

The Committee found Ms A to be quiet spoken, but she left no doubt in giving her testimony that she believed that she was assaulted sexually by what Dr. Iqbal did to her.

The Committee accepts her evidence as credible and reliable in relation to what occurred on the examination in May 2011. The reasons follow:

- The Committee noted that Ms A gave her evidence fairly and objectively and did not express malice towards Dr. Iqbal. There was no evident ulterior motivation for her testimony other than bringing forth the truth. She stands to gain nothing;

- Ms A gave her testimony in a mature manner and was emotionally controlled through most of her evidence, even when describing the sensitive details of the DRE and vaginal touching;
- Ms A was probed as to the details of the length of time that the examination lasted and it was put to her that she exaggerated the length of time of the DRE. The Committee agreed that any time given would be a guess at best and that a patient in her position may feel that an uncomfortable examination goes on longer than it actually does. Her estimate of three to four minutes for the rectal portion and two to three minutes for the vaginal is not unreasonable in the circumstances. What she describes is not a normal DRE, which the Committee agrees could be completed in under a minute;
- The Committee finds that she was honest in responding to questions regarding the details of the examination when admitting she could not recall. Many of the details probed were elements of a physical examination which she would not necessarily be aware of. After four years, she claimed that some details of the visit were foggy and the Committee is of the view that lacking a medical background, she would not likely recall such elements as a BP reading, or HEENT examination. Similarly, her inability to detail accurately all of the office accoutrements did not detract from her evidence;
- In describing the touching that she experienced, she was consistent both in direct and cross examination. She maintained her composure, despite the graphic nature of her testimony. There were two instances where she made inconsistent statements to a College investigator and these will be dealt with below;
- Recognizing the limits on the use of after the fact conduct, her evidence of returning to her car and being so upset that she cried for a time and waited, until she was composed, before driving is a realistic response to the examination she said she experienced. A complainant's emotional state is circumstantial evidence that the events occurred only where there are no other reasonable explanations for the conduct: the Committee finds that Dr. Iqbal's touching was not clinically justified, is not open to misinterpretation by Ms A and that there is no other explanation for her emotional reaction in the circumstances;

- The Committee is not persuaded that her action in making a return appointment or her delay in proceeding with a written report to the College was relevant in terms of whether an assault had occurred;
- Ms A is a patient with a long medical history where she would have had numerous intimate examinations in the past. There was no question that what she experienced with Dr. Iqbal was different to past clinical examinations;
- She was consistent in reporting no fresh rectal bleeding, rather a history of fecal occult blood, for which her colitis was adequate explanation;
- The Committee accepts her evidence that she was not offered a gown; it was clear that Dr. Iqbal examined her as she said he did “fully dressed”, and that she was only asked to pull her pants down before the rectal area was accessed; and
- The Committee is of the view that it would be difficult to comprehend that Ms A would confabulate such a traumatic and self- debasing story. Her description of not knowing what to do, crying in her car, considering calling the police, or telling the receptionist, is a realistic and plausible response to a serious violation of her body.

Counsel for Dr. Iqbal questioned Ms A on statements she had made to a College investigator in an interview on March 13, 2012, indicating that she did not know or was not sure whether she felt one finger or more on DRE. In her evidence before the Committee, she testified that Dr. Iqbal used more than one finger and on cross examination, she acknowledged that she was not sure. What was clear to the Committee was that she was unable to directly see how many fingers Dr. Iqbal used and that her testimony was based on what she felt. Normal DRE is performed with one finger. The examination she described hurt, and involved feeling the bones of his hand against the bones of her pelvis to the extent she cried out. Under such circumstances, she may have honestly felt he used more than one finger or that she was not sure. This did not detract from the Committee’s view of her credibility or the reliability of her recount as to the examination. She did not duck the questions posed to her and admitted the inconsistency, which she described as being how she felt. The Committee does not find the inconsistency to be material.

Counsel for Dr. Iqbal challenged the reliability of Ms A's evidence in view of her lack of recollection of whether she was in the prone or supine position for the alleged vaginal examination. Her testimony before the Committee was that for the rectal examination, she was prone, but she was unsure for the vaginal examination. In the March 13, 2012 interview with the College investigator, she acknowledged telling him that she did not turn over. She then wrote to the investigator on June 10, 2012 that she had rolled over for the vaginal examination. When confronted in regard to the change, she said it was confusing with the passage of time and stress. Counsel for Dr. Iqbal suggests that her evidence is not reliable. The Committee disagrees. She has nothing to gain by asserting she is unsure currently. She admitted her memory for some details is foggy. Whether vaginal probing occurred in the prone position or supine position does not negate the fact that any vaginal examination is inappropriate in the circumstances. She had no difficulty recollecting a digital intrusion in her vagina. On the material facts, her evidence is consistent.

The Committee accepts her evidence overall, finding her recount of events to be honest and truthful. The Committee acknowledges that her memory for some particulars may not be perfect, but the evidence she gave of the actual events at issue was clear, consistent, and in the Committee's opinion, reliable.

Ms B

The Committee found Ms B to be without pretence and plain speaking. She testified in a direct manner responding appropriately to questions posed to her both in cross examination and in chief. She described events clearly and consistently.

She was definite in characterizing the aspects of her visit to Dr. Iqbal that affected her the most, using terms that appeared to truly reflect how she felt. An example was the lack of hand washing after he had a finger in her vagina without using gloves. She said this grossed her out horribly. It was further apparent to the Committee from the office layout and photographs submitted (Ex. 18, 19 A-M) that there was no washbasin in Dr. Iqbal's

office and that he would have to leave the room and go to the washroom to wash his hands.

It was also apparent that Ms B had no wish to proceed with a complaint in the time following her one visit to Dr. Iqbal. It was only after repeated requests from her family doctor that she eventually made a complaint. Indeed had her doctor not been required to make a mandatory report, her complaint would not likely have ever been made.

Ms B exhibited no malice toward Dr. Iqbal, simply noting that she never wanted to see him again. She stands to gain nothing in giving her evidence as she did. She has no interest in the outcome of the case and no motivation to mislead or misrepresent what was done to her.

Her description of wanting to be reassured by her doctor as to why Dr. Iqbal might want to examine her as he did, speaks to the trust she had that physicians perform examinations for the benefit of their patients. She spoke to her doctors, hoping to be reassured.

While her memory was not perfect as to all the details of the history she imparted to Dr. Iqbal or other parts of the examination he performed, the Committee is of the view that she answered questions to the best of her ability. As has been noted by the courts, testimony is not a memory test. She was consistent in giving her evidence about when she was unable to remember. She did not embellish her evidence. She did not read her medical record and the Committee is of the view that her failure to recall specific items of history or common elements of a physical examination did not detract from the accuracy and face of her testimony.

When pressed as to whether she had read the transcribed interview she had with the College investigator, she admitted that she was unable to read and write, an admission it appeared that embarrassed her, yet was made quietly and honestly.

Her evidence was focused on her personal experience and she left no doubt that her recall of the vaginal examination done by Dr. Iqbal was sexual and intended to stimulate her. She was explicit about his not touching her clitoris or anus. Her description of crying in her car after the examination for what had occurred or what she believed had occurred was a realistic response in the Committee's view, and circumstantial evidence in support of her version of the events, given the Committee's finding that it was not in the circumstances a misinterpretation of a medical examination by Dr. Iqbal and that there was no other reasonable explanation for her emotional state.

She was pressed in cross examination to admit she exaggerated the time of the vaginal examination when she said ten minutes. She simply replied that it felt that long. The Committee accepts her explanation. She was also questioned in detail about Dr. Iqbal not using gloves. There was no question in her mind that after he did the vaginal examination (before he left the room to get the needle), he had no gloves on.

There were aspects of her visit which she could not recall such as having an injection in the right trochanteric bursa. This is recorded in her medical record. Her lack of recall was consistent when revisited repeatedly and did not diminish the strength of her testimony.

The Committee considered that at the time she saw Dr. Iqbal, she was unwell, and had endured family deaths and a severe illness involving her husband. With a diagnosis of fibromyalgia, it was clear her life at that time was a struggle. This however, in the view of the Committee, had no bearing on the veracity of her evidence. The Committee did not believe that Ms B lied about or misinterpreted the events at issue given the unusual positioning she described and the nature of the vaginal touching.

The Committee finds her to be a credible witness who gave forceful testimony about the events which took place. The Committee finds her evidence reliable.

Ms C

The Committee finds Ms C to be direct and consistent in giving her evidence and in discriminating between what she knew and did not know. She was straightforward in her responses and did not avoid answering questions on personally embarrassing material. She was not reluctant or afraid to give a description of the intimate touching she alleges and her description of likening this to sexual activity was clear.

She did not recall details such as some of the medical and social history that Dr. Iqbal recorded in her medical record. She agreed that they could have discussed such things. She also did not recall all of the elements of the physical examination such as examining parts of her head, eyes, ears, etc. She did not recall accurately, which joint he injected. The Committee's view, given four years had passed, is that her lack of memory of these particulars was reasonable.

Ms C described rectal bleeding to Dr. Iqbal as occurring time and again, on and off. Her father told her it sounded like haemorrhoids. She had gone to her family doctor years before to check and nothing was found. Her father said she might have fissures, which are tears when a bowel movement is too hard or big. Ms C testified that she was not having rectal bleeding at the time she saw Dr. Iqbal (Vol. 3, pgs. 20-21). It was not a concern for her. She described this symptom as bright red blood now and again when she wiped herself (Vol. 3, pg. 64). She attributed the bleeding to pushing too hard, too fast and tearing herself. She said she did not have genital sores and diarrhoea. She did not recall whether Dr. Iqbal asked her about rectal pain (Vol. 3, pg. 22) but did recall him mentioning tags. In the Committee's view, these details speak to the accuracy of her evidence.

She recalled the gowning process and described this in detail. She testified he told her to remove her clothes (jeans and socks) from the waist down while standing in front of her holding up the gown and facing her (Vol. 3, pg. 22). Her description of him grabbing her underwear on each side and sliding them down to her ankles, when she was in the prone position, was explicit. She also testified that after he was finished, "he takes my underwear and he slides them back up over my bum, and tells me to roll over" (Vol. 3,

pg. 35). This was not usual practice and the Committee was of the opinion that her recall was accurate.

Her description of him spreading her bum cheeks and pushing around with one finger like he was searching for something rings true. She was clear that he did not enter her anus. Her description of him then sliding two fingers down to her vagina and starting to wiggle them back and forth and in and out (Vol. 3, pg. 124) was clear and unembellished. She testified he touched her clitoris in a manner that she felt was like “a person trying to turn the other person on” (Vol. 3, pg. 30). She had no hesitation in describing the acts as sexual. She testified that there was no break in moving from the rectal area to the vagina and she identified this as contrary to normal hygiene practices she had been taught as a little girl. Ms C had no difficulty speaking about this embarrassing sequence of events.

She was observed to show no malice to Dr. Iqbal. She recognized the wiggling of his fingers was wrong, but wanted to give him the benefit of the doubt. She thought maybe he was checking her for genital sores, even though she had told him that she had never had them.

She denied being hostile to Dr. Iqbal in respect to the invoice she received for a blood test, which was not covered by insurance, and said it played no role in her interaction with her doctor or her decision to complain to the College. While the exact date she received the invoice is not apparent from the evidence, the date she contacted Dr. Iqbal’s office inquiring about the invoice is clearly a week after she saw her family doctor. She testified that “even if I did have it, I didn’t voice those concerns with her. I voiced my concerns about the things that made me uncomfortable that he did to me” (Vol. 3, pg. 177).

Her decision to speak to her family doctor was not based on anger, but clearly related to asking whether the examination she had experienced was proper or not. She testified in cross examination that he came across as a very polite and caring person. The reason for following through with the College was “because I didn’t want it to happen to anybody

else” (Vol. 3, pg. 50). In the view of the Committee, both actions were not unusual and her description and balance speaks to truthfulness.

She was an experienced patient, able to discern usual positions for examination. The Committee accepts it would be highly unlikely that she would roll onto her stomach, unless told to do so.

Her lack of accuracy in respect as to whether it was the knee or ankle injected is not, in the Committee’s view, material. After a period of four years, memory is less than perfect and the fact that she erred, in saying it was her knee rather than her ankle that was injected, did not undermine the balance of her testimony. She knew he took fluid from one spot and simply thought it was her knee, not her ankle.

Her second visit to Dr. Iqbal was necessitated by her continuing symptoms. She testified “I wanted to get feeling better so I could just hold my daughter” (Vol. 3, pg. 186). Her testimony was candid and persuasive. She testified she did not want to believe that anything was wrong.

Her reasons for not returning to see Dr. Iqbal were clearly stated. He watched her strip and that made her uneasy (Vol. 3, pg. 40). The intimate examination of “her privates” did not sit right with her. “It all just felt very wrong” (Vol. 3, pg. 40). The Committee finds her credible and her evidence reliable.

Based on the testimony given and for the reasons cited above, the Committee finds Ms C is both credible and reliable in respect of her evidence as to her interaction with Dr. Iqbal.

Ms D

The Committee finds Ms D gave direct and forthright testimony. She was direct in her responses. At times, she was emotional and teary.

The Committee viewed her evidence as credible and reliable:

- She freely admitted that she thought there was nothing wrong with the examination she experienced on her first visit in May 2011. She was frank and open that she believed that his rectal examination was done because she mentioned bloody diarrhoea and looking for vaginal ulcers;
- Her recall of where he was standing while she dressed and undressed was precise and consistent, and she described him standing beside the shelf in the opposite corner of the room;
- Her description of the June 2011 visit to Dr. Iqbal was clear and detailed insofar as the rectal examination was concerned. It was deep and uncomfortable. She clarified that she really did not know if he used two fingers but thought so because of what she felt. She describes the motion as circular and then in and out many times. She was clear that she felt violated;
- Her description being shocked because of the vaginal probing, which followed the rectal exam, and how she knew he did not change gloves, is believable. How it affected her was in keeping with what is held to be unhygienic practice. She said he did not wash his hands. The Committee noted the examination room lacked a basin to do so;
- That he then returned to inserting his finger in her rectum after the vaginal probing would be difficult for a patient to conceive, unless it actually occurred;
- While she stated she had never had a rectal examination before, she was not naïve in respect of vaginal examinations and she identified that what Dr. Iqbal did was not like vaginal examinations she had before. Still, she testified she thought he was looking for ulcers;
- On her return visit in August, she lied to him saying she was having her menstrual period, so as to avoid any further intimate examinations. The letter sent by Dr. Iqbal to her family doctor relating to that visit confirms that is what she told him;
- While she had concerns about Dr. Iqbal, she returned to his office because she needed help and there was no other doctor to go to;
- Her report to the College was prompted by a discussion about what had happened when she saw her new rheumatologist; and

- Ms D has nothing to gain from this proceeding and exhibited no malice towards Dr. Iqbal.

In cross examination, she was pressed for a number of details mentioned in her medical record. This included a detailed medical history, and social and family history as well. Her admission that she had no recall for these details or other aspects of her physical examination does not in the view of the Committee undermine her credibility or the reliability of her evidence. These interactions occurred a number of years before, and a medically untrained young woman would in the opinion of the Committee not remember such detail.

It was suggested to Ms D that she gave a number of different versions of the examination Dr. Iqbal performed in June 2011, the second visit. In a telephone discussion on July 2, 2014, she agreed she told a College investigator that she was on her back for the internal vaginal examination and could not recall if he then put fingers in her rectum. She realized that what she told him was wrong and called him of her own volition, on which occasion she told him that Dr. Iqbal inserted fingers in the vagina, rectum and then vagina. She acknowledged the confusion even in what she told him when she called him back (vagina to rectum and back to vagina) and that of her testimony before the Committee (rectum to vagina and back to rectum). She was definite however in giving her evidence that the sequence of rectum to vagina stood out because you do not do that. She explained that at the time of the first telephone call, she had just had a baby and was not expecting his call. She lacked sleep and was looking after three children under the age of two. The Committee accepts her explanation as reasonable and did not find it undermined her credibility.

The Committee attached no significance to her delay in contacting the College, to her lack of confronting Dr. Iqbal or her return to see Dr. Iqbal for a total of four visits. She did not have another rheumatologist available to go to. While her memory for secondary detail with respect to medical history and elements of the physical examination

performed is sketchy, the Committee finds the detail of the intimate examinations to be clear and accepts it as truthful.

The Committee accepts her as a credible witness and her evidence in respect to the examinations performed on her by Dr. Iqbal to be reliable.

Dr. Iqbal

The Committee was concerned with aspects of Dr. Iqbal's testimony as set out below.

Dr. Iqbal took his time in the witness box to expound on the question posed to him. He indulged in circumlocution, even when simple questions were asked of him on examination-in-chief. There are many examples, three of which illustrate this point, e.g., when questioned on the examination of Ms B for fibromyalgia (Vol. 8, pgs. 47-48), why patients would inadvertently enter his office (Vol. 6, pgs. 144-150), and when discussing the uncomfortable nature of rectal examinations (Vol. 6, pgs. 151-157).

While his manner of giving evidence does not determine its truthfulness, the Committee noted that he used these opportunities to repeatedly invoke features of his background and the hard work that he had done. His evasiveness and reluctance to respond in a straightforward fashion along with his insistence on being loquacious all the while casting himself as a careful and caring physician, called his credibility into question in the view of the Committee observing him.

When challenged as to the sexual allegations made by the complainants, he was consistent in his denial. However, he repeatedly testified that he would not do such things as he is happily married, is a devout Muslim and has worked so hard to be able to practise. In the Committee's view, this went beyond an effort to give the Committee a complete picture (Vol. 7, pg. 125, Vol. 8, pg. 86, Vol. 6, pg. 92).

He also used his testimony to paint a picture of the complainants that might impact their credibility. For example, the evidence given by Dr. Iqbal about patient Ms D where he

mentions four times the fact that she is anxious, has panic attacks and sees a psychologist (Vol. 6, pg. 48, 51-52). With Ms B, he emphasized her family and social difficulties.

Many of Dr. Iqbal responses appeared to be constructed in response to the testimony of the expert witnesses or the allegations. For example, the discomfort of rectal examination described by Dr. X, he infers as her problem not his, implying he does not hurt patients. He repeatedly describes offering chaperones (though he admitted in 2011 his practice in this respect was variable) and leaving the examining room while patients were undressing and dressing, which are the specific elements noted in the failure to meet the standard of practice allegations.

In his City 1 office, where he saw Ms A, he admitted he stayed in the room but said he offered her privacy by turning his back and walking away to get gloves. It was clear to the Committee from the photos that this would require only a few steps. The office set up was such that if he did step out of the room, it would be right into the waiting area where patients would be seated. In the Committee's view, he had a dismissive approach to patient privacy.

Dr. Iqbal took the position that patients misunderstood the prone position for the left lateral position. The Committee does not accept this. The patients were for the most part seasoned and, in particular, Ms A who had had many rectal exams performed in the past. The Committee does not believe either she or Ms C would assume that position, unless they were asked to do so. There was no clinical reason for examination in the prone position. Further, it would have been a simple matter to have them roll to the standard left lateral position.

Dr. Iqbal testified that he offered Ms A a gown and chaperone and she declined, even though he had told her he was going to do a rectal exam that she had consented to. The Committee considered it unlikely that Ms A would refuse a gown if offered in such circumstances. Dr. Iqbal then proceeded to examine her by lifting her clothing, suggesting he was quite comfortable examining patients when fully dressed in this

manner (Vol. 5, pg. 116-117). The Committee does not accept that he offered either a chaperone or a gown to Ms A, and the facts were just as she testified.

Dr. Iqbal, when addressing issues not documented in the medical record such as gowning or leaving the room, had no hesitation in saying he left the room whenever the undressing/dressing occurred. The Committee was of the view that it would be highly unlikely for him to remember specifically that he left the room in this case. He was a busy rheumatologist seeing upwards of 5,000 patients annually and these events were four years distant.

Aspects of Dr. Iqbal's evidence were inconsistent and unbelievable to the Committee. He testified that Ms A claimed to have a new symptom of rectal bleeding which made it important for him to do a DRE, yet he never mentioned this in the referral letter sent to Dr. R. This patient had recently had a thorough DRE, perianal examination and a colonoscopy procedure performed and if he had considered her symptoms of such concern, it makes no sense not to have informed her gastroenterologist.

With Ms D, she reported new bloody diarrhoea yet he said he did only a perianal exam and not a DRE on the May 2011 visit. He does not record either the amount or frequency of the bloody diarrhoea. When she returns and informs him of black stool, he does a DRE to confirm melena, which is a concern to him, but does not perform a FOBT or haemoglobin (hgbn). He makes no mention of DRE in his consult letter.

As to the sexual nature of the examinations performed, Dr. Iqbal was consistent in his denial.

Dr. Iqbal testified that if patients have a problem with how they are examined, they should come to him or speak up. This, in the view of the Committee, demonstrates a failure to understand the sensitive and intrusive nature of intimate examinations and how they affect patients. The Committee is also of the opinion that there was a lack of balancing the need for intimate examinations with privacy concerns.

The Committee noted Dr. Iqbal's evidence that he had an intention tremor involving his left hand. He testified that this is aggravated by stress. He did not rely on this as a source of patient misinterpretation but indicated that he mentioned it so the College would know. He also testified that as a consequence, he had taught himself to do procedures with the right hand. He steadfastly maintained that he always performed DRE's using his left index finger. His right index finger was shorter, missing the terminal phalanx as a consequence of a childhood accident. The examination room set up in his offices is what would be expected for a right handed physician. The Committee is left with the impression that Dr. Iqbal was capable of performing intimate examinations with either hand. The Committee also concludes that examinations that were described in the evidence were technically possible.

In conclusion, the Committee finds his evidence to be self-serving and embellished. The Committee did not find him credible and was not of the view that it could rely on his evidence.

Overview of the Issues

The issues before the Committee are as follows:

1. Did Dr. Iqbal fail to meet the standard of practice by failing to properly provide for patient privacy or by performing inappropriate examinations?
2. Did Dr. Iqbal engage in sexual abuse of patients and if so what was the nature of the sexual abuse?
3. Did Dr. Iqbal engage in conduct which would be viewed by the membership as disgraceful, dishonourable or unprofessional?

Law and Legal Principles

The Committee understands that the burden of proof is on the College and that the standard of proof is on a balance of probabilities. The allegations in this matter are serious and the Committee understands that the evidence to support a finding must be clear, cogent and convincing as the courts have set out.

Failure to Maintain the Standard of Practice

A failure to maintain the standard of practice of the profession is an act of professional misconduct under section 1 (1)2 of O.Reg. 856/93, made under *the Medicine Act, 1991*, S. O. 1991, c.30.

The standard of practice has been defined as the standard expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find that there has been harm in order to find there has been a failure to maintain the standard of practice.

It is the responsibility of the Committee to review all of the evidence and determine what the standard of practice was at the time in question and whether it was maintained.

Sexual Abuse

The jurisdiction of the Committee to make a finding of professional misconduct derives from section 51 (1) of the Code which provides, in part:

51. (1) A panel shall find that a member has committed an act of professional misconduct if,

[...]

(b.1) the member has sexually abused a patient;

Subsection 1 (3) of the Code provides that "sexual abuse" of a patient by a member means,

(a) sexual intercourse or other forms of physical sexual relations between the member and a patient,

- (b) touching of a sexual nature, of the patient by the member, or
- (c) behaviour or remarks of a sexual nature by the member towards the patient.

The Code also provides in subsection 1 (4):

- (4) For the purposes of subsection (3), “sexual nature” does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

Disgraceful, Dishonourable or Unprofessional Conduct

Paragraph 1 (1) 33 of Ontario Regulation 856/93 made under the Medicine Act, 1991 (“O. Reg. 856/93) provides:

- 1. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

- 33. An act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by the members as disgraceful, dishonourable or unprofessional.

There is no statutory definition of “disgraceful, dishonourable or unprofessional”.

Avoiding Myths About Sexual Abuse

The Supreme Court of Canada has made it clear that sexual abuse cases should be decided without stereotyped assumptions about how victims of abuse are expected to behave. The Court noted in *R. v. D. D.* [2000], at para 65:

...there is no inviolable rule on how people who are the victims of trauma like a sexual assault will behave. Some will make an immediate complaint, some will delay in disclosing the abuse, while some will never disclose the abuse. Reasons for delay are many and at least include embarrassment, fear, guilt, or a lack of understanding and knowledge. In assessing the credibility of a complainant, the timing of the complaint is simply one circumstance to consider in the factual

mosaic of a particular case. A delay in disclosure, standing alone, will never give rise to an adverse inference against the credibility of the complainant.

Decision and Reasons

The Committee concludes after review of all the evidence that Dr. Iqbal has engaged in sexual abuse and disgraceful, dishonourable or unprofessional conduct as alleged in respect of four patients and that he has also failed to maintain the standard of practice of the profession.

The Committee finds the evidence of each of the four complainants in this matter to be unembellished, clear and credible. Dr. Iqbal provided evidence which was unbelievable and coloured to support his position, and for the reasons cited earlier in our decision, we find his evidence not credible or reliable.

Findings

The Committee sets out its findings in respect of each of the four complainants individually and will then comment on the evidence in its entirety.

Findings in respect of Ms A

The Committee accepts that Ms A had a longstanding serious medical condition, was hospitalized in 2011 for a bowel perforation, and was seen by Dr. Iqbal for a rheumatology consultation. Her diagnosis at that time was either Crohn's disease or Wegner's granulomatosis. Her gastroenterologist, Dr. R, and Dr. Iqbal had decided on a treatment plan including Prednisone and Imuran after her infection was controlled. Ms A saw Dr. Iqbal at his City 3 office for follow up in May 2011. It is what happened at that office appointment, specifically what was said and how she was examined, that is disputed.

1. Did Dr. Iqbal fail to maintain the standard of practice of the profession in his care of Ms A?

Privacy

Ms A testified that Dr. Iqbal did not offer her a gown or a chaperone and did not leave the room during the time she was undressing or dressing. Dr. Iqbal testified he offered her both a gown and chaperone and that she declined. Dr. Iqbal agreed that he did not leave the room while Ms A took down her pants. He testified that he turned his back and moved away to afford her privacy. He agreed he should have left the room and did not.

The Committee relies on the evidence of the expert witnesses in determining the standard of practice in these circumstances. Dr. X testified that it was a failure to maintain the standard of practice by not giving a patient a gown to change into and not leaving the room during the time she changed. Dr. Y agreed that the standard of care requires the physician to either leave the room or create a barrier while a patient is changing and to use appropriate draping. He cited as a possible exception an instance where a patient might say it is not necessary to leave and quickly dress after the examination before the physician had the opportunity to leave the room.

The Committee accepts the evidence of the expert witnesses as to the standard to be met. The Committee also accepts the evidence of Ms A over that of Dr. Iqbal based on its determination of their respective credibility. It was Dr. Iqbal's duty to respect his patient's privacy by leaving the room while she undressed and dressed and by ensuring she was properly draped, which includes covering exposed intimate areas until that area is examined.

The Committee finds Dr. Iqbal failed to maintain the standard of practice of the profession in regard to patient privacy when he did not ensure appropriate draping and failed to leave the room when Ms A was undressing/dressing.

Appropriateness of Examination

Position of Patient

There is no dispute between the parties that Dr. Iqbal carried out a perianal and rectal examination and that Ms A was in the prone position when she had this performed.

The Committee relies on the evidence of Dr. X that the left lateral position is standard when performing a rectal examination. It is the position which is the easiest and this is how medical students are taught. She further opined that performing rectal examination in the prone position would be more awkward and difficult (Vol. 4, pg. 46).

Dr. Y opined that the prone position is an unusual position; however he testified that you would certainly get a good view of the perianal region and that it would meet the standard. Dr. Y made the assumption that the prone position was the most comfortable for the patient. He recounted that one of his “bosses” used that position so it is not “a no” (Vol. 9, pg. 54).

The Committee prefers the evidence of Dr. X and accepts that the standard in Ontario is that DRE and/or perianal is performed in the left lateral position. What Dr. Y may have been exposed to in his training in the UK has no weight. He was not questioned on what he taught medical students.

Ms A testified that he asked her to lie on her stomach. Dr. Iqbal said he asked her to turn over on her side and she rolled on to her stomach. He could have simply asked her to turn back on to her side but did not. It was not a matter of this being uncomfortable for her. The Committee accepts Ms A’s version of these events over that of Dr. Iqbal based on its assessment of their respective credibility. In particular:

- Ms A was a seasoned patient who had many previous rectal examinations and would not be likely to roll on to her stomach for this to be done. The Committee finds she trusted him and followed his instructions.
- The Committee did not accept Dr. Iqbal’s excuse that he felt that rectal examinations can be carried out in the left lateral, prone or bent over position and that these were not wrong. Regardless of where he observed rectal examinations done in such

positions, he had years of post-graduate training in Canada and would have been fully aware that the left lateral position was the standard practised and taught in Ontario.

- There was no evidence, which indicated that this position was less painful, or any other reason for Ms A to have assumed the prone position.

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession when he performed a perianal and DRE examination on Ms A when she was in a prone position.

Necessity of Examination

The Committee considered the evidence of Ms A, Dr. X, Dr. Y and Dr. Iqbal in regard to the necessity for a DRE and genital examination given the circumstances of Ms A.

Ms A testified that Dr. Iqbal asked her about rectal and vaginal fissures. She responded that she had vaginal sores in the past, 12 to 13 years prior, but had none currently. She told him she never had rectal fissures but had had hemorrhoids in the past. Ms A testified that he asked her about rectal bleeding and she said there was none that she had noticed but that stool samples always showed blood. Her evidence was consistent on this point. She testified that he asked for consent to do a rectal and vaginal examination because a lot of times there are fissures present that were not known to the patient. She consented.

Dr. Iqbal testified that she had rectal bleeding, which to him was new. He noted occasional rectal bleeding in his medical record.

The Committee accepts the evidence of Ms A that she had no rectal bleeding meaning she saw no red blood from the rectum but that her stools showed positive when tested.

Dr. X opined that based on the patient's history; there was no clinical indication to perform a DRE. Dr. X noted that during Ms A's recent hospital admission, her bowel had been thoroughly investigated, including a perianal and DRE, and both were found to be normal. Ms A also had a colonoscopy and she was under the care of a gastroenterologist.

Dr. X said that doing a DRE at that time (May 2011) is not likely to produce any new information to confirm or refute a diagnosis or change the treatment plan (Vol. 4, pgs. 100-101). Dr. X also opined there was no reason to touch Ms A's vagina, as she had no history of current genital ulcers and no symptoms of vaginal pain.

Dr. X testified (Vol. 4, pg. 162) a physical examination is directed, and to go searching parts of the body just because one might find something is not a reasonable approach. Further, (Vol. 4, pg. 172) when intimate examinations are involved, special consideration comes into play and there has to be an appropriate reason to do so (Vol. 4, pg. 179).

Dr. Y had a different view and opined that a perianal examination and DRE were important and reasonable (Vol. 9, pg. 38). Dr. Y assumed that Ms A was bleeding from the rectum and his belief was that things were changing. He emphasized thoroughness and where it is so vital to reach a diagnosis that "every single diagnostic clue is important". He was of the view that diagnosing a fistula would dramatically weigh the diagnosis to Crohn's disease. He characterized her as clearly extremely ill, notwithstanding Dr. Iqbal's comment in the medical record that in May 2011, he found her to be very stable with no other systemic evidence of inflammatory activity or vasculitis and he planned to see her in three months.

Dr. Iqbal testified that his reason for doing a perianal and DRE was twofold. First, he was concerned about rectal bleeding, and he wanted to confirm that and look for a local cause (Vol. 7, pg. 88). To him, it was a new finding. He acknowledged that she had chronic occult blood loss from the gastrointestinal tract and anemia. Second, he thought he may forward the diagnosis. He acknowledged that he could not make a diagnosis of Crohn's Disease on perianal or DRE but it could help towards a diagnosis. He was confident from his experience that he could distinguish a normal from an abnormal finding.

In his letter to Dr. R, he says Ms A reports occasional rectal bleeding. He notes a history of hemorrhoids. He reports her condition as very stable. He specifically does not mention doing a DRE in his consult letter.

The Committee carefully considered all of the evidence and accepts the opinion of Dr. X. Ms A had a full and complete gastrointestinal evaluation performed by Dr. R in April 2011. This included a perianal examination and DRE and no abnormality was found. The Committee accepts the evidence of Ms A over that of Dr. Iqbal in regards to her evidence that she saw no rectal bleeding. She was clear and consistent on this point. Dr. Iqbal's reasoning and actions are impossible to reconcile. Ms A was under active management by a gastroenterologist whom she had already seen since discharge from hospital. She had no new complaints that would lead to the need for a DRE or a vaginal examination. No thoughtful consideration was afforded her privacy interests. The Committee is sensitive to the need for doctors to be thorough and diligent but they are also expected to take into account and balance patients' privacy interests in exercising their judgment. The DRE, perianal and vaginal examinations were unnecessary given the circumstances; they were invasive and added nothing to her care.

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession when he performed a perianal, a DRE and vaginal examinations, which given the circumstances were unjustified and unsupportable.

Manner of Examination

In addition, the Committee was faced with two widely differing descriptions of just how the intimate examinations were performed on Ms A by Dr. Iqbal.

Firstly, the Committee finds that neither a rectal nor a vaginal examination were appropriate in the circumstances. The evidence of Dr. X and Dr. Y is clear that a vaginal examination in a rheumatology setting is not appropriate. Dr. Y agreed with Dr. X as to the appropriate manner of performing a DRE except that he felt the finger would be introduced further than two inches. He further testified there is going to be a degree of in and out movement. Lubricant and gloves are used and the examination lasts seconds.

Ms A described an examination of her rectum that is not reconcilable with a normal DRE. This will be discussed further in the following section dealing with sexual abuse. Ms A reported vaginal probing, which does not equate to a proper clinical examination. Furthermore, the movement from rectal probing to vaginal probing without changing gloves is offensive and disregards any sense of proper hygiene.

The Committee accepts the description of Ms A as to the manner of the examination that Dr. Iqbal performed. For the reasons stated previously, the Committee does not find Dr. Iqbal to be credible and does not accept his description of the examination performed.

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession in his manner of performing rectal and vaginal examinations of Ms A, which in the circumstances were not called for in any event.

To summarize, the Committee finds that Dr. Iqbal failed to maintain the standard of practice in respect of Ms A by failing to ensure her privacy (failing to leave the room while dressing and not ensuring appropriate draping), by performing examinations in the prone position, by performing intimate examinations that were not necessary, and in the manner he performed the intimate examinations.

2. Did Dr. Iqbal sexually abuse Ms A?

The Committee relies significantly on its respective assessments of the credibility of Ms A and that of Dr. Iqbal. There are widely divergent descriptions of the acts performed and no reconciliation is possible. Misinterpretation of the examinations done is unrealistic in the context of a mature patient who is no stranger to intimate examinations.

The evidence of Ms A was clear and detailed. After starting a rectal examination which felt normal, Dr. Iqbal moved to repeatedly and forcefully moving his finger(s) in and out of her rectum in a sexual manner. He did this over a period of time, which to her felt like three to four minutes. During this time, he made sexual type grunting noises. He was so forceful that he jerked or moved her on the table. It was painful and she cried out.

Without changing gloves, he moved directly to insert his fingers in her vagina and again moved them in and out in a sexual manner. On these issues, her evidence was consistent. Dr. Iqbal denies doing the DRE in such a manner and testified that he did not touch her vagina.

The Committee accepts the evidence of Ms A for the reasons cited in our respective assessments of their credibility. The Committee notes in particular that:

- Ms A was detailed and consistent in her description of the alleged abuse;
- The Committee observed no malice in the evidence given by Ms A. There was nothing to suggest she would make up such a story for any purpose let alone to destroy the career and reputation of a physician;
- The Committee finds it improbable Ms A would testify to such an embarrassing experience had it not actually happened;
- In the absence of any reasonable basis for a misinterpretation of his actions or other explanation for her emotional reaction, the compelling nature of her evidence as a whole, including her immediate reaction of crying in her car, telling her husband and the eventual reporting of the acts to the College. (The Committee understands that reporting the conduct to others does not prove that the conduct occurred);
- The Committee did not accept that Ms A would misunderstand the prone position for the left lateral position as offered by Dr. Iqbal. His evidence was self-serving and not credible in the Committee's view;
- The sexual nature of the touching; and
- The expert evidence accepted that rectal and vaginal examinations were unjustified in the circumstances.

The Committee finds Dr. Iqbal sexually abused Ms A during an office visit in May 2011, by repeatedly and forcefully moving his finger(s) in and out of her rectum in a sexual manner and without changing gloves, moved directly to insert his fingers in her vagina and again moved them in and out in a sexual manner, under the guise of examinations.

3. Did Dr. Iqbal engage in disgraceful, dishonourable or unprofessional conduct with respect to Ms A?

The Committee also finds that Dr. Iqbal engaged in disgraceful, dishonourable or unprofessional conduct based on the findings as stated. It was clear to the Committee that Dr. Iqbal did not act in the interest of his patient when he failed to respect her privacy and subjected her to unjustified and improper intimate examinations, sexual touching under the guise of intimate examinations, which were unjustified.

Findings in respect of Ms B

1. Did Dr. Iqbal fail to maintain the standard of practice of the profession in his care of Ms B?

Privacy and Assisting to Remove Clothing

The Committee had to deal with the conflicting evidence of Ms B and Dr. Iqbal. For reasons cited earlier in our assessment of their respective credibility, the Committee accepts the evidence of Ms B and rejects that of Dr. Iqbal where they are in conflict.

There is no dispute that Dr. Iqbal saw Ms B in May 2011 at his City 3 office. She had been referred for a rheumatology opinion by her family doctor (Dr. S) for symptoms suggestive of fibromyalgia. She went alone.

The consultation began with Dr. Iqbal asking her how she was feeling. It was clear from the letter that Dr. Iqbal sent to her family physician that he took a thorough medical history and in particular, details a number of social factors (death of mother, serious accident involving her husband, disturbed sleep and poor memory).

Ms B did not recall Dr. Iqbal providing her with a gown or drape. He did not offer her a chaperone. Dr. Iqbal testified that she was given a gown though there was no intimate examination to be done. He did not offer her a chaperone as he did not believe it was necessary with the kind of examination he proposed for Ms B.

Dr. Iqbal testified that she was seated in a chair at his desk for the initial history. Ms B testified that she recalls sitting on the examination table for the examination. She had her clothes on. Whether she was seated on the examination table or in a chair during the medical history taking is of no importance in the view of the Committee.

At this point, the evidence of Ms B and Dr. Iqbal differs dramatically. She recalled Dr. Iqbal pushing on various points asking her if it hurt. He then had her lay down on her back and examined her stomach and legs. Ms B testified that he asked her to take her pants off and that he told her he had to check pressure points in her vagina. It was established by expert evidence that no such pressure points or tender points exist. She testified that she took down her pants and underwear “lifted my butt up, and I just scooted them down” (Vol. 1A, pg. 151). As she was doing this, he took off her shoes (she had slip-ons at the time) and grabbed the bottom of her pants and helped her take them off. The Committee does not accept Dr. Iqbal’s evidence that he has never helped patients undress, and finds that in fact, he did help to undress Ms B.

Ms B testified that at the end of the consultation and after giving her a cortisone shot, he told her to get dressed. He never left the room and he watched her get dressed. Dr. Iqbal says he left the room while she was undressing and he has never watched a patient undress.

As noted earlier, the Committee heard testimony from Dr. X and Dr. Y that the standard of practice requires the physician to leave the room while the patient is undressing and dressing. Further, Dr. X testified that a physician should never assist the patient in removing any clothing (Vol. 4, pg. 147).

The Committee accepts the evidence of Dr. X, Dr. Y and the evidence of Ms B and finds that Dr. Iqbal failed to maintain the standard of practice of the profession by failing to provide for patient privacy when he remained in the room while she undressed and dressed. The Committee also finds that he failed to maintain the standard of practice by assisting her to remove her shoes and pants and accepts Dr. X’s opinion on this point.

Necessity of Vaginal Examination

The Committee accepts the evidence of Ms B that Dr. Iqbal examined her vagina during the May 9, 2011 consultation. The Committee rejects Dr. Iqbal's claim that he did not touch her vagina. The evidence of the experts is clear. This type of examination is not part of a rheumatology consultation and there are no pressure or tender points to test for fibromyalgia in the vagina.

The Committee finds Dr. Iqbal failed to maintain the standard of practice of the profession in performing an unjustified examination in an improper manner.

2. Did Dr. Iqbal sexually abuse Ms B?

Ms B testified that while lying on her back, and after having her remove her pants and underwear, Dr. Iqbal put his finger in her vagina. She testified that this went on too long and he started wiggling his finger up near the top of her vagina. She believed he was looking for pressure points in her vagina related to fibromyalgia. She said it felt normal at first but then it felt like a long time and that it was "like Dr. Iqbal was trying to stimulate me" (Vol. 1A, pg. 154). She testified that he did not wear gloves or use lubricant. She testified she was scared and did not know what was happening. Her legs were spread apart and she tried to close them but he just pushed them back open. She claimed this examination made her feel "dirty and gross" (Vol. 1A, pg. 155).

Dr. Iqbal testified that he did not touch her vagina.

The Committee finds that Ms B's testimony is to be believed over that of Dr. Iqbal:

- Ms B was plain spoken, clear, consistent in giving her evidence about the vaginal probing she experienced;
- Her description and reaction to a lack of hand washing was convincing;
- Ms B had no wish to complain to the College and did so reluctantly;
- Ms B's evidence overall was plausible, she demonstrated no malice and stands to gain nothing from this proceeding; and

- Dr. Iqbal's pattern of testifying and painting Ms B as having social, family, employment problems and poor memory in a manner by which he sought to impugn her credibility, was not accepted by the Committee.

The Committee finds that Dr. Iqbal did touch Ms B just as she testified he did. The Committee further accepts that he attempted to stimulate her by wiggling his finger while at the top of her vagina. The Committee finds this to be sexual abuse, touching of her vaginal area in a sexual manner under the guise of an intimate examination.

The Committee finds that Dr. Iqbal sexually abused Ms B by penetrating her vagina with his finger and moving it in an attempt to stimulate her.

The Committee heard evidence from both Dr. Iqbal and Ms B that after the vaginal probing as described above, he administered cortisone shot(s). Ms B recalls only one shot, Dr. Iqbal testified there were two, one in the right trochanteric bursa or hip region and one in the ischium or sit bone. The medical record indicates that two cortisone injections were administered.

The allegation of sexual abuse here arises from the manner in which Ms B describes Dr. Iqbal giving the cortisone injection. Her explanation is detailed. She testified he told her that a cortisone shot would be good for her groin pain. Dr. Iqbal left the room to get the shot(s). When he came back, he asked her to lie down on her stomach with her legs apart (she still had no bottoms on). Her head was down and she found it embarrassing. He gave her an injection, which she described as between her vagina and her "bum hole". She said he had a finger just inside her vagina while he was giving her the injection and that right after, he started massaging around the spot where he gave her the needle. She testified that as he was massaging the area he was making weird noises like moaning. When he was done, she testified she sat up and started getting dressed; she remembered that at that time thinking "he just had his hands in my vagina and near my vagina and he never washed his hands. It grossed me out horribly" (Vol. 1A, pg. 160).

Dr. Iqbal testified that he palpated Ms B's groin (area of the inguinal ligament) when he was doing the abdominal examination and he did so through the gown. He agreed that he gave her an injection and rubbed the area he injected. He testified that she was in the left lateral position when he injected the ischial bursa. He denied ever having a finger in her vagina.

The Committee accepts the evidence of Ms B as a truthful description of what she experienced on the May 2011 visit to Dr. Iqbal's office. In addition to the particulars noted above, the Committee notes:

- Dr. Iqbal's testimony, in which he painted himself in a positive light and Ms B otherwise. He repeatedly referred to himself as not the kind of person who would do such things, invoking his stable and happy home, 25 year marriage, the hard work he has done and his motivation to contribute to Canada. He testified as to the importance of his Muslim faith. He does this all the while saying that Ms B has significant social problems, memory difficulty and the like.
- While Ms B's memory for some aspects of the visit are not clear, the Committee did not believe it reasonable that she would recall much of what she told him at the examination. She did not deny that she must have told him about her family and her work. This did not influence the Committee's assessment of her credibility.
- While counsel for Dr. Iqbal takes the position that she was exaggerating when she described that the examination of her vagina took ten minutes, the Committee does not give this weight, as set out in our assessment of her credibility.

The Committee rejects that sexual assault is improbable because Dr. Iqbal has a busy office; neither the window in the door, which was uncovered, nor the risk of being interrupted protect against sexual abuse. The assaults occurred when the patient was on the examination table, which is not visible from outside the door. Staff knocked before entry and Dr. Iqbal was well aware of office routine.

The Committee finds Dr. Iqbal sexually abused Ms B by having a finger in her vagina and massaging the area without medical justification, while he performed a cortisone injection.

3. Did Dr. Iqbal engage in disgraceful, dishonourable or unprofessional conduct with respect to Ms B?

The Committee finds that Dr. Iqbal engaged in disgraceful, dishonourable and unprofessional conduct in regard to the above. He acted in a manner contrary to the interest of his patient, Ms B, when he ignored her privacy interests and by engaging in disrespectful, sexually abusive and exploitive behaviour.

Findings in respect of Ms C

1. Did Dr. Iqbal fail to maintain the standard of practice of the profession in his care of Ms C?

There was no dispute that Ms C saw Dr. Iqbal in June 2011 and July 2011. She had been referred for pain throughout her body; she had difficulty walking and shooting pains in her hands. She had a history of epilepsy and psoriasis.

Privacy

On the first visit and after taking a history, Dr. Iqbal indicated he wished to do a physical examination and handed her a gown. She said he stood about two feet in front of her holding up the gown while she removed her pants and socks. She testified after examining her in the sitting position on the examination table, he asked her to roll onto her stomach. He pushed on her back, hips and spine. She testified that he grabbed onto her underwear and pulled them down to her ankles. She testified Dr. Iqbal did not offer her a chaperone and he did not leave the room while she changed. Dr. Iqbal's evidence differs. Dr. Iqbal testified that he left the room while she changed and did not pull down her underwear.

Dr. X's testimony is that the standard of practice of the profession is for the doctor to leave the room while a patient undresses. She further testified that it is not appropriate for a doctor to assist the patient in undressing. The standard of practice is clear and not disputed.

The Committee prefers the evidence of Ms C over that of Dr. Iqbal based on its respective assessments of their credibility and the reliability of their testimony. Ms C gives a detailed description and the Committee accepts this to be true. The Committee did not accept as plausible that Dr. Iqbal would have a clear recollection given that he was a busy practitioner, her story was not unusual in a rheumatology practice and that this type of detail is not recorded in the medical record.

The Committee finds that Dr. Iqbal failed to maintain the standard of the profession in not affording due regard to patient privacy and assisting her undressing.

Appropriateness of Position for Examination

Position of Patient

There was no dispute that Ms C was examined in the prone or face down position. Ms C testified he asked her to lie on her stomach. Dr. Iqbal states that Ms C rolled on to her stomach of her own accord. He then proceeded to do a perianal examination, which took only a matter of seconds. Ms C testified after pushing around in the rectal area, Dr. Iqbal slid his fingers into her vagina. Dr. Iqbal denies touching her vagina.

Dr. X testified that a visual inspection of the perianal area takes place with the patient in the left lateral position with the legs pulled up. It may involve some palpation if anything out of the ordinary is seen. Perianal exams are rarely done in rheumatology practice unless there is a concern about IBD. She testified there is no indication to do a perianal examination in any other position. Dr. Iqbal, Dr. Y and Dr. X all agree that a perianal examination lasts only a matter of seconds and does not involve touching of the vagina. Dr. Iqbal testified that Ms C was in pain due to her arthritis and he thought it was enough that she was on her stomach and he proceeded to do the examination. Dr. Y notes that the

perianal area can be visualized with the patient in the prone position and that it may be done in that position if it is more comfortable for the patient.

While the Committee was aware that Ms C had significant tenderness in her joints, there was no evidence to suggest that she was more comfortable in the prone position. Even if she had assumed this position on her own (which the Committee does not accept), it would have been a simple matter for Dr. Iqbal to have her roll back to the appropriate standard position. The Committee is of the view that this seasoned patient would not have rolled onto her stomach, unless she was asked to do so by Dr. Iqbal.

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession when he performed a perianal examination on Ms C when she was in a prone position.

Necessity of Perianal Examination

The Committee also considered the justification for the examination performed by Dr. Iqbal. Ms C testified that she reported occasional rectal bleeding. The details of this indicate that she saw blood on the toilet tissue when she wipes from time to time.

Dr. X opined that there were no features of IBD in the patient's history. The patient denied diarrhoea, abdominal pain and anal fissures. In her opinion, there was no need to do a perianal examination.

Dr. Y had a different view. In his opinion, the fact of intermittent rectal bleeding required a perianal examination, as the rheumatologist should be considering the possibility of Crohn's disease. He testified that the incidence of Crohn's disease in patients with psoriasis was higher than the normal population. Dr. X agreed with Dr. Y position was that there was an element of judgment to be considered that is required in this case. Dr. Iqbal was concerned with the history of rectal bleeding, which he testified could be related to IBD and this was in his mind given her symptoms of inflammatory arthritis.

The Committee reviewed carefully the evidence of Ms C and Dr. Iqbal. The Committee agreed that in balancing symptoms and the need for a particular examination, there is an element of judgment. Dr. Iqbal testified regarding his concern. It was insufficiently clear to the Committee that the performance of a perianal examination given all the circumstances, while it may have been excessively thorough, was not unreasonable. The Committee makes no finding in this respect.

Vaginal Touching

The Committee accepts the evidence of the experts that vaginal touching is not part of a perianal examination. Ms C clearly describes at the June 2011 visit Dr. Iqbal sliding his fingers down and touching her vagina.

The Committee accepts Ms C's evidence as a true description of that visit. Based on its assessment of credibility set out earlier, the Committee finds that Dr. Iqbal did a perianal examination in an inappropriate position and inappropriately touched her vagina and clitoris.

The Committee finds that Dr. Iqbal has failed to maintain the standard of practice of the profession in the manner and position of the examination he carried out and inappropriately touching her vagina and clitoris.

To summarize, the Committee finds that Dr. Iqbal failed to maintain the standard of practice in respect of Ms C by failing to ensure her privacy and assisting her in undressing, in the manner and position (prone position) he performed a perianal examination, and by inappropriately touching her vagina and clitoris during the examination.

2. Did Dr. Iqbal sexually abuse Ms C?

The Committee was faced with evidence from Ms C and Dr. Iqbal which is irreconcilable.

Ms C describes the touching of her vagina and clitoris in a manner which can only be interpreted as sexual touching.

Ms C testified that on the visit of June 2011 at Dr. Iqbal's office, while she was lying face down, Dr. Iqbal spread her bum cheeks and pushed around with his finger as though he was searching for something. He did not enter her anus. Without a break, he slid his fingers down to her vagina and started wiggling them and he touched her clitoris. She testified she thought the rectal part of the examination lasted about five minutes and the vaginal part a little less. She testified that it felt like he was trying to turn her on and related what he was doing to her early sexual experience with her husband. This was unlike any vaginal examination she had before. She thought he might be looking for vaginal sores though she had told him she had none.

Dr. Iqbal testified that he did not touch her vagina.

The Committee relies on its respective credibility assessment of Ms C and Dr. Iqbal and finds Ms C's version of events to truly depict what happened.

The Committee refers in particular to:

- The detailed description by Ms C of the examination Dr. Iqbal performed;
- The nature of the vaginal touching and the consistency of her evidence;
- The concern around moving from the rectum to the vaginal area without changing gloves, which the Committee viewed would likely stand out to a patient; and
- Ms C has no interest in the outcome of this proceeding.

The Committee observed no enmity toward Dr. Iqbal. On the contrary, Ms C appeared only to question the propriety of what he had done in explaining this to her family doctor.

Dr. Iqbal implies that Ms C misapprehends his examination, testifying as to what she thinks happened. The Committee does not agree. Her evidence was specific and clear as

to the manner and area of touching. The Committee does not find her memory distorted or impaired.

The Committee further accepted the evidence of Ms C that the invoice she received did not factor into her decision to report Dr. Iqbal to the College. The invoice issue as motive to report an incident of sexual abuse is speculative at best. The Committee is of the view that regardless of whether Ms C was upset or not by the CAT scan results being unavailable, this did not translate into a complaint of sexual abuse against Dr. Iqbal.

The Committee finds Dr. Iqbal sexually abused Ms C on the office visit of June 2011 by touching her vagina and clitoris in a sexually stimulating manner under the guise of a medical examination.

3. Did Dr. Iqbal engage in disgraceful, dishonourable or unprofessional conduct in respect to Ms C?

The Committee finds Dr. Iqbal to have engaged in disgraceful, dishonourable or unprofessional conduct with Ms C by engaging in disrespectful, sexually abusive acts and failing to act in his patient's interest.

Findings in respect of Ms D

1. Did Dr. Iqbal fail to maintain the standard of practice of the profession in relation to Ms D?

Privacy

The Committee accepts that Ms D attended Dr. Iqbal on four occasions. The issues to be decided relate to the visits of May 2011 and June 2011. There was no dispute that Dr. Iqbal gave Ms D a gown and that she used it. The issue to be decided is whether he left

the room while she changed. On this point, the evidence given by Ms D and Dr. Iqbal differs.

At the first visit in May 2011, Ms D testified that after discussing her medical history, Dr. Iqbal asked her to remove her clothing from the bottom half. She was standing by the examination table and Dr. Iqbal was in the opposite corner of the room by his shelf. Her mother, who had accompanied her on that visit, remained seated in a chair at Dr. Iqbal's desk and faced away so she could not see Ms D. She believed he gave her a paper sheet.

After he finished the examination, he asked her to get dressed. Ms D testified that while she was getting dressed, Dr. Iqbal was in the room over by his shelf.

On her second visit in June 2011, Ms D testified she went alone. He did not offer her a chaperone and remained in the room over by his shelf while she was changing.

She was challenged in cross examination that she had given an inconsistent statement to the College investigator in February of 2014 when she told him she did not remember when asked if he told her to get undressed. She indicated that she has no problem remembering significant things like being asked to remove her pants or having fingers inside her body. She testified in cross examination (Vol. 2, pg. 107) when it was suggested to her that Dr. Iqbal left the room when she changed that she remembered because she found it odd. She compared this to male doctors she had in the past who left the room. The Committee accepts Ms D's evidence.

Dr. Iqbal testified he left the room while the patient undressed and dressed both on the visit of May 2011 and June 2011.

The Committee accepts the evidence of Ms D finding it to be persuasive. The Committee accepts her reason for being able to remember and her description of what happened truthful. The Committee did not accept Dr. Iqbal's version. The Committee believed it

unlikely that he would have such a specific recollection of whether he left the room or not. He had a busy office that day and had seen many patients in the intervening years.

The standard of care with respect to privacy and the expectation of how a physician should behave is set out earlier in the testimony by Dr. X and is not disputed by Dr. Y. It is accepted by the Committee that the doctor should leave the room or provide a barrier when patients are changing to allow for privacy.

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession in respect of Ms D by not respecting her privacy when he remained in the room while she changed.

Appropriateness of Examination

Ms D was referred to Dr. Iqbal with a diagnosis of lupus and fibromyalgia. Among her complaints was bloody diarrhoea. The Committee accepts that on the May visit, he did a DRE and looked at and touched the lower part of her vulva and labia as Ms D testified he did. At the June 2011 visit, when there was concern regarding melena, the Committee accepts that he repeated the DRE and after examining the rectum, he inserted fingers into her vagina and then reinserted a finger(s) back into the rectum.

Dr. X did not take issue with doing a DRE where there was concern regarding the patient having a significant gastrointestinal bleed but felt that if it was truly of concern that there would be further steps taken, i.e., postural vital signs recorded, hgbn measured, stool tested for blood. Dr. Y was strongly of the view that DRE was essential. The Committee accepts that the performance of a DRE was reasonable, but the touching of the labia and lower part of the vulva was not.

It was not disputed that the vaginal “examination” as described by Ms D at the June 2011 visit, and which the Committee accepts took place, was inappropriate in a rheumatology setting.

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession by separating the labia and touching the lower part of the vulva in May 2011, and performing an unnecessary “examination” of Ms D’s vagina in June 2011.

2. Did Dr. Iqbal sexually abuse Ms D?

The events of concern with respect to sexual abuse occurred on the May 2011 visit to Dr. Iqbal’s office and on the June 2011 visit.

May 2011 visit

Ms D testified she remembers the examination beginning with her sitting on the examination table while he examined her fingers and other joints. He then asked her to lie on her left side which she did with her knees bent up. She testified she felt him separate her bum cheeks and then he inserted two fingers in her rectum and felt around. He felt around in a circle and then in and out; lasting a few seconds. He then separated the labia and just looked at the outside; he did not insert any fingers in her vagina. She had told him about bloody diarrhoea so she assumed he was looking for a cause. Her mother remained in the room seated at Dr. Iqbal’s desk.

Dr. Iqbal testified that he told her he would do a rectal area exam (he explained that patient’s do not understand perianal) as she had noted bloody diarrhoea. He testified that he held the buttock up and only did a visual inspection, there was no rectal penetration. He testified that “as I remember, there was part of the lower genitalia exposed (vulva).

He testified there was no touching of the external genitalia. He did not see any rectal ulcers or rashes or blood around the anal area.

Dr. Iqbal was evasive in responding to her bloody diarrhoea saying it was an important symptom yet he did not document how many times she was having it (Vol. 6, pg. 64). It is evident from the chart that neither an occult blood test nor repeat hemoglobin (hgbn) was requested. The last hgbn on record done May 2011 is normal and the referring letter,

May 2011, does not mention bloody diarrhoea. This material inconsistency raised questions, in the Committee's view, about why the examination was done.

Ms D was questioned extensively regarding inconsistent statements made to a College investigator. She agreed she told him at an interview on February 28, 2014 that Dr. Iqbal "was feeling around looking, like in my rectum". She said that what she meant by that was fingers in her rectum. There was no question in her evidence that she felt he performed a DRE on that occasion. The Committee accepts her evidence on this point.

She was also challenged in cross examination that her memory was poor for details of her medical history and routine parts of the physical examination which she was unable to recall. She admitted that many of the facts which Dr. Iqbal recorded in his history were true, just that she did not recall telling him. The Committee accepts this as reasonable.

Ms D was consistent in her description of the rectal examination and vulvar touching that occurred in May 2011 and the Committee accepts this based on the above and our respective assessments of their credibility.

The Committee finds Dr. Iqbal engaged in sexual abuse of Ms D in May 2011, by touching her lower vulva and separating her labia when there was no clinical justification to do so.

June 2011 visit

There is no dispute that Ms D was alone at this visit or that she told Dr. Iqbal that she had noted black stool. Her rheumatologic problem was lupus and inflammatory arthritis. The manner and extent of the examination Dr. Iqbal performed June 2011 are disputed.

Ms D testified that the rectal examination that Dr. Iqbal performed was deeply penetrating, very uncomfortable and lengthy. She testified she sensed two fingers (she could not be sure it was two but it felt like it was). She described the motion as circular and in and out many times. It made her feel violated. He shocked her then by inserting his

fingers into her vagina. She knew he did not change gloves because he did not move from where he was standing. He did not wash his hands. He used the same movements (circular and in and out) when his fingers were in her vagina. His fingers then went back into her rectum again with similar motions. She testified that the first time he examined her in May 2011, he was not as aggressive or deep on the rectal examination and in June 2011, he actually inserted his fingers into her vagina.

At her last appointment with Dr. Iqbal, she recalls she told him that she was having a menstrual period so as not to be examined again.

In June 2011, Dr. Iqbal denies putting fingers in her vagina and says that he performed a rectal examination in the correct way. He performed a rectal examination because of his concern she had melena stool. That he did not record a DRE in the medical record is attributed to oversight. His concern was a GI bleed. He found no melena stool.

The Committee carefully assessed the respective credibility of both witnesses and accepts the evidence of Ms D. The respective credibility assessments are set out in full earlier in our decision.

In particular the Committee was influenced by:

- The detail and description of the sexual nature of the exam;
- The unusual sequence of going from rectum to vagina, which the Committee recognizes would be of considerable import to the patient. It is implausible that Ms D would make up such a demeaning experience;
- Her evidence was consistent as to the manner of the intimate examinations performed;
- The Committee was satisfied that the inconsistent statements made to the College investigator were satisfactorily explained; and.
- Ms D has no interest in the outcome of the proceeding and no motive or malice to have testified as she has done.

The Committee finds Dr. Iqbal engaged in the sexual abuse of Ms D by inserting his fingers into her rectum and vagina and moving them in a sexual manner under the guise of a medical examination.

3. Did Dr. Iqbal engage in disgraceful, dishonourable or unprofessional conduct?

The Committee also find Dr. Iqbal to have engaged in disgraceful, dishonourable or unprofessional conduct in regards to the above and his disrespectful, sexually abusive conduct towards Ms D and his failure to act in her best interests.

Summary of the Findings

Ms A

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession in respect of Ms A by failing to ensure her privacy (failing to leave the room while dressing and not ensuring appropriate draping), by performing examinations in the prone position, by performing intimate examinations that were unnecessary and in the manner he performed these examinations.

The Committee finds Dr. Iqbal sexually abused Ms A during an office visit in May 2011 by repeatedly and forcefully moving his finger(s) in and out of her rectum in a sexual manner and without changing gloves, moved directly to insert his fingers in her vagina and again moved them in and out in a sexual manner, under the guise of medical examinations.

The Committee also finds that Dr. Iqbal engaged in disgraceful, dishonourable or unprofessional conduct based on the findings as stated. It was clear to the Committee that Dr. Iqbal did not act in the interest of Ms A when he subjected her to improper and unjustified touching of a sexual nature under the guise of intimate medical examinations.

Ms B

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession by failing to respect the privacy of Ms B (failing to leave the room while dressing and assisting undressing) and by performing an unjustified examination in an inappropriate manner.

The Committee finds that Dr. Iqbal sexually abused Ms B by penetrating her vagina with his finger and moving it in a sexual manner. The Committee also finds Dr. Iqbal sexually abused Ms B by inserting a finger unnecessarily in her vagina, while he performed a cortisone injection.

The Committee finds that Dr. Iqbal engaged in disgraceful, dishonourable or unprofessional conduct in regard to the above and that he acted in a manner contrary to the interest of his patient, when he ignored her privacy interests and engaged in disrespectful and exploitive behaviour.

Ms C

The Committee finds that Dr. Iqbal has failed to maintain the standard of practice of the profession by failing to respect Ms C's privacy, by assisting her in removing her clothing, and in the manner and position of the examination he carried out and inappropriate touching of the vagina.

The Committee finds Dr. Iqbal sexually abused Ms C on the office visit of June 2011 by touching her vagina and clitoris in a sexually stimulating manner under the guise of a medical examination.

The Committee finds Dr. Iqbal to have engaged in disgraceful, dishonourable or unprofessional conduct with Ms C by engaging in disrespectful acts and failing to act in his patient's interest.

Ms D

The Committee finds that Dr. Iqbal failed to maintain the standard of practice of the profession by failing to respect the privacy of Ms D by remaining in the room while she changed and by performing inappropriate examinations of her vagina.

The Committee finds Dr. Iqbal to have engaged in sexual abuse of Ms D in May 2011 by touching her lower vulva and separating the labia without clinical justification, and in June 2011, when he inserted his fingers into her rectum and vagina and moved them in a sexual manner under the guise of a medical examination.

The Committee finds that Dr. Iqbal engaged in disgraceful, dishonourable or unprofessional conduct in regard to the above and that he acted in a manner contrary to the interest of his patient, Ms D when he ignored her privacy interests and by engaging in disrespectful and exploitative behaviour.

The Committee is satisfied that each and all of the above allegations made individually in respect of the four complainants are supported by clear, cogent and convincing evidence.

SIMILAR FACT EVIDENCE

The Committee is satisfied that the College has proved its case in respect to each of the four complainants by overwhelming evidence. The Committee finds that it does not need to consider the evidence of each as similar fact evidence to support the evidence of the others. Nevertheless, the Committee does wish to express its opinion that the evidence does meet the test for the admission of similar fact evidence and that it does support the evidence of each of the other complainants.

The similarities between the evidence of the complainants as to the touching that took place and the manner of touching goes far beyond what could be coincidental with the four patients who did not know each other. The Committee rules out collusion.

The evidence is strong in rebutting Dr. Iqbal's defence that the complainants were not telling the truth, or that they misinterpreted or were mistaken about otherwise medically

indicated examinations, or that Dr. Iqbal lacked the opportunity to engage in such abuse in the medical clinics in which he worked.

An analysis of the connecting factors demonstrate that all of the incidents occurred within approximately one year of Dr. Iqbal obtaining an independent practice certificate.

The acts are similar in detail in a number of important respects, and there are distinctive features unifying the incidents of similar acts:

- 1) In three of these cases the complainants describe being on their stomach, an inappropriate position for the examination or procedure in question;
- 2) Two of the complainants reported groaning or moaning noises from Dr. Iqbal;
- 3) All three women who were the subject of rectal or perianal exams reported that Dr. Iqbal moved from the rectum to the vaginal area, causing them concern.

Further, the nature of their complaints and the manner in which they were examined makes coincidence unlikely. These include:

- A disrespectful approach to respecting privacy;
- Repeated intimate examinations in the context of a rheumatology practice;
- A clear identification of sexual violation in the context of clinical examination;
- A clear attempt to sexually stimulate patients;
- Use of the prone, an inappropriate position;
- Examinations which were offensive moving from rectum to vagina; and
- Lack of consideration of cleanliness (hand washing, use of gloves).

The Committee finds that the evidence of each of the complainants is admissible in the case of the others to rebut Dr. Iqbal's suggestion that the complainants are either lying or mistaken about the vaginal and rectal touching, the fact that Dr. Iqbal did not leave the room, and the fact that Dr. Iqbal assisted in removing the clothing of two of the complainants.

The Committee fully understands that it is the strength of the evidence, and not the character of the physician, that is in issue. The Committee does not admit or use the evidence as evidence of bad character. In assessing the prejudice of this evidence, the Committee had clearly in mind that evidence of discreditable conduct is inherently prejudicial. However, the probative value of the evidence in this case outweighs its prejudicial effect, to rebut Dr. Iqbal's defence that the complainants lied or are mistaken about what occurred.

In any event, and as previously stated, the Committee finds that the allegations of professional misconduct have been proved on clear, cogent, and convincing evidence, without the need to use the similar fact evidence.

The Committee is of the view that Dr. Iqbal manipulated and exploited his vulnerable patients in a demeaning manner. The sexualizing of examinations suggests a pattern of behaviour, which the Committee finds deeply disturbing and offensive.

PENALTY AND REASONS FOR PENALTY

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario delivered its written Decision and Reasons on Finding in this matter on September 24, 2015. The Committee found that Dr. Iqbal has committed acts of professional misconduct in that, in respect of four patients, he has engaged in sexual abuse, he has failed to maintain the standard of practice of the profession, and that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee heard submissions on penalty and costs on October 20, 2015, and delivered its penalty and costs order on that date, with written reasons to follow.

EVIDENCE AND SUBMISSIONS ON PENALTY

The Committee received Victim Impact Statements from three of the complainants in this matter (Exhibits 30 to 32). The descriptions they provided of the profound and enduring influence of Dr. Iqbal's misconduct were moving. This included loss of self-worth, a mistrust of doctors and others in the medical field and symptoms of panic and anxiety. In addition, Dr. Iqbal's actions have had a significant impact on the victims' families. Difficulty with intimate relationships and withdrawal from social situations illustrate the widespread consequences of such serious professional misconduct.

The College, in their submissions, asked for the revocation of Dr. Iqbal's certificate of registration. The College took the position that revocation was mandatory in view of the Committee's findings and given section 51(5)(2)(iv) of the Code. That section of the Code provides that a member's certificate of registration shall be revoked on a finding of sexual abuse which involves masturbation of the patient by the member.

The College also asked under section 51(2) 5.1 and 5.2 of the Code that Dr. Iqbal be required to reimburse the College for the cost of counselling and therapy that may be provided to the four patients under the program required under section 85.7 of the Code, and to provide security acceptable to the College in the amount of \$64,240.00 to guarantee the payment of any amounts the member may be required to reimburse.

Further, the College asked for a reprimand and payment to the College of costs in the amount of \$49,060.00 representing eleven hearing days at the tariff rate of \$4,460.00 per day.

Counsel for Dr. Iqbal took no position in respect of the College's penalty submission. They also took no position as to whether the misconduct in this matter constituted masturbation or whether mandatory revocation was required by law. It was counsel for Dr. Iqbal's position that a reasonable costs award was \$40,000.00.

DECISION AND REASONS ON PENALTY

The Code contains specific penalties for findings of sexual abuse. Subsection 51(5) states:

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. 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. encouragement of the patient by the member to masturbate in the presence of the member. 1993, c. 37, s .14 (3)

In addition to the mandatory requirements of the Code, the Committee was mindful that the penalty imposed should be proportional to the misconduct. The nature and seriousness of the misconduct is to be taken into account. Well accepted penalty principles, including protection of the public, maintaining confidence in the profession and specific and general deterrence, needed to be considered as well.

Nature and Seriousness of the Misconduct

While the Committee made findings of failing to maintain the standard of practice and of disgraceful, dishonourable or unprofessional conduct in respect to all four patients, it was the finding of sexual abuse in respect to these same four patients which drove the penalty determination.

In the case of Ms A, the Committee found Dr. Iqbal committed sexual abuse by repeatedly and forcefully moving his finger(s) in and out of her rectum in a sexual manner. Without changing gloves, he moved directly to inserting his fingers in her vagina and again moved them in and out in a sexual manner. This was done under the guise of clinical examinations.

In the case of Ms B, the Committee found Dr. Iqbal committed sexual abuse by penetrating her vagina with his finger and then wiggling his finger at the top of her vagina in an attempt to stimulate her, under the guise of a medical examination. He also committed sexual abuse when he had a finger in her vagina while he performed a cortisone injection.

In the case of Ms C, the Committee found Dr. Iqbal committed sexual abuse by touching her vagina and clitoris in a sexually stimulating manner, under the guise of a medical examination.

In the case of Ms D, the Committee found Dr. Iqbal committed sexual abuse by inserting fingers into her rectum and vagina and moving them in a sexual manner, under the guise of a medical examination.

These patients described sexually stimulating actions performed by Dr. Iqbal, including repeated in and out movements of the rectum and vagina and in one case touching of the clitoris. They were violated in an intimate and most abhorrent manner. The Committee agreed with the submissions of the College that these actions constitute masturbation and, as a consequence, immediate and mandatory revocation of Dr. Iqbal's certificate of registration was appropriate.

In reaching this conclusion the panel considered the definition of masturbation as set out in the Oxford Dictionaries (British and World Version on-line) 2013 Oxford University Press and in Dorland's Illustrated Medical Dictionary 27th Edition, W.B. Saunders

Company. While there is some variation in the definitions, the common element is sexual stimulation of the genitals.

In addition, the Committee noted and adopted the reasoning of the Discipline Committee in *Karkanis v. College of Physicians and Surgeons of Ontario 2014 ONSC 7018*, where the Committee found that the sexual stimulation of a patient's genitals constitutes masturbation. In its reasons the Committee stated that this was precisely the type of conduct envisioned by the legislature when it enacted the sexual abuse provisions of the Code, which expressly included revocation of a member's certificate of revocation for masturbation of a patient by a member.

While the Committee found revocation of Dr. Iqbal's certificate of registration to be mandatory under the Code, the dimensions of the misconduct in this matter were such that nothing short of revocation would suffice, even if not required by law. Protection of the public, proportionality and maintaining the public trust demand nothing less than revocation of Dr. Iqbal's certificate of registration which removes him from the practice of medicine in Ontario.

Funding for Therapy

The nature and extent of the sexual abuse perpetrated by Dr. Iqbal was particularly callous and cruel. All four patients were extraordinarily vulnerable given their significant symptoms. The enduring effects of the abuse they were subjected to are best illustrated in selected quotes from the victim impact statements.

“I have had a loss of self-confidence and self-worth. It has incited anxiety and at some points panic and fear. Thoughts of the assault have consumed me at times so I can think about nothing else.”

“Anxiety has gripped me at times with respect to approaching males in different situations. I always seem to be wary, watching and waiting for something negative to happen.”

“My marriage, our sexual relationship and intimacy has suffered because of the apprehension and fear I experience when participating in foreplay and sexual intercourse.” (Ms A)

“The events that occurred that have brought me to write this letter have greatly affected my life. It has made me question whether or not I should go to or trust a male physician.”

“After experiencing this trauma, I have not always been able to feel comfortable sexually with my husband and have even shied away from him on occasion.” (Ms B)

“As a lupus patient any stress in my life creates a flare of my illness.”

“My anxiety and panic has increased since the incidents with Tariq Iqbal.”

“I feel taken advantage of and disrespected. My life with my spouse has been greatly impacted. Intimacy has changed due to the damage Tariq Iqbal has caused”. (Ms D)

In these circumstances, the Committee determined that it was appropriate to order reimbursement from Dr. Iqbal of funding provided by the College to any of the patient’s for counselling or therapy. The College also ordered Dr. Iqbal to post security acceptable

to the College in the amount of \$64,240.00 (the maximum amount, representing \$16,060.00 for each of the four patients sexually abused) within 60 days.

Reprimand

A reprimand is required by law where a finding of sexual abuse has been made. The force of a personal reprimand should not be underestimated. A reprimand will provide the Committee the opportunity to address the member's misconduct in a face to face encounter. It also supports the principles of specific and general deterrence.

Costs

The Committee determined that payment by Dr. Iqbal to the College of its costs is appropriate in this matter. The College was 100% successful in proving its case and obtaining findings on each head of professional misconduct for all four patients. The hearing took place over eleven days (ten hearing days and one penalty hearing day).

The Committee was aware that costs should be reasonable and not punitive. The Committee determined that the costs of eleven hearing days payable to the College was fair and reasonable in the circumstances. The Committee did not agree with counsel for Dr. Iqbal's position that the quantum of costs should be reduced to \$40,000.00.

The Committee ordered that costs in the amount of \$49,060.00 representing eleven days at the tariff rate of \$4,460.00 be payable by Dr. Iqbal to the College within 60 days. This is a partial indemnification of costs, as it does not cover the actual costs of the hearing let alone the costs of the investigation in this matter.

ORDER

On October 20, 2015, the Committee ordered and directed that:

1. the Registrar revoke Dr. Iqbal's certificate of registration, effective immediately.
2. Dr. Iqbal appear before the panel to be reprimanded on a date to be fixed by the hearings office which shall be no later than six (6) months from the date this Order becomes final.

3. Dr. Iqbal reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, and shall post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within sixty (60) days of the date this Order becomes final, in the amount of \$64,240.00.
4. Dr. Iqbal pay costs to the College in the amount of \$49,060.00 within sixty (60) days of the date this Order becomes final.

TEXT of PUBLIC REPRIMAND
Delivered April 20, 2016
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. TARIQ IQBAL

Dr. Iqbal, it is always unfortunate when a member of our profession appears before this Committee. An essential component of the physician-patient relationship is trust and that the physician will always place the best interests of their patients before their own. You have breached that trust. Being a physician involves a responsibility to care for your patients in an appropriate, civil and respectful manner, none of which you exhibited. This Committee was shocked and dismayed to hear of the reprehensible manner you treated some of your most vulnerable patients. It was callous, unthinking, reprehensible and unforgiveable. Your behaviour was not only profoundly disturbing to the patients you abused but also to the physician and public members of this Committee. There is little to say other than we, the profession and the public condemn your behaviour in the strongest terms.

Your Revocation will demonstrate that the profession cannot and will not tolerate such egregious behaviour from its members.

You have brought shame not only to yourself but also to the profession as a whole. There is no place in our profession for a physician who abuses their

patients for self-gratification. You will now leave this hearing room as a disgraced physician.

THIS IS NOT AN OFFICIAL TRANSCRIPT