NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Mohan Krishnan Raja, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name of the complainant, or any information that could identify the complainant 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.

This is also notice that the Discipline Committee ordered a ban on the publication of the name and any information that would identify the close relative of Dr. Raja referred to in evidence and exhibits at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 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. Raja, 2017 ONCPSD 49

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) f 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. MOHAN KRISHNAN RAJA

PANEL MEMBERS:

DR. M. GABEL (CHAIR)
MR. S. BERI
DR. P. CHART
MS D. GIAMPIETRI
DR. E. STANTON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS E. GRAHAM

COUNSEL FOR DR. RAJA:

MS C. BRANDOW
MS S. MARTENS

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

Hearing Dates:	July 10 to 12, 2017
Decision Date:	November 27, 2017
Release of Written Reasons:	November 27, 2017

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 July 10 to 12, 2017. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

The Notice of Hearing alleged that Dr. Mohan Krishnan Raja committed an act of professional misconduct:

1. 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 has engaged in the sexual abuse of a patient; and

2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93"), in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO ALLEGATIONS

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

BACKGROUND

Dr. Raja is a 39 year old physician, who has held a certificate of registration from the College of Physicians and Surgeons of Ontario since 2009. Dr. Raja has a family practice and a methadone practice located in St. Catharines. Patient A, the complainant in this matter, is a former patient of Dr. Raja in her 30's who saw Dr. Raja at his methadone clinic.

The allegations of sexual abuse and disgraceful, dishonourable or unprofessional conduct arise from the alleged conduct of Dr. Raja during a number of clinical appointments when Patient A attended Dr. Raja for care and supervision, while she was on a methadone maintenance program (MMP).

After Patient A moved and left Dr. Raja's methadone practice, enrolling in another methadone program, a mandatory report was made to the College.

THE ISSUES

This case raises two primary issues as follows:

1. During a clinical examination, did Dr. Raja lift the left side of Patient A's bra, exposing her left breast and then perform an examination of her chest, including touching her breasts?
2. If yes, did Dr. Raja engage in sexual abuse of a patient and/or disgraceful, dishonourable or unprofessional conduct?

FACTS AND EVIDENCE

Summary of the Evidence

The Committee heard the testimony of Patient A, Dr. Raja and Mr. Jeffery Mathews, the office manager at the methadone clinic where Dr. Raja practises. Various exhibits were filed as evidence, including clinical records, layout plans, photographs of one of the methadone clinics where Dr. Raja practised, the letter of complaint from Patient A and the College's Policy on Maintaining Appropriate Boundaries and Preventing Sexual Abuse.

Undisputed Facts

Dr. Raja is a graduate of the medical school at the University of Western Ontario (2007). He completed his family practice residency in Kingston, Ontario in 2009. He is the father of two young children and has been married for eight years.

Dr. Raja has had additional training in methadone therapy, including a course at the Centre for Addiction and Mental Health (CAMH) with an on-line component and exam, followed by shadowing another physician for a period of time. He obtained a partial exemption and, after a practice audit, received a full exemption to provide methadone care. He has been providing methadone treatment since 2012. The scope of his care is opiate substitution.

Dr. Raja currently works about four days a week in family practice, and one day a week in a methadone clinic in St. Catharines.

Patient A is in her 30's and a mother; she also cares for another child. Patient A moved from St. Catharines to a town in 2015.

Patient A met Dr. Raja when she first attended the methadone clinic (the ONTRAC clinic) on St. Paul Street in St. Catharines in February 2014. Her sibling was also attending this clinic and seeing Dr. Raja.

Patient A had been given pain pills years ago for a sports injury and had become addicted.

Patient A was accepted as a patient at the methadone clinic in February 2014 and attended every one or two weeks, until October 2015.

Patient A saw Dr. Raja on all these visits, except for two visits with Dr. Y, and two visits with Dr. Z, occasioned by changing the day she was seen.

In the methadone clinic, patients usually see a physician at least once a week. The patient may attend at the day and time of their choosing. Urine is screened, blood tests may be done, and there is a meeting with the doctor, which includes a review of current status and a plan for care. Methadone dosage is prescribed and may be adjusted. Methadone is taken daily in the pharmacy, except if the patient has "a carry" which enables the patient to take the methadone at home. Carries are earned and valued by patients, because of convenience, as they do not have to attend the pharmacy each day; a maximum of six carries can be earned.

From February 2014 to October 2014, Patient A was seen at the methadone clinic located on St. Paul Street in St. Catharines. From October 2014 to March 2015, the clinic, which was still known as the St. Paul clinic, changed its location to the main floor of a building on Bond Street in St. Catharines. From March 2015 until October 2015, the office in which Dr. Raja saw patients at the Bond Street site, where Patient A saw Dr. Raja, moved upstairs. It was during this period of March to October, 2015 that the alleged misconduct took place.

Dr. Raja would perform on occasion elements of physical examination during the course of following Patient A while she was on the MMP.

Patient A last saw Dr. Raja in October 2015, when she arranged care at a methadone clinic located in the town. The medical record documents that Patient A had 52 visits between February 2014 and March 2015 and 30 visits from March 2015 to October 2015.

Disputed Facts

Patient A asserts that on two occasions during the time she was seen upstairs at the methadone clinic located on Bond Street, Dr. Raja asked her to lie down on the examination table and raise her shirt above her bra. He then flipped up her bra on the left side, fully exposing her left breast. He then checked her heart rate with his stethoscope placed above, to the side, and underneath her breast. Patient A asserted, "sometimes, he would have his fingers and just, sort of, move my breast out of the way to get the

stethoscope where he wanted to place it." Patient A was unable to specify on which visits these acts occurred. Patient A also asserted that after the first visit, during which she was laying down, Dr. Raja would examine her almost every time, unless she had her boyfriend or sibling with her.

Dr. Raja agreed that on occasion, when warranted, he did a limited cardiovascular (CVS) examination by listening Patient A's heart sounds in the second left intercostal space at the sternal border. On two occasions, he did a more focused CVS examination by listening to her heart in four locations, specifically the left and right second intercostal space, the fourth left interspace and the fifth interspace in the mid-clavicular line. Dr. Raja asserted that at no time did he raise her bra or expose her left breast. Dr. Raja asserted he would not have examined her had she not consented.

Testimony of Jeffery Mathews

Mr. Mathews has been the Clinic Manager at the methadone clinics (St. Paul Street and Bond Street sites) for six and a half years. His role includes scheduling, lab technician, payroll, and building manager. He does phlebotomy and intramuscular injections and is an advocate for patients.

Between 2011 and May 2014, the clinic was on the second floor of the St. Paul Street site, as depicted in exhibit 5. At this site, an examination table is located in the room marked "Testing Computer Room". From May 2014 until the end of July 2014, the clinic was on the first floor of the St. Paul Street site, as depicted in Exhibit 6.

Mr. Mathews testified that there was a partition separating the two areas of the clinic, which may not be as big as depicted in the layout (he said it used to be the site of a fish tank). Patient A disagreed it was there, as indicated below. On further questioning, Mr. Mathews testified that the open space separating the two rooms was an estimated 20 feet. He testified that the lower part of the partition was ten to eleven feet in length, and the upper part was approximately six feet. According to Mr. Mathews, there were no

examination tables. The spot marked “staff position” was an area where he was frequently standing, but there was no physical station there.

The next facility move was a return to the first location of the clinic from July 2014 until October 20, 2014. The layout was similar.

On October 28, 2014, the clinic moved to Bond Street and was located on the main floor, as depicted in Exhibit 9, until March 2015. After March 2015, the layout is set out in Exhibit 7, two levels were used and an examination table was located in the doctor’s office on the second floor.

Mr. Mathews testified that Patient A did not confide in him, and that she seemed pleasant. He testified that he recalled her being dazed or confused at times. He said he noticed track marks when doing a phlebotomy. Even though he was the “go to” person for patients, he said she never indicated to him that there was a problem. He made an appointment for her to have a Holter monitor (ambulatory electrocardiogram), but she never had this done. Mr. Mathews testified he has never conducted a physical examination on a patient.

Testimony of Patient A and Dr. Raja

Patient A testified that she had become addicted to pain medication after a sports injury. She testified that she went to the St. Paul Street clinic, which was convenient for methadone treatment. Patient A testified she had a family physician that she could see within a week or two if needed. She saw Dr. Raja weekly during the relevant time. Dr. Raja testified that he saw Patient A and she followed the usual pattern for patients in the MMP (patients are seen twice weekly during the initial stabilization phase, then once weekly).

Patient A did not recall seeing either Dr. Y or Dr. Z until counsel for Dr. Raja showed her the medical record, which she agreed was more accurate than her memory. Dr. Raja testified that Patient A saw Dr. Z on two occasions – one occasion because of a holiday,

and on one other occasion – and that she saw Dr. Y twice. Aside from this, both Patient A and Dr. Raja agreed that he was the only physician she saw for her MMP.

Patient A testified that at her initial visit, she had an examination. She described this as a blood pressure and heart check. She did not recall who carried out the examination, but she testified it would have been Dr. Raja or Jeff Mathews (the clinic manager).

Dr. Raja testified that he had no specific recollection of this visit, but that he did examine her on her initial visit, and that he would have done so in the room down the hall from the doctor's office (Testing Computer room marked on exhibit 5). Dr. Raja testified that at the initial visit, she would have first been seated on the examination table and then lain supine for the abdominal examination. He testified that she would have been fully clothed.

Patient A testified that there was no examination table at the St. Paul Street clinic. However, under cross-examination, she agreed that it was possible that she was sitting on the examination table in the "intake room" on her initial examination.

Patient A testified that she met with College investigators in 2016 at her home. On cross examination, Patient A was asked whether she told Mr. McNamara, one of the investigators, that she had any examinations conducted by Dr. Raja on her first visit. Patient A testified that she could not recall what she had said in response to Mr. McNamara. When informed by counsel for Dr. Raja that her answer was "no", she explained that what she meant was she had not had the type of examinations she was complaining about. She said she was busy and did not sit down and think about dates and times. She believes what she said earlier to the investigators, is the same as her testimony at the hearing, just that there are more details now.

Patient A acknowledged that the layout of the clinic when it was located downstairs [the first floor] on St. Paul Street was as shown in exhibit 6, with two exceptions. According to Patient A, there was no partition or staff position as shown. She stated it was an open

room. According to Patient A, there was no specific examination room. Dr. Raja disagreed with Patient A's description of the main floor layout, specifically when she said there was no partition wall, as shown in exhibit 6.

Patient A agreed with the upstairs layout depicted in exhibit 5. She said the room, marked "Testing Computer", may have had an examination table, but she was unsure. She testified that the only time she was in the Testing Computer room was for the intake examination. Patient A said there was no examination table in the doctor's office where she saw Dr. Raja for her weekly MMP visits. Dr. Raja confirmed in his testimony that the only examination table was in the Testing Computer room.

Both Dr. Raja and Patient A agreed that at each appointment, Dr. Raja would inquire about any issues Patient A was having and how she was doing. Both Dr. Raja and Patient A agreed on the routine sequence of events at a methadone maintenance visit. First, there was a urine check. Then, she would wait her turn to go into his office. Dr. Raja would ask her about any new social or medical issues, including whether she was "using". He would then give her a prescription and she would leave. According to Patient A, if there was "an issue", they would discuss it and if a physical examination was needed, he would perform it.

Dr. Raja testified that he would do a physical examination when warranted. He explained that patients seen in the methadone clinic tend to have more comorbidities and that symptoms may be masked. Dr. Raja testified he feels it is "the right thing to do" to make sure he does not miss a health problem. Dr. Raja testified that in his training, he learned to do a brief CVS assessment (as in a general check-up) by listening to a patient's heart sounds in the second left intercostal space at the sternal border. He also learned to do a focused CVS examination when there was a worry or suspicion of a cardiac problem, by listening to four areas – the left and right of the sternum in the second intercostal space, the left fourth intercostal space at the sternal border and the fifth intercostal space in the mid-clavicular line.

Dr. Raja testified he would close his eyes to focus on the heart sounds while he listened. Patient A testified she did not notice if his eyes were closed when he checked her heart. Dr. Raja testified that he learned in his training that as long as the skin was accessible, there was no need for gowning. Patient A testified that she never was provided with a gown or a drape.

Patient A testified that the process was different after the clinic moved to the upstairs level of the Bond Street site in March 2015. She did not recall that the clinic first operated on the main floor (October 2014 to March 2015), and then moved upstairs. After March 2015, there was an examination table in the doctor's office. As before, she would leave a urine specimen for screening and wait in the waiting room to be called. After asking her the basic questions, she testified that Dr. Raja had her sit on the examination table. Using his stethoscope over her clothes, he checked her back and front. He checked her heart rate with the stethoscope and took her pulse at her wrist with his fingers. She said this started several weeks after he started seeing her upstairs at the Bond Street site. Dr. Raja confirmed that the upstairs doctor's office at Bond St. had an examination bed.

Patient A testified that in the following few weeks, the examination changed again. She testified that Dr. Raja would ask her to lie down and then he would check the heart rate as before, over her clothing, or he would move or shift her top at the neckline a little. She said he did not check her back. She testified that later, the examination changed again. Patient A testified that Dr. Raja would ask her to pull her shirt up above her bra. After doing so, she testified, Dr. Raja again checked her heart in different areas around her breast. She testified that he placed the stethoscope on her skin above her breast, to the side and underneath; her bra was left in place. Dr. Raja testified that he did not ask Patient A to lift her shirt above her bra.

Patient A testified that following this, on two, or possibly three, occasions during different examinations, when she was lying flat on the examination table, Dr. Raja flipped up her bra by pulling on the bottom of it. He did this just on the left side, and her left breast was fully exposed. According to Patient A, he put the stethoscope on her skin

around the breast and sometimes used his hand to move the breast out of the way. She said, “He would just sort of push it over or lift it up a little bit to place the stethoscope.” She stated that in doing so, he just touched the sides of her breast and up from the bottom. She said that he no longer listened to her back and she could not recall whether he checked her pulse at the wrist. According to Patient A, Dr. Raja made no sounds during the examination. Patient A said that there was no touching of the nipple. Patient A testified that after this, the examinations went back to being done with her shirt up and bra in place. Dr. Raja testified that he never moved the left cup of her bra exposing her breast.

Patient A testified that at the Bond Street site, Dr. Raja performed an examination every Friday, unless someone was with her (e.g., boyfriend or sibling), in which case, he would not do an examination on the table.

Dr. Raja testified that he had no recollection of touching Patient A’s breast. He recalled that, in general, she had a number of medical complaints. He said, “far more than the average patient… there was IV drug use and she had a friend who threatened suicide.” Patient A agreed that there was an occasion where a friend of hers cut himself and threatened suicide. Patient A agreed that Dr. Raja had given her Doxipen to help her sleep. Dr. Raja explained that when she reported her friend was cutting himself, he prescribed Doxipen.

Both Patient A and Dr. Raja agreed that he helped her at times with medication for sleeping and headaches. Patient A did not recall details of physical examinations or whether they were done on the occasions when she had complaints.

Patient A testified that Dr. Raja would say he wanted to check and make sure everything was okay. She said she was never offered a chaperone or a drape. Dr. Raja agreed. Dr. Raja testified that when he examined Patient A, he told her that he wanted to examine her and on each occasion, demonstrated on his own body where he would touch her. He testified that he asked her permission every time. He did this by saying, “May I listen to

your heart?" or "May I listen to the top of your heart?" and "May I listen to a couple of spots on the bottom of your heart?" and then gesture on himself. He testified that for the abdominal examination, he asked, "Can I examine your abdomen?" He would gesture where he wanted to examine asking, "May I place my hands on your skin?" Patient A did not recall the gestures.

Dr. Raja explained that as a family doctor, he is comfortable doing examinations within his scope, if they are warranted. He said that as a physician, he is more aware of missing a medical diagnosis, because of an experience where a person with personal connection to him had a delayed diagnosis of a brain tumor and suffers from some deficits.

Dr. Raja testified that Patient A was, for the most part, a reliable patient. He thought she was sincere, wanted to be a good mother, and wanted to find a job. He agreed she was candid about drug usage, and while she had a prescription for benzodiazepines, she did not abuse this. Dr. Raja agreed that Patient A did not express self-harm or criminal activity and exhibited no disruptive behavior. Patient A worked her way up to six carries over seven months. Patient A testified that she never got up to six carries, but she said she was not certain near the end. When shown her medical record, she agreed she had six carries at the time of her last visit with Dr. Raja.

Dr. Raja agreed that breasts are a sensitive part of the body, private and of a sexual nature. He agreed that there needs to be a reason to examine the breasts and patient permission. Dr. Raja agreed that the exposure and touching Patient A described is inappropriate and sexual in nature.

When Patient A mentioned what happened at her visits with Dr. Raja to X (a physician at methadone clinic in the town, where she moved), he told her he had to report it to the College. Patient A testified that she thought Dr. Raja's examinations were inappropriate but did not amount to assaults.

Patient A's Appointments with Dr. Raja

Dr. Raja and Patient A were asked about specific visits as follows:

Month, 2014

Dr. Raja testified he looked in Patient A's throat while she was seated as she still had a sore throat. There was oedema and exudate present and he prescribed penicillin. The week before, Patient A had complained of a sore throat, cough and fever and Dr. Raja referred her to her family doctor. Patient A agreed she remembered discussing a sore throat and cold with Dr. Raja and that he examined her glands. She said she did not consider this a "physical examination."

Month, 2014

Dr. Raja testified that he prescribed Macrobid for a urinary infection when Patient A reported cramping in the lower abdomen and requested a pregnancy test. Patient A agreed she recalled speaking to Dr. Raja when she thought she was pregnant, but could not recall the day. She also agreed when shown her medical record that Dr. Raja prescribed an antibiotic for a urinary tract infection. Dr. Raja testified that no examination was done on that day.

Month, 2014

Dr. Raja prescribed Diflucan for a malodorous whitish discharge (presumed to be vaginal). No physical examination was done. Dr. Raja testified it was not warranted. Patient A had no specific recollection but when shown her medical record, agreed with its accuracy.

Month, 2014

Dr. Raja examined Patient A's right anticubital fossa as she had noted a small area of redness. He prescribed antibiotics. Patient A recalled parts of this appointment. She recalled talking to Dr. Raja about redness in the area she was injecting.

Month, 2014

Dr. Raja testified he prescribed Keflex for redness in the anticubital fossa for infection from IV drug use. Patient A recalled talking to Dr. Raja only once about the issue. Upon consulting her medical record, she agreed it occurred twice.

Month, 2014

Patient A complained of a sore throat. Dr. Raja testified that no examination was warranted.

Month, 2014

Patient A complained of abdominal pain. Dr. Raja testified she described it as 6/10 and that she had no fever, chills or sweats. He testified that no examination was warranted.

Month, 2015

Dr. Raja testified he did a physical examination on Patient A, including listening to her lungs and heart (second intercostal space only) and palpated her sinuses, while seated in the doctor's office. Dr. Raja said she had been sick for two weeks with cough, fever nausea and a tight chest. He prescribed Amoxil for sinusitis. Patient A did not dispute that she complained of fever, cough or nausea. She did not recall an examination.

Month, 2015

Dr. Raja testified he performed a physical examination, including a heart examination (second interspace), a respiratory examination, and a CNS examination. He noted Patient A's history of worsening headaches over four to five months. No clothing was removed. Patient A recalled a couple of times talking to Dr. Raja regarding headaches. She said she wondered if they could be related to Clonidine, a drug he gave her for sweats.

Month, 2015

Patient A's record indicates "flu yesterday", "frequent emesis, feeling better". Dr. Raja testified that no examination was warranted.

Month, 2015

Dr. Raja testified that Patient A mentioned panic attacks, heart racing, chills, fever and sweats. He said no examination was performed. She was asked to see her family doctor for Holter monitoring (an ambulatory electrocardiogram).

Month, 2015

Dr. Raja testified Patient A was still noting symptoms of her "heart racing." No examination was warranted. She had not followed up with her family doctor so he asked his clinic manager to arrange the monitoring. Patient A could not recall being referred to her family doctor for Holter monitoring for palpitations.

Month, 2015

Dr. Raja testified he did a CVS exam (left interspace), a respiratory and abdominal examination on Patient A. He said Patient A had just had a positive pregnancy test confirmed at a walk-in clinic and had been referred to an obstetrician. Patient A was noted as happy and had no complaints. Dr. Raja testified that he would have listened to her heart while she was sitting on the examination table and she would have laid flat only for the abdominal exam. Dr. Raja testified that it is his practice to do a physical examination on a newly pregnant woman to rule out ectopic pregnancy. Dr. Raja testified that with methadone, symptoms can be dulled and she is at high risk for PID (pelvic inflammatory disease). He explained the effect of methadone on the fetus.

Month, 2015

Dr. Raja testified he did another physical examination on Patient A, including examination of her heart in four locations and an examination of her cranial nerves. He

testified that Patient A had reported to him that she had a miscarriage and had gone to the hospital for laboratory tests and ultrasound to confirm. She had occasional palpitations and headaches. Dr. Raja testified that he was concerned about the risk of infection of her heart valves. Patient A testified she recalled an abdominal examination after a miscarriage, she believed it was the only one, other than at the initial assessment. Patient A testified that he pushed around her abdomen lightly, but she could not recall how many times. She agreed on cross-examination that other abdominal examinations were performed when she was pregnant, but did not recall whether chest and lungs were examined on those occasions. She testified that she found nothing unusual about the abdominal examination.

Month, 2015

Dr. Raja testified that he performed a physical examination on Patient A, including listening to her heart (in four positions) in the supine position, and then leaning forward. He explained that he was listening for a friction rub. No abdominal examination is recorded. The medical record indicates that Patient A had reported a bladder infection that had been treated at a women's clinic that week, and occasional palpitations, lasting only seconds, and not as frequent. Dr. Raja said he was worried about missing something. He testified that she provided access to skin when she raised her shirt. Patient A could not say if this was one of the occasions when her breast was exposed.

Month, 2015

Dr. Raja performed another physical examination on Patient A, including the abdomen and CVS. He noted no hepatomegaly (enlargement of the liver). Dr. Raja said he was aware at this time that Patient A had tested positive for Hepatitis C, and that she was being followed by a hepatologist and a counselor. Dr. Raja said that she had no pain and no other problems at this time. He testified he palpated the abdomen in the supine position and checked the second intercostal space, while she was seated on the examination table. Patient A recalled talking to Dr. Raja about Hepatitis C. She testified this was one of the times he had her lay down and pulled her shirt up. When asked if this was one of the times her breast was exposed, she was unsure.

Month, 2015

Patient A's medical record indicates she had reported being approximately eight weeks pregnant. Her only related complaint was some nausea. Her urine screening was clear at that time and she had earned four carries. Dr. Raja testified he did a further CVS, respiratory and abdominal examination. He testified that the heart examination would include only the left second interspace and she would have been clothed. He testified that he was concerned about an ectopic pregnancy and she was fine with the examination.

Month, 2015

Dr. Raja testified that he performed a further physical examination, notwithstanding Patient A had no complaints. He examined the respiratory system, heart (left second interspace only) and abdomen in the usual way. He testified Patient A was fine with him performing the examination.

DECISION AND REASONS FOR DECISION

Law and Applicable Legal Principles

The Committee recognizes that the onus of proof is with the College to prove the allegations. The standard of proof is on a balance of probabilities, based on clear, cogent and convincing evidence.

Sexual Abuse

Sexual abuse is defined in the Health Professions Procedural Code as follows:

1(3) In this Code, "sexual abuse" of a patient by a member means,

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

Exception

(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.

The Supreme Court of Canada in *R. v. Chase*, [1987] 2 SCR 293 provides further guidelines for determining whether the conduct at issue is of a "sexual nature". The test to be applied is an objective one: "viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer."

The Panel may consider the following:

(a) the body part touched;
(b) the nature of the contact;
(c) the situation in which it occurred;
(d) the words and gestures accompanying the act; and
(e) all other circumstances surrounding the conduct.

While sexual intent may be a factor in determining whether or not the conduct was of a sexual nature or purpose, it is not a prerequisite to a finding that conduct was of a sexual character or nature. It is one of many factors to be considered in the circumstances.

Again, in *R. v. Litchfield*, [1993] 4 SCR 333, the Supreme Court has indicated that all the circumstances surrounding the conduct in question will be relevant to the question of whether the touching was of a sexual nature and violated the complainant's sexual integrity.

The Committee further considered prior cases heard before the Discipline Committee of this College.

In *CPSO v. Peirovy* (2016), the Committee noted that the female breast is private and sensitive, both physiologically and emotionally. Female patients have a right to expect that physicians will understand and respect their privacy when examinations of this nature are carried out. The Committee found that deliberate touching of the breast without consent and for no proper medical reason constitutes sexual abuse.

In *CPSO v. Sazant* (2009), the Committee found that while it was unable to conclude with certainty how often inappropriate contact took place, it was nonetheless satisfied to the requisite degree that sexual contact took place.

Disgraceful, Dishonourable or Unprofessional Conduct

This is a catch-all provision in the medical profession's professional misconduct regulation intended to capture serious or persistent disregard for a member's professional obligations. Conduct need not be immoral or dishonest to fall within this definition. Members are to be judged according to the consensus of the profession (see: Steinecke, *A Complete Guide to the Regulated Health Professions Act*, Toronto: Thomson Reuters, 2017).

Credibility and Reliability

The Committee is aware that credibility and reliability are different legal concepts. The Committee must assess both the credibility of each witness and the reliability of their testimony. Credibility refers to the witness' sincerity and willingness to speak the truth as he or she believes the truth to be. Reliability relates to the witness' ability to accurately observe, recall and recount the events in issue. That is, the witness' honesty must be assessed, along with whether his or her evidence is reliable or can be counted on to be accurate.

When assessing credibility and reliability, the Committee should look to the totality of the evidence and assess the impact of any inconsistencies. The Committee recognizes that

when assessing the credibility, a witness' inconsistencies on minor matters are normal and the Committee need not resolve every alleged inconsistency in the evidence.

In *CPSO v. Beairsto* (2016), the Committee set out the factors they used for assessing credibility and reliability. This Committee had regard for these same factors:

- Did the witness seem honest?
- Is there any reason why the witness would not be telling the truth?
- An interest in the outcome of the case or any reason to give evidence that is more favourable to one side or the other?
- Did the witness seem able to make accurate and complete observations about the events at issue?
- Did the witness have a good memory?
- Did any inability or difficulty that the witness has in recalling events seem genuine, or did it seem made up as an excuse to avoid answering questions?
- Did the witness' evidence seem reasonable and consistent as she/he gave it? Did she/he say something different on another occasion?
- Do any of the inconsistencies in the witness' evidence make the main points of the testimony more or less believable or reliable? Is the inconsistency important? Does it seem like an honest mistake? Is it a deliberate lie? Is the inconsistency because she/he said something different on another occasion, or that she/he failed to mention something? Is there any explanation for the inconsistency and if so, does it make sense?
- What was the witness' manner when she/he testified? The Committee recognizes that while demeanor is a relevant factor in a credibility assessment, demeanor alone is a notoriously unreliable predictor of the accuracy of evidence given by a witness.

Decision

Issue 1: During a clinical examination, did Dr. Raja lift the left side of Patient A's bra, exposing her left breast and then perform an examination of her chest including touching her breasts?

The Committee was faced with two very different descriptions of what took place. The description of events as testified to by Patient A is irreconcilable with that of Dr. Raja, who testified that certain of the alleged events (such as the exposure of the breast) did not happen. After scrutinizing the respective credibility and reliability of Patient A and Dr. Raja, and having regard for the totality of the evidence, the Committee accepts the version of events given by Patient A for reasons set out below.

Credibility of Patient A

Patient A described consistently and without hesitation the nature and extent of the examinations that were of concern to her. She testified that on two, or possibly three, occasions, Dr. Raja flipped up her bra on the left side and exposed her left breast. Dr. Raja listened to her heart sounds in four spots with the stethoscope on her skin and his fingers may have pushed part of her breast aside. There was no embellishment or obvious exaggeration. She does not describe any touching of the breast as there would be in a breast examination, i.e., massaging or touching of the nipple. The examination left her feeling scared and uncomfortable. Her recall of these events was clear and unwavering. Patient A consistently described a sequence of events when she was seen upstairs at the Bond Street site, which she found increasingly intrusive. This started with her sitting on the examination table, with her shirt in place. Dr. Raja listened with the stethoscope on the front and back of her chest. She did not view these examinations as concerning. He then progressed to asking her to lie down on the examination table with her shirt in place and listened again to the front of her chest, but not the back. As the visits went on, he asked her to lie down on the examination table and pull her shirt up, exposing her bra. He listened to her heart in different spots at the periphery of her left breast. After this, on two

or three occasions, the conduct noted in the above paragraph occurred. Dr. Raja then went back to having Patient A lie down with her shirt up.

Patient A appeared unsophisticated, clear spoken, and did her best to answer questions. She was honest and straightforward, which is illustrated by her response to questions posed by counsel for Dr. Raja regarding an earlier version of events she gave to a College investigator. Her response, "so I didn't really have a lot of time to just sit and think about it" and "well, I tried to remember as much as I could then, with everything that was going on in my life at the time" speaks to her directness. She agreed she missed certain details of her story when she spoke to the College investigator. She explained that she thought what she told the investigator was just about the same, but she remembered a few more details at the hearing.

Patient A admitted to having a poor memory. She admitted readily and consistently that she could not say for certain on which visits the alleged inappropriate examinations were performed. This impacted the reliability of her testimony, but in a peripheral way. In the context of a large number of visits, carried out frequently and which, to a large extent, were routine, it is not unexpected that Patient A would not be precise in recalling specifics of individual visits. She did recall issues, which were important to her, such as pregnancies, miscarriages, headaches, and other symptoms.

The Committee noted that Patient A testified in an unbiased manner; her description, when telling her story, was not overstated. Patient A gave no evidence that impugned the clinical care rendered by Dr. Raja. She does not stand to benefit from the outcome of this hearing. There is no obvious reason for her to make a false claim against Dr. Raja. She was genuine, open, and exhibited no pattern of untruth or confabulation. She testified as to what she experienced, saw, and heard, and never embellished her evidence or tried to involve her sibling or boyfriend.

The Committee noted that Dr. Raja testified that Patient A was not a disruptive patient. He said she did not act out, and her response to losing a "carry" was to try to get it back.

Dr. Raja characterized Patient A as motivated to be a good mother and that she tried to find a job. While at the commencement of her MMP, her urine screens were positive, a review of her entire course of care suggests that she was overall compliant and had improved with respect to her addiction problem.

The Committee did not accept the evidence of Mr. Mathews that Patient A was at times dazed and confused. There was no time frame associated with this observation. The Committee noted that based on Mr. Mathews' evidence, Patient A did not engage significantly with him. The Committee notes that Dr. Raja dealt with Patient A far more often and in greater detail than Mr. Mathews and he did not testify that she was dazed and confused.

The Committee noted that Patient A became visibly upset upon discussion of her past drug use; she voiced that she understood that her evidence might not be believed, because of the stigma of her history. Indeed, this fact made her hesitant to tell anyone about what she believed was an inappropriate examination.

By the time Patient A left Dr. Raja's care, she had earned the maximum six carries. While she did not recall this fact until she was taken to her medical record, she accepted without argument what was written over her memory.

As Dr. Raja's care of Patient A proceeded, there were an increasing number of examinations. According to her medical record, Patient A was seen by Dr. Raja 52 times from February 2014 to March 2015, during which time she had two physical examinations. Patient A was seen by Dr. Raja 30 times from March 2015 to October 2015, during which time she had six physical examinations. This is consistent with her evidence. The medical record clearly indicates that there were two occasions where her heart was auscultated in four areas, which is consistent with her evidence.

Aside from her poor memory for dates and times, there were a number of inconsistencies in Patient A's evidence, which the Committee finds do not undermine the reliability of her evidence. Specifically, the Committee noted the following minor discrepancies:

St. Paul Street Clinic Layout (first floor)

Patient A described an open layout. Dr. Raja disagreed with her description, indicating a partition and staff position. The matter was clarified by Mr. Mathews who indicated that there was a partition, which left a wide opening between the rooms of approximately 20 feet, and that there was no physical station, where the staff position was marked. The Committee finds that Mr. Mathews, with the number of duties he had to attend to, would not always be standing in the staff position. The Committee accepts Patient A's description to be reasonably accurate and finds no significant inconsistency between her evidence and the evidence of Mr. Matthews in this regard.

Interview with the College investigator

Patient A agreed on cross-examination that her statements given to the College investigator did not coincide exactly with the sequence of events she gave in her testimony at the hearing. She testified at the hearing that Dr. Raja did the heart examination while she was lying down on the examining table with her shirt in place. She told the College investigator that Dr. Raja would ask her to sit up on the examining table, and then ask her to lift her shirt. When counsel for Dr. Raja pointed out to her that she left out a period of time when the shirt stayed down, Patient A responded that she did not purposely leave anything out, but acknowledged the inconsistency. She explained that it was a short period of time that her shirt stayed in place. The Committee accepted her explanation, having regard to the frequency of her visits and repetitive actions of Dr. Raja at those visits. The Committee does not view this inconsistency as material.

Medical Record

Patient A claimed that she had a heart examination at almost every visit after Dr. Raja started to ask her to lie down, unless she was accompanied by her boyfriend or sibling.

The medical record shows that while examinations were done more often at the Bond Street location, there were a number of visits where there is no record of a CVS examination. Her boyfriend is noted as present on only one occasion, which was at the time when she was pregnant. It is not recorded whether the boyfriend came at other times, or whether her sibling accompanied her on some visits. The Committee noted this inconsistency, but finds it was not determinative. The Committee accepts that Patient A's evidence that the examinations occurred at every, or almost every, visit is inconsistent with the documentation in the medical record. It is clear, however, that six examinations were documented in the period from March to October, 2015 and there was an increase in the number of examinations over the trajectory of her care. The Committee did not consider this inconsistency material; it is the manner in which two of these examinations were performed which is at issue.

Memory Deficits

The Committee notes that Patient A had significant deficits in recalling precisely the dates. She was also unable to recall the clinic layouts at specific times, and did not recall seeing doctors other than Dr. Raja. She readily deferred to the medical record. She did not guess. At the initial appointment, she did not recall whether it was Dr. Raja or Mr. Mathews who saw her, but the Committee noted that there were only two men in the clinic. Mr. Mathews testified he does not do physical exams. In the context of her care at the methadone clinic, the Committee accepts that Patient A would likely not recall many of the above details, as this was not something that she focused on.

The Committee finds that, overall, Patient A was a credible witness, and that she gave an honest and truthful description of the examinations she experienced while under Dr. Raja's care. While the reliability of her testimony was hampered by her failure to recall a number of specific details, these were generally regarding peripheral issues and her failure to recall the details was understandable. The Committee finds that the reliability of Patient A.'s evidence regarding the core issues and events important to her was not impaired.

Credibility of Dr. Raja

Dr. Raja was direct and presented his evidence clearly. He said he had no specific recollection of touching Patient A. He examined her on her initial visit to the methadone clinic in February 2014 and followed her regularly on the MMP.

When he testified about the examinations he performed, he referred to Patient A's medical record and did not speak from his memory. His evidence based on the medical records was about what he would have done, not based on a specific memory of what he did in each examination. He was clear in giving his reasons for doing specific examinations.

Dr. Raja portrayed himself as a careful and caring physician. He explained that he was more sensitive than others, because of a delayed diagnosis involving a person with personal connection to him. The Committee noted that notwithstanding his claim of being concerned about missing something, the examination of Patient A's medical record shows a number of instances where Patient A had complaints, but he did not examine her (e.g., June 2014, July 2014, August 2014, April 2015, April 2015, and June 2015). In some circumstances, he referred Patient A to the family doctor or prescribed medication without an examination, but his evidence was the same in all instances: "examination was not warranted". Further, there were instances where examinations were performed when Patient A had no complaints (e.g. May 2015, July 2015, July 2015, and October 2015). On several of these visits, Patient A was in the early stage of pregnancy and the diagnosis and management of her pregnancy was in the hands of others. Dr. Raja testified that he wanted to rule out ectopic pregnancy, even in the absence of significant symptoms, as methadone can dull a patient's symptoms.

The Committee was not asked to make any findings about whether an examination was in fact required in these cases, but notes that the failure to perform an examination in these cases (as opposed to the cases in which he performed the examinations) is not consistent with Dr. Raja being an overcautious physician. The Committee does not accept that this

pattern of care is that of an overcautious physician and finds Dr. Raja's credibility to be impugned.

Dr. Raja has no recollection of touching Patient A, yet he maintained that he would never have touched her in the manner she described. In referring to all the examinations he performed, he spoke from what his usual standard of practice would be. His responses often appeared to be rehearsed. The Committee noted that in his communication with the College, Dr. Raja indicated that he could have inadvertently touched Patient A's breast. Dr. Raja testified about how he obtained patient consent. He explained that he wanted to make sure everything was fine and demonstrated with gestures, using his own body, as to what area he would be examining. He was adamant that he asked for patient permission on every occasion for every exam. The Committee does not accept this as realistic. The Committee finds, instead, Dr. Raja was superficial with Patient A, leaving her with no understanding of what his concerns were and why he specifically felt examinations needed to be done. The Committee viewed Dr. Raja's testimony on the issue as self-serving. In the Committee's view, this impacts his credibility after he portrayed himself to the Committee as committed and overcautious.

The Committee views as examples of questionable diligence the lack of notes to the family doctor; an office set up which was not conducive to physical examinations; no gowns or drapes; and a medical record which does not contain recorded blood pressure readings, or comments about pulse rate in the face of a patient complaining of a racing heart, and no throat/urine cultures done prior to prescribing antibiotics. While Dr. Raja was not directly questioned on these issues, the photographs illustrate the office was likely designed to function as a methadone clinic and not a family practice. This, again, puts into question Dr. Raja's credibility about being cautious and careful.

Dr. Raja testified that there was evidence that patients' trust was enhanced where methadone treatment and family practice were combined and that he embraced this as increasingly the norm. Nonetheless, it was clear from Patient A's medical records and her testimony that she understood she was seeing him for opiate substitution. Dr. Raja was

aware Patient A had a number of other caregivers to look after her other problems (family doctor, women's clinic, walk-in clinic, and obstetrician).

Dr. Raja was less than forthright when he raised suspicion that Patient A may have a personality disorder. He alluded to a lack of empathy when she appeared nonchalant in relating her friend's attempted suicide. He did not explore this further and left an unfavourable impression of her without foundation.

With respect to the CVS examinations he conducted, Dr. Raja was consistent and adamant that he did not touch Patient A's bra. However, the Committee is of the view that it would not be unreasonable to shift the bra or the breast to satisfactorily assess heart sounds, if one had real concerns about a cardiac problem. His response in this context appeared unrealistic to the Committee.

Therefore, the Committee, while recognizing Dr. Raja's consistent denial of the allegations, does not accept that he is a credible witness. His evidence was purposeful and self-serving. The Committee preferred the evidence of Patient A on the central issue of what happened during the examinations in question.

Medical Record

While Patient A's medical record does not indicate whether or not Dr. Raja lifted her bra during the course of examinations, the medical record clearly demonstrates that he had the opportunity to do so. Further, Patient A's course of care and weekly visits over the course of 19 months can explain her lack of specific memory of what went on at each of these visits. Patient A was not questioned about whether she had reviewed her chart prior to the hearing. Dr. Raja was questioned extensively on the medical record. He, likewise, had few specific recollections. He spoke from what he would have done in a similar situation or what his usual practice would have been.

Patient A's medical record indicates that up to March 2015, during the course of her 52 visits to the MMP, Dr. Raja performed two cardiac (CVS) examinations on Patient A

(January 2015 and January 2015). In neither case was she lying down, as the clinic set up at the time the two examinations were performed did not have an examination table. The need to repeat the CVS within two weeks is unexplained. During the period from March 2015 to October 2015, a total of six cardiac (CVS) examinations were recorded over the course of 30 MMP visits. Of the six CVS examinations recorded, there are two examinations recorded (June 2015 and July 2015) where the documentation suggests a more thorough cardiac examination was performed. This suggests some variability in the manner and extent of the CVS examinations performed.

Context of Practice

Patient A understood that Dr. Raja was her methadone doctor, yet he acted as a doctor of convenience. The Committee found it puzzling that Dr. Raja, who is familiar with family practice and treatment of methadone patients, would permit the apparent confusion in care responsibilities. This patient had a variety of health care providers, including a family doctor, hepatologist, obstetrician, and she attended a walk-in clinic and women's clinic. The resulting blurring of boundaries of responsibility resulted in a lack of coordinated care and a lack of communication among her health care providers which was not in her best interest. Dr. Raja should have been aware of this, yet he appeared to foster an expansion of the service he offered to Patient A. The Committee finds that this could only confuse Patient A in regard to her expectations and heighten her sensitivity when physical examinations were repeatedly performed for reasons that were not clear. This is consistent with her description of the examinations making her feel scared and uncomfortable.

Conclusion

Having regard to the respective credibility of the witnesses, and considering the totality of the evidence, the Committee finds that Dr. Raja in at least two examinations of Patient A had her raise her shirt above her bra, lifted the left side of her bra and exposed the left breast. He then listened to her heart sounds in four areas, which included touching the

periphery of her left breast with his stethoscope and pushing aside her breast for optimal skin contact.

Issue 2: Does Dr. Raja's conduct constitute sexual abuse and/or disgraceful, dishonourable or unprofessional conduct?

Sexual Abuse

To prove the allegations of sexual abuse, the College must lead evidence that the conduct at issue is sexual in nature. The College did not argue that the examinations performed by Dr. Raja were not medically indicated, or that insufficient consent was obtained. There was no expert evidence adduced by the College on these points.

In their position that Dr. Raja's conduct constituted sexual abuse, the College relied on the description of the physical examination, during which Dr. Raja first lifted the left side of Patient A's bra, which resulted in exposure of the left breast, and then performed a heart examination by auscultation of her heart with a stethoscope. The College also relied on Dr. Raja's statement on cross-examination that the exposure and touching Patient A described is inappropriate and sexual in nature.

The Committee accepts that the conduct described above occurred. The Committee further accepts that a women's breasts are private and of a sexual nature. Generally speaking, in the social context, there is a wide variety of opinion regarding exposure of a woman's breasts and a debate about when and where the exposure of a woman's breasts is acceptable. This is quite different, however, from the exposure of breasts in the context of a medical appointment in a doctor's office. In this setting, the patient trusts the physician will act in her best interest and act appropriately. When in a patient's sphere of intimacy, anything done that is not for the benefit of the patient is suspect and is reprehensible.

The Committee finds that Dr. Raja made his patient feel uncomfortable and exposed when he lifted her left bra. However, the Committee notes that there is no evidence that

Dr. Raja made any comments of a sexual nature. While he did raise her bra, there is no evidence to suggest he touched her breast in a sexual manner. The Committee notes that there was no fondling, massaging of the breast, squeezing, or touching of the nipple described.

Patient A testified she was under the impression that the purpose of the examination of her heart sounds was "to make sure everything is ok". Although not a requirement for a finding of sexual abuse, there was no sexual interest expressed.

Dr. Raja performed an examination of Patient A's heart, while she was recumbent with her left breast exposed. The Committee accepts that listening to the heart sounds in the four areas described by Dr. Raja is an acceptable focused cardiac examination. Examination of the heart in this manner with a stethoscope would involve placing the stethoscope close to the breast or at the periphery of the breast. In some cases, the breast would need to be pushed aside for optimal contact between the stethoscope and skin. For this reason, the Committee does not accept that Dr. Raja's statement on cross-examination that the exposure and touching Patient A described is inappropriate and sexual in nature is determinative. Instead, the Committee finds there is no sexual character to the examination as performed in this fashion.

There was no evidence adduced to suggest that Dr. Raja touched Patient A's breast in a sexual manner. While he may have touched her breast while carrying out the examination of her heart, such touching of the breast in this context does not constitute a violation of sexual integrity.

Patient A's response to this examination was that it made her feel very uncomfortable, threatened and scared. She did not confront him as she feared he might write something in her file, or take away some of the carries she had. She did not tell anyone in a position of authority as she did not think she would be believed. Her discomfort, while understandable and embarrassing, does not, in the Committee's view, mean that his conduct constituted sexual abuse.

Most importantly, in this matter, the complainant testified as to how she viewed what happened to her at the hands of Dr. Raja. In her complaint to the College following the mandatory report, she described the examination she experienced as inappropriate. Further, when on cross-examination, Dr. Raja's counsel noted that she told Dr. X's intake worker that she felt the examinations were inappropriate, but not actually an assault, Patient A acknowledged that she did not perceive Dr. Raja's conduct on those examinations as an assault.

The Committee is of the view that Dr. Raja's conduct in exposing Patient A's left breast during examination of her heart, while disrespectful and unthinking, was not of a sexual nature. Dr. Raja's approach appeared to have a mechanical quality, but was not of a sexual character. Flipping up the bra and exposing of the breast was certainly inappropriate, but does not, in the circumstances of this case, constitute convincing evidence of a violation of Patient A's sexual integrity, to support a finding of sexual abuse.

Conclusion

Therefore, the Committee finds the allegation of sexual abuse not proved.

In making this decision, the Committee notes that this decision would not preclude a finding of sexual abuse based on inappropriate exposure of a patient's breast in different circumstances.

Disgraceful, Dishonourable or Unprofessional Conduct

As to the allegation of disgraceful, dishonourable or unprofessional conduct, the Committee considered the following factors in reaching its decision:

- Dr. Raja failed to respect the privacy owed to his patient;

- The unanticipated exposure of her breast on its own constitutes a significant boundary violation;
- Dr. Raja was inconsiderate when he exposed Patient A's breast;
- Dr. Raja did not understand or disregarded how his actions would make Patient A feel;
- Dr. Raja's explanation to Patient A of why he needed to repeatedly listen to her heart sounds was unclear or nonexistent;
- Patient A was a particularly vulnerable patient, which makes a lack of respect for her dignity and privacy more egregious.

In failing to respect his patient's privacy by not offering appropriate draping and by unnecessarily exposing her left breast during examinations, Dr. Raja left his patient feeling uncomfortable and scared. She needed to understand why he was examining her. His explanations were superficial and left her wondering about his true motive. In his manner of examination, he had little regard as to Patient A's sensitivity or the embarrassment she might experience.

Conclusion

Having regard to these factors, the Committee finds the allegation of disgraceful, dishonourable or unprofessional conduct to be proved.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the finding made at the earliest opportunity.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Mohan Krishnan Raja, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name of the complainant, or any information that could identify the complainant 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.

This is also notice that the Discipline Committee ordered a ban on the publication of the name and any information that would identify the close relative of Dr. Raja referred to in evidence and exhibits at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 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. Raja, 2018 ONCPSD 22

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) f 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. MOHAN KRISHNAN RAJA

PANEL MEMBERS:

DR. M. GABEL (CHAIR)
DR. P. CHART
MS D. GIAMPIETRI
DR. E. STANTON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS E. GRAHAM

COUNSEL FOR DR. RAJA:

MS C. BRANDOW

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

Penalty Hearing Date:	April 20, 2018
Penalty Decision Date:	April 20, 2018
Penalty Reasons Date:	May 1, 2018

PUBLICATION BAN

PENALTY DECISION AND REASONS FOR DECISION

On November 27, 2017, the Discipline Committee found that Dr. Mohan Krishnan Raja committed an act of professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in his treatment of Patient A.

On April 20, 2018, the Committee heard evidence and submissions on penalty and costs and set out its penalty and costs order with written reasons to follow.

FACTS AND EVIDENCE

Agreed Statement of Facts on Penalty

The following Agreed Statement of Facts on Penalty was filed as an Exhibit at the hearing (Exhibit 12):

1. On June 3-4 2016, Dr. Raja attended a one-and-a-half day course on *Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship* through the Western University's Schulich School of Medicine and Dentistry. Dr. Raja's Post-Workshop Appraisal of Quality of Registrant Participation is attached at Tab A to the Agreed Statement of Facts on Penalty.

Other Exhibits

The Committee also received as exhibits a Victim Impact Statement (Exhibit 13) and a Brief of Letters of Support (Exhibit 14).

SUBMISSION ON PENALTY

Counsel for the College and counsel for Dr. Raja made a joint submission as to an appropriate penalty and costs order as follows:

1. Dr. Raja appear before the panel to be reprimanded.

2. The Registrar suspend Dr. Raja's certificate of registration for a period of two (2) months, to commence at 12:01 a.m. on May 18, 2018.

3. Dr. Raja pay to the College its costs of this proceeding in the amount of $22,000.00 within thirty (30) days from the date of this Order.

PENALTY DECISION AND REASONS

In considering the proposed order, the Committee was mindful of the principles which are well established in considering an appropriate penalty. In this matter, the principles of particular importance included denunciation of the misconduct, specific deterrence of the member, general deterrence of the profession, rehabilitation of the member where appropriate, and maintenance of public confidence in the profession and in the College's ability to regulate the profession in the public interest. The primary consideration and encompassing principle is protection of the public.

The Committee is also aware of the court's direction that a joint submission should be accepted by the Committee, unless the proposed penalty would bring the administration of justice into disrepute or is otherwise contrary to the public interest (*R v. Anthony-Cook*, 2016 SCC 43).

The Committee accepted the penalty proposed by the parties as appropriate sanction and commensurate to the misconduct found in this matter.

The reasons for the Committee's decision are set out below.

Aggravating Factors

Nature of the Misconduct

The complainant in this matter was particularly vulnerable, facing challenges related to her struggle with addiction and other medical and social issues. She was attending Dr. Raja for follow-up while on a methadone maintenance program. She did not understand why Dr. Raja exposed her breast while doing an examination of her heart. Dr. Raja intruded into her sphere of intimacy and left her feeling scared, threatened and embarrassed.

The Committee found Dr. Raja's conduct in examining Patient A to be unthinking and disrespectful. His explanation of why he needed to listen to Patient A's heart sounds was unclear or nonexistent. He failed to respect his patient's dignity and privacy and was insensitive and inconsiderate in exposing her breast.

Physicians need to have heightened awareness with regard to maintaining appropriate boundaries and need to show respect for modesty and body integrity. It is also necessary to provide sufficient explanation to patients to meaningfully communicate. Failure to do so results in patients' confusion about the possible motive for certain actions and sets the stage for negative consequences. Both maintaining appropriate boundaries and meaningful communication are integral to a healthy patient-doctor relationship and are necessary to ensure that public and patient trust is not eroded.

The nature of Dr. Raja's misconduct, which caused this patient to feel threatened and scared, is an aggravating factor in this case.

Victim Impact Statement

The Committee noted the following from the Victim Impact Statement, which illustrates the effect and some of the negative consequences that this patient experienced.

> *" I have lost all sense of security and well being when I attend a doctor appointment.*
>
> *Going to a doctor appointment is a very long and emotional process for me now. The day of the appointment I wake up feeling sick with anxiety. This feeling continues all day. When the time comes to leave I sit and debate about cancelling and whether or not it's actually important for me to go. At this point more than half the time I do in fact call and cancel my appointment."*

Mitigating Factors

There were a number of mitigating factors which the Committee acknowledged. Dr. Raja enrolled in the course on *Understanding Boundaries and Managing the Doctor-Patient Relationship.* Dr. Raja completed this course prior to the hearing and the comments made by the facilitator were very positive. Dr. Raja co-operated in coming to an agreement on penalty, thus shortening the penalty hearing. In addition, Dr. Raja has no prior discipline history with the College.

The Committee does not give substantial weight to letters of support, particularly when the writers may not be aware of the details of the misconduct. However, based on the information provided by nurses and colleagues, the Committee accepts that Dr. Raja has engaged in reflection and taken actions, which suggest that rehabilitation has been effective.

Case Law

The case law cited below illustrates a range of appropriate penalty and in the Committee's view, is consistent with the penalty proposed by the parties in this case.

In *CPSO v. Li*, 1996 ONCPSD 21, the misconduct involved a number of patients and was more egregious than that of Dr. Raja. The penalty order included a three-month suspension, a reprimand and a number of conditions aimed at remediation and a practice reassessment.

In *CPSO v. Wilson*, 2016 ONCPSD 46, the misconduct bore similar features to Dr. Raja's in that the conduct during an examination was not adequately explained. Physician insensitivity was a common feature in both Dr. Wilson's and Dr. Raja's case. There were significant aggravating factors in Dr. Wilson's matter, including a prior complaint to the CPSO resulting in a caution for similar behaviour. In addition, Dr. Wilson demonstrated a lengthy delay in completing advised remediation. The penalty order included a four-month suspension.

In *CPSO v. Choptiany*, 2011 ONCPSD 29, the misconduct related to failing to maintain respectful boundaries in performing examinations of an intimate nature, and failing to explain and ensure that his patient was comfortable in what he was about to do. Similar to Dr. Raja, Dr. Choptiany undertook voluntary remediation. A two-month suspension was ordered.

Conclusion

For the reasons stated above, the Committee concluded that the penalty proposed by the parties in this matter is fair, reasonable and proportionate.

ORDER

In its written order of April 20, 2018, the Committee ordered and directed on the matter of penalty and costs that:

1. Dr. Raja appear before the panel to be reprimanded.

2. The Registrar suspend Dr. Raja's certificate of registration for a period of two (2) months, to commence at 12:01 a.m. on May 18, 2018.

3. Dr. Raja pay to the College its costs of this proceeding in the amount of $22,000.00 within thirty (30) days from the date of this Order.

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

TEXT of PUBLIC REPRIMAND

Delivered April 20, 2018

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. MOHAN KRISHNAN RAJA

Dr. Raja,

One of the basic principles of being a physician is the respect we have to our patients. It is one of the factors in their care and healing. This respect is shown in both in our words and in our actions. The more vulnerable a patient may be due to their circumstances and illness, the more aware it is to be necessary in our caring interactions.

You failed in many ways to honour this basic precept, and in doing so caused harm and emotional pain. You failed to explain in a manner understandable to the patient what you were going to do, how you were going to do it, and basic care to provide coverings to maintain modesty and body integrity.

While your patient did not express that she felt sexually violated, you did violate her physical and emotional space by the way you examined her. This was a failure on your part and we express our disappointment and our dismay.

We are also aware that you've made strides in understanding the issues, changing your behaviour, and that we expect going forward that you will continue to be attentive to your communications and interactions with your patients. We hope this process and your reflection on your behaviour will result in your heightened awareness of how you perform as a physician and will allow you to help your patients by not only good medical practice, but by respect and caring interactions.