NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Sherapartap Singh Rai, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity or any information that could identify the patient under subsection 47(1) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 45 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. Rai, 2016 ONCPSD 1**

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. SHERAPARTAP SINGH RAI

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MR. S. BERI
DR. E. STANTON
MS. D. DOHERTY

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. M. KELLYTHORNE

COUNSEL FOR DR. RAI:

MR. T. FISHER

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Hearing Dates on Finding: July 27 to 29, 2015
Decision Date on Finding: January 19, 2016
Release of Written Reasons on Finding: January 19, 2016

Penalty Hearing Date: May 6, 2016
Penalty Decision Date: May 6, 2016
Release of Written Reasons on Penalty: July 20, 2016

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 27 to 29, 2015. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

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

1. under clause 51(1)(b.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, 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*, 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. Rai denied the allegations in the Notice of Hearing.

FACTS AND EVIDENCE

(a) Overview of the Issues

Dr. Rai and Ms. A were in a continuous sexual relationship from January 2007 until approximately 2011. They were married in the United States in 2009.

During the period of their relationship, Dr. Rai treated Ms. A nine times at the Emergency Room (ER) of the local hospital when he was working there as the emergency physician on duty. He treated her once in a walk-in clinic about eight months after their relationship began. Dr. Rai did a Pap test and ordered some blood work for her on that occasion.

Subsection 1(3) of the Code defines "sexual abuse" of a patient by a member as:

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 a member, or
c) behaviour or remarks of a sexual nature by the member towards the *patient.*

[Emphasis added]

It is not disputed that Dr. Rai and Ms. A engaged in the type of sexual acts that are captured by subparagraph 1(3)(a) of the Code. However, as emphasized, to fall within the meaning of the sexual abuse as defined in the legislation, the Discipline Committee must find that the sexual relations occurred between a physician and a patient. The Discipline Committee cannot make a finding of sexual abuse if a physician engages in sexual relations with someone who was not a patient at the time that the sexual relations took place.

This case raises two issues:

1) Was Dr. Rai in a doctor-patient relationship with Ms. A at the same time he was in a sexual relationship with her?
2) Did Dr. Rai engage in conduct that would reasonably be regarded by members as dishonourable, disgraceful, or unprofessional?

(b) Summary of the Evidence

The Committee heard from three witnesses called by the College: Ms. Z, who is the current Emergency Room (ER) supervisor at Hospital 1; Ms. A, who was Dr. Rai's second wife and partner; and Dr. Rai's first wife, Dr. B.

Many of the facts are undisputed: Ms. A and Dr. Rai had a sexual relationship. It is also undisputed that Dr. Rai assessed, diagnosed and treated Ms. A on one occasion in a clinic and on nine occasions at Hospital 1's ER over a number of years.

The Committee received into evidence copies of Ms. A's clinic file, her ER visits, and her Ontario Health Insurance Plan (OHIP) records, all of which were filed on consent as business records under Section 35 of the *Evidence Act*.

Other exhibits included the divorce decree between Dr. Rai and his first wife and a wedding certificate from the marriage of Dr. Rai and his second wife, Ms. A, in 2009.

Ms. Z

Ms. Z is a nurse practitioner who works as the ER Director at Hospital 1. She testified that there are a total of four hospitals in the region. Hospital 1 is the only hospital in this particular town in Ontario. There are three other hospitals that are 45 minutes to one hour away.

Ms. Z testified that, from 2007 to 2010, there were about 14 physicians who worked in Hospital 1's ER, some of them full-time and most of them part-time. Usually there was only one physician on duty in the ER at that hospital.

Ms. Z testified that there were criteria in place to determine whether a second physician should be called in to work if the ER was busy. These criteria included a wait time longer than four hours and more than 14 patients waiting to be seen. She testified that sometimes they were unable to fill the call list, implying that there were times when there would not be a second physician to call in. In addition, there were nurse practitioners who worked from 10 a.m. until 10 p.m., six days a week. On Sunday, the nurse practitioners would work from 12 noon to 8 p.m.

Ms. Z explained that a triage nurse assesses a patient attending the ER and assigns them a triage score from 1 to 5, based on the Canadian Triage Acuity Scale (CTAS). A score of 1 indicates that the patient has no vital signs and requires resuscitation. A score of 2 or 3 is an urgent case. A score of 4 or 5 is less urgent, and such a patient may see the nurse practitioner, if one is available. Ms. Z testified that it is the triage nurse who assesses the patient and decides whether the patient sees a doctor or nurse practitioner.

Ms. Z testified that, if the doctors change shifts, and a doctor other than the one noted on duty on the original ER form sees the patient, the second doctor crosses out the previous doctor's name and inserts his own.

Ms. Z had no knowledge of Dr. Rai's schedule in the years 2007 to 2010, nor did she have knowledge of his OHIP billings. She testified that the ER Record belonged to the hospital and could not be removed by the attending doctor.

Ms. A

Ms. A testified that she met Dr. Rai when she was 20 years old. She said that in January 2007 she began a sexual relationship with him. From then on, they were together as a couple.

Ms. A understood that, at the time, Dr. Rai was separated from his wife and that she was studying in New York City. In October 2009, Ms. A and Dr. Rai were married in Las Vegas. There was some turbulence in their relationship but despite the problems. they continued their relationship until approximately the fall of 2011.

Ms. A testified that she had had several pregnancies with Dr. Rai, but they all resulted in either miscarriages or abortions.

Ms. A testified that she never had a family doctor nor did she ever tell anyone that Dr. Rai was her family physician. When she needed care, she said she went to a walk-in clinic or to Hospital 1's ER.

An OHIP billing in Dr. Rai's billing number exists for Ms. A dated May 2009, which included a minor assessment and a Pap test. Ms. A said that she did not recall attending Dr. Rai on this date. She testified that she went to the clinic to get her record for this visit, and discovered there was no record of her being there that day.

The Committee found Ms. A to be a credible and reliable witness. Her testimony was straightforward and, although there were parts of her testimony that were less than

flattering to her character, she was straightforward in recounting them. Ms. A appeared to have no animosity toward Dr. Rai and, when asked, she stated that she did not feel sexually abused by him.

Ms. A's Patient Encounters with Dr. Rai.

The Committee heard detailed evidence of the following:

- one walk-in clinic visit with Dr. Rai at a walk-in clinic; and
- a number of emergency attendances at Hospital 1's ER when Dr. Rai was the ER physician on duty.

August 2007

Ms. A first saw Dr. Rai in August 2007 at a walk-in clinic. Ms. A testified that she wanted to have a Pap test done. She discussed this in a non-medical setting with Dr. Rai because she felt comfortable seeing him for that procedure. After asking him where he would be working that day, she attended at the walk-in clinic where he was on duty. Dr. Rai performed a Pap test on Ms. A. There was no evidence presented to suggest that Dr. Rai tried to dissuade Ms. A from seeing him for the Pap test.

Clinical notes from that encounter indicate that Dr. Rai did the Pap test and ordered some blood work related to the fatigue that Ms. A complained of. There is a note in handwriting, that does not appear to be Dr. Rai's, indicating that payment was made for that visit.

October 2007

Ms. A testified that she went to the Caribbean in September 2007 and returned to Canada in October 2007 for medical care. She was having pain and came to the ER of Hospital 1 in October 2007 at 8:05 p.m. The triage nurse assigned Ms. A a score of 4, meaning less urgent. However, on the top of the ER form, Ms. A's triage was listed as "urgent." It is

the triage nurse who decides whether the patient should see the ER physician on duty, and Ms. A was referred to Dr. Rai as the ER physician on duty at that time.

According to the ER record, Ms. A was seen by Dr. Rai, who completed tests and diagnosed her with right lower quadrant (abdominal) pain. There was the question of an ectopic pregnancy. Dr. Rai did some investigations and told Ms. A to return in the morning for an ultrasound of the pelvis. He also gave her instructions regarding the risk associated with rupture of an ectopic pregnancy and bleeding. She was discharged home in the company of a family member, according to the ER record.

October 2007

Ms. A returned the following morning at 11:30 a.m. and was triaged as level 3 or emergent, according to the ER record. Dr. Rai diagnosed an ectopic pregnancy rupture. Ms. A was referred to a surgeon who subsequently performed abdominal surgery and removed the ectopic pregnancy by conservative manipulation of the fallopian tube.

March 2008 (first visit)

According to the ER record, Ms. A attended at the ER because of abdominal pain that she had had for four days. Ms. A testified that she went to the ER at 9:29 p.m., because the pain had gotten worse and she said that she had nowhere else to go. She was triaged as 4, or less urgent, and according to the triage nurse's note, Ms. A told the nurse about her previous ectopic pregnancy. Dr. Rai was the ER physician on duty, and attended Ms. A on that visit, according to the records. Dr. Rai diagnosed pregnancy, and he wanted to rule out another ectopic pregnancy. He ordered blood work as well as a follow up ultrasound of the pelvis that Ms. A had in March 2008, according to the medical records.

March 2008 (second visit)

Ms. A attended Hospital 1's ER again in March 2008 at 6:30 a.m. She denied that she had arranged this visit ahead of time with Dr. Rai. She was triaged at level 4, or less urgent, and was assigned to be seen by Dr. Rai. She continued to have pain in her lower left quadrant of the abdomen. The findings on ultrasound of March 2008 were compatible for

a normal uterine pregnancy, but inconclusive for another ectopic pregnancy. The radiologist suggested that Ms. A have further blood tests and another ultrasound in seven to ten days. Dr. Rai examined Ms. A and ordered the tests that the radiologist had suggested.

March 2008 (third visit)

According to the clinical records, Ms. A went to Hospital 1's ER around midnight in March 2008 because she was nauseous and vomiting. The triage nurse did not give her a formal triage score, but the ER report listed her condition as less urgent. Ms. A was assessed and referred to Dr. Rai, who examined her. She was six weeks pregnant. She was examined, diagnosed with dehydration, and treated.

July 2008

Ms. A testified that she could not move her fifth finger after cutting it on glass a few days before while she had been out of the country on vacation. She recalled discussing the problem with Dr. Rai and the fact that she could not move it, but she did not recall whether he told her to come to the ER. Ms. A attended the ER, and, according to the clinical record, she was given a triage score of CTAS 5, or non-urgent. However, she was referred by the triage nurse to see Dr. Rai, who examined her finger and referred her to a plastic surgeon for consultation. She also received a tetanus shot.

November 2008

Ms. A went to the ER on this date complaining of left flank pain and urinary tract symptoms. She arrived in the ER at about 7 p.m. and had a CTAS score of 3, or urgent. Dr. Rai examined her, ordered investigative tests, and treated her for pyelonephritis or a kidney infection.

February 2010

Ms. A attended the ER at 10:12 p.m. complaining of abdominal pain. She was triaged with a CTAS score of 4, or less urgent. Dr. Rai examined her and ordered investigations.

She was discharged within an hour, and the diagnosis was "abdominal pain, not yet diagnosed."

November 2010

Ms. A testified that she had no recollection of this visit to Hospital 1's ER. However, the ER record indicates she attended at 1:30 p.m. and was complaining of low back pain and difficulty sleeping. She was given a CTAS score of 3, or urgent. Dr. Rai examined her and diagnosed her with muscular back pain. He prescribed medication for her that was given in the ER. She was discharged within about 15 minutes.

Dr. B

Dr. B is the ex-wife of Dr. Rai. They were married in 2001 and their divorce was finalized in 2012. They have two children. Dr. B studied in the U.S. During her studies there, their children lived with Dr. Rai's parents in a city in Ontario.

In October 2007, Dr. B discovered that her husband was cheating on her with Ms. A. Dr. B then separated from him. She never returned to their home after 2008, although prior to 2008, she testified that she had seen makeup and evidence of another woman living there. She testified that Ms. A would sometimes answer the phone.

Dr. B testified about her husband's heavy work schedule. She testified that his superiors warned him that he was going to burn out. He was doing his residency and working 18 hours a day sometimes in walk-in clinics and ERs. She said that Dr. Rai was working in the ER five to six nights a week. Although it was suggested in cross examination that Dr. Rai was under a lot of pressure because of family demands for financial support because his sister was getting married, Dr. B testified that she was not sure about this since she was not living in the area.

Following the divorce, Dr. B was awarded custody of their children. After Dr. Rai was enrolled in the Physician Health Program through the Ontario Medical Association, there was a period of time where he had only supervised access with the children. However,

Dr. B testified that she has seen an improvement in her ex-husband and has no difficulty with the fact that he now has unsupervised access. She testified that their relationship is currently polite, and that they focus on the welfare of the children.

The Committee found Dr. B to be credible and reliable in her testimony. She was straightforward and did not appear to embellish any details of the turmoil of her relationship with Dr. Rai prior to their divorce. She appeared to have no animosity toward him.

The Law, Legal Issues, and Findings

Legal Principles

The Committee recognizes that the College has the onus of proving the allegations against Dr. Rai to the requisite standard of proof, on the balance of probabilities. The evidence must be clear, cogent and convincing in order to satisfy this test.

The relevant legislation governing sexual abuse is outlined earlier in this decision. As stated in *Leering,* the purpose of the provisions of the Code is to prevent a health care professional from using the power imbalance between him and the patient to obtain consent to sexual activity. Sexual abuse has been held by the courts to occur where there is a concurrence of a sexual relationship and a physician-patient relationship. There is no need for further inquiry once those factual determinations have been made.

As outlined in the College's policy, "Maintaining Appropriate Boundaries and Preventing Sexual Abuse," trust is the cornerstone in the physician-patient relationship. When a patient seeks care from a physician, the patient trusts that the physician is a professional and, as such, will treat the patient in a professional manner. When a physician sexualizes the relationship, it is a clear breach of trust.

The policy also states that a power imbalance exists in the doctor patient relationship in favour of the physician. The physician is in a position of trust and power, and is duty-bound to act in the patient's best interests. Sexual activity and romantic interactions

interfere with that relationship. The legislation was enacted to protect the patient from sexual abuse by physicians. The legislation, together with the policies of the College, contributes to the protection of the public.

It is not disputed that Ms. A and Dr. Rai were in a sexual relationship, and had been for several months before he saw her for the first time at a walk-in clinic and subsequently, in the ER for nine visits over three years.

The overarching issue in this case is whether or not the medical treatments were incidental to the spousal relationship or whether the medical treatments gave rise to a physician-patient relationship, with Ms. A as Dr. Rai's "patient" within the meaning of the Code.

Treatment of a Spouse by a Physician

The Ontario Court of Appeal in *Mussani* agreed with the conclusion of Justice Then, who stated at paragraph 153 of the Divisional Court decision in the same case that:

> "Interpreting "patient" for the purposes of a s. 51 (5) 2 of the Code as including a spouse would be an unreasonable interpretation of the legislation. The sanction in s. 51(5) 2 is ordered if "a panel finds a member has committed an act of professional misconduct by sexually abusing a patient." It is far fetched to characterize the intimate relationship between spouses as 'sexual abuse' merely because a physician may have treated his or her spouse."

The Appeal Court then elaborated at paragraph 101:

> "The fact that during the course of a marriage a physician may provide incidental medical care to his or her spouse is unlikely, in my view, to establish a physician/patient relationship which could attract the discipline procedures of the Code."

The Committee looked at the issue of whether or not Ms. A was a patient through the lens of previous jurisprudence in *Leering* and *Mussani*. The courts clearly state that it would be unlikely that a spouse would be considered a patient, and that it would be far-fetched to characterize an intimate relationship as sexual abuse merely because a physician

provided incidental treatment to his spouse. In the view of the Committee, this would include a common-law spouse.

What is Incidental Medical Care?

The Court of Appeal in *Leering* considered the definition of "incidental." Black's Law Dictionary defines it as "subordinate to something of greater importance; having a minor role," while the Oxford English Dictionary's definition is "occurring or liable to occur in fortuitous or subordinate conjunction with something else of which it forms no essential part; casual."

As discussed in *Leering*, incidental medical care refers to conduct that is minor in nature, casual, or arising in a fortuitous conjunction with the spousal relationship. Examples included where a doctor and her spouse are in an accident and the doctor provides on-the-spot emergency care to her spouse; or where a chiropractor's spouse suffers a muscle spasm and the chiropractor performs a manipulation in order to provide immediate relief. It would be unreasonable for the spouse to be denied treatment in such circumstances, according to the Court of Appeal in *Leering*.

The courts have held that incidental care does not refer to frequency of care; however, the courts have stated that where medical treatment is provided on a regular basis by appointment in an office and where payment is expected, it is most unlikely that such treatment would be considered "incidental."

How is "Patient" Defined?

The *Code* does not define "patient."

The *Mussani* case gives some guidance on this issue. The Court of Appeal of Ontario agreed with Justice Then of the Divisional Court, who stated at paragraph 84 of Then's decision that:

> "To the extent that "patienthood" is not obvious in a given circumstance, it is a factual inquiry that is subject to interpretation by the tribunals and the courts. There is nothing about the impugned provisions that prevents a court or tribunal from giving sensible meaning to their terms."

The Committee considered all of the facts and circumstances in order to determine whether Ms. A in her spousal relationship with Dr. Rai was also a patient of Dr. Rai. In considering this case, the Committee looked at precedents from the College, and sought guidance from the Ontario Court of Appeal in *Leering* and *Mussani*. The facts in *Leering* were most analogous to the present case, as that chiropractor had been in a relationship with a woman whom he subsequently treated. The context and details are important for the Committee to consider.

In *Leering*, the Discipline Committee of the College of Chiropractors of Ontario ("Chiropractors Discipline Committee") had found that Dr. Leering was guilty of professional misconduct for having sexually abused a patient. The Chiropractors Discipline Committee revoked his certificate of registration pursuant to the zero-tolerance, mandatory revocation provision in the Health Professions Procedural Code.

In *Leering*, Dr. Leering met the complainant in 2004 and they moved in together in 2005. A month later, the complainant began regular chiropractic treatments with Dr. Leering. She received 28 treatments between April and October 2005. Dr. Leering billed her and, although she did not actually pay him, he marked her bills as paid and she in fact submitted them to her insurer for reimbursement. When she received the money, she passed it along to Dr. Leering. Their romantic relationship ended in October 2005. When Dr. Leering attempted to collect the balance owing for his chiropractic services to the complainant, his former partner made a complaint to the College of Chiropractors of Ontario.

In the *Leering* case, the chiropractor was in a committed sexual relationship with the complainant before she became his patient. It was not disputed that the complainant and the chiropractor were in a doctor-patient relationship. In the present case, Dr. Rai disputes that Ms. A was his patient within the meaning of the Code.

In his case, Dr. Leering argued that, because the sexual relationship began before the complainant became his patient, the zero tolerance/mandatory revocation policy should not apply. The Chiropractors Discipline Committee rejected his argument, holding that the key concern in sexual abuse cases is the protection of the public, which applies no matter when the patient relationship commences in relation to the sexual relationship. The Chiropractors Discipline Committee adopted the reasoning of *Rosenberg v. College of Physicians and Surgeons of Ontario* (2006), 275 D.L.R. (4th) 275. In *Rosenberg*, if the Discipline Committee were to create a "spousal exemption," they would be concerned with examining and deciding whether a relationship qualified as "spousal" rather than focusing on the central question posed by the legislation – namely, whether there was a concurrent sexual and physician-patient relationship.

This Committee panel fully accepts that there is no general spousal exemption under the Code.

Several factors convinced the Chiropractors Discipline Committee in *Leering* case that the complainant was indeed a patient. These included:

- the doctor-patient relationship was not disputed;
- the chiropractor opened a patient file and included a history, physical examination, diagnosis, plan of management, prognosis, diagnostic imaging reports, and a written record of treatments;
- the complainant completed a consent-to-treatment form;
- the chiropractor began billing immediately;
- the chiropractor wrote a letter referring to her as his patient;
- the chiropractor wrote a formal patient discharge letter;
- the chiropractor recorded her information in financial records;
- the chiropractor filed an insurance claim for orthotics for the patient;

- the chiropractor wrote a consultation letter to the patient's primary physician;
- the chiropractor made written statements to the complainant referring to her as his Ms. And his clinical patient; and
- the chiropractor wrote an e-mail to the complainant setting out his terms of treatment for her with regards to following his advice, and informing her that she would be discharged from treatment if she did not do so.

Was Ms. A a Patient of Dr. Rai?

In considering whether Ms. A was a patient of Dr. Rai, the Committee was guided by the above factors as well as those outlined in the College of Physicians and Surgeons of Ontario v. Redhead (2014), as taken from College of Physicians and Surgeons of Ontario v. Rabin (2003). These factors include:

- whether the physician had a patient file for the patient, including history, physical examination, diagnosis, plan of management, prognosis, diagnostic imaging reports, and a written record of treatments;
- whether there were OHIP billing records for services provided by the physician to the patient;
- the number and nature of treatments received by the complainant from the patient, and the location in which those treatments were received;
- whether any of the medical services involved psychotherapy;
- whether the complainant ever received a consent-to-treatment form;
- whether there was any documentary evidence in which the physician referred to the complainant as his or her patient;
- whether there were any letters of consultation written to the complainant's primary physician;

- whether there were any letters reporting back to the physician about the complainant;

- whether the complainant was seeing other physicians, and, in particular, whether the complainant had her own family physician when the sexual relationship began;

- whether the physician referred the complainant to other professionals; and

- whether the physician prescribed medication to the complainant under his or her signature.

The Committee considered the context and nature of Ms. A's treatment by Dr. Rai with above factors in mind about what characterizes a doctor-patient relationship and what characterizes the incidental medical care of a spouse.

Context and Nature of Dr. Rai's Treatment of Ms. A

In this case, there was no evidence that Dr. Rai provided *regular* care for Ms. A with office appointments for which there was payment. There is no evidence that Dr. Rai possessed a file for Ms. A that included her medical history, plan of management, a summary of diagnostic tests, or treatment options. Dr. Rai did complete clinical notes for her in the ER record as well as for the one walk-in clinic visit.

Since ER visits are billed differently from direct billings to OHIP, there were no OHIP billing records. However, it appears from the OHIP records that Ms. A's visits to ER were recorded. There is no OHIP record for the visit to the walk in clinic in August 2007, even though the clinical note has a "paid" in handwriting beside Dr. Rai's note.

Two other OHIP billings are noted for Ms. A dated May 2009 but no clear evidence was brought to show that Dr. Rai in fact saw Ms. A on that occasion. Although business records are *prima facie* proof of OHIP billing in Dr. Rai's name, the Committee did not conclude that Dr. Rai himself or a secretary billed OHIP. Clerical errors abound in the

Hospital records, as the Committee heard in the testimony of Ms. Z. There is conflicting evidence in this instance as well. The Committee heard evidence from Ms. A that she went to the clinic where the billing took place. That clinic had no record of her visit, nor did they have a chart for her. She also testified that she has no memory of any such visit at the clinic. The Committee finds that the May 2009 visit did take not place, given the lack of clear, cogent evidence, and the evidence that contradicts this billing notation.

Furthermore, in the clinical record, there was no history of psychotherapy, no consent to treatment forms, and no reference to Ms. A as his patient. Some ER forms did list Dr. Rai as Ms. A's family doctor, but the Committee did not place much weight on this evidence, as there were numerous errors in the ER records, as per the testimony of Ms. Z. As well, Ms. A also denied that Dr. Rai was her family doctor or that she ever referred to Dr. Rai as her family doctor.

Some test results listed Dr. Rai as the "interested party" (presumably instead of "referring doctor"), as those tests were the ones he had ordered from the ER. Dr. Rai did no letters of consult, although he did ER referrals of Ms. A in 2007 to a gynecologist and in 2008 to a plastic surgeon. There are no references to her as his patient. He gave her no prescriptions, although he did order two medications to be given in the ER in November 2010 when she came in for back pain.

The Committee considered the number and nature of clinical visits by Ms. A to Dr. Rai. In summary, she saw Dr. Rai on one occasion at a walk in clinic about eight months after they began their romantic relationship. The evidence was that Ms. A discussed with Dr. Rai ahead of time the fact that she wanted to have a Pap test. Ms. A told him that she would feel comfortable seeing him for the pelvic examination. This visit will be referenced later in the Committee's decision.

Ms. A was seen by Dr. Rai on nine occasions in the ER. In fact, the evidence suggests that she only saw Dr. Rai, and never any other physician. The Committee heard no evidence that the visits were arranged with Dr. Rai ahead of time, or that there was another physician available in the ER to see her when she visited.

The Committee looked at the nature and context of Ms. A's ER visits. All of them were at Hospital 1's ER, the only hospital in the small town. Although Ms. Z testified that there were three hospitals within a 45 minute to one hour drive away, Ms. A testified that she had nowhere else to go for care once the walk-in clinic was closed. The nature of Ms. A's complaints in attending Hospital 1's ER precluded those options, in the Committee's view.

When Ms. A attended the ER in October 2007, there was a question of an ectopic pregnancy. She had abdominal pain such that it hurt to move or cough. The Committee considered that it was appropriate for her to seek care at the local hospital. Once she was in Dr. Rai's care at the ER, it was appropriate for him to ensure that she was stable and to arrange for follow-up tests and an ultrasound of the pelvis. According to the clinical notes, after Dr. Rai explained to her the risk of a rupture of the pregnancy and a hemorrhage, she was allowed to return home with her family member.

Ms. A returned to the ER the next day where she was assessed again, had a consult with the gynecologist, and subsequently had laparoscopic surgery to deal with the ectopic pregnancy. In the Committee's view, this appointment was an appropriate follow-up. Although it was less than ideal that the man responsible for Ms. A's pregnancy was assessing and treating her problem, it was his duty to do so once she had entered the ER, given the seriousness of the problem and the potential for dire consequences. Even if Dr. Rai had wanted to transfer her to another hospital, he still had to do the initial assessment and provisional diagnosis of her problem in order to assess whether she was safe to be moved. Ms. Z discussed the protocol for calling in another physician and there was no evidence that the protocol criteria were met to justify calling in a second ER physician, if one was available.

In March 2008, when Ms. A attended again at Hospital 1's ER, the ER record indicates that she again had abdominal pain and that she told the triage nurse about her previous ectopic pregnancy. Her pregnancy test was positive. Dr. Rai was on duty in the ER. He recorded a history of the problem and completed investigations to rule out an ectopic pregnancy. The Committee considers this visit an appropriate one for the same reasons outlined above.

Later on in March 2008, Ms. A returned to the ER at 6:30 a.m., four days after her last visit. According to the triage note, the patient returned in order to get a second ultrasound as the one completed from the March 9 visit was inconclusive about whether or not she had an ectopic pregnancy. Ms. A had no family doctor, and it was appropriate that she had follow-up regarding a problem that was initially investigated in the ER in March 2008.

Ms. A arrived in the ER after midnight on a third date in March 2008, and told the triage nurse that she was pregnant and that she was feeling light-headed with nausea and vomiting. Dr. Rai diagnosed dehydration, and she was sent home after investigation and treatment. The Committee considered that it was appropriate that Ms. A be seen at her local hospital, given her presenting symptoms, as it was not clear what the problem was until she was examined.

In the July 2008 visit, Ms. A went to the ER about a finger that had been cut on holiday in Florida a few days earlier. She went to the ER and was referred to Dr. Rai as he was the ER physician on duty. He arranged an appointment with a plastic surgeon. The Committee considered this as incidental care, as the main remedial need was for a plastic surgeon to repair her injured finger.

Ms. A's visit in November 2008 was rated as an urgent visit, and she saw Dr. Rai, who was the ER physician on duty. Dr. Rai completed an examination, investigation and treatment for pyelonephritis, and Ms. A was then discharged home. Ms. A was ill, as noted by the triage score of 3. It was appropriate for Ms. A to be seen in her local hospital for this problem, as it was easily treated, according to the clinical record.

On her next visit in February 2010, about 15 months later, at 10:05 p.m., Ms. A arrived at the ER with diffuse abdominal pain. According to the ER record, she had a triage score of 4, or less urgent. She had a previous self-inflicted abdominal injury almost two months previously and she questioned an abscess. Dr. Rai was the ER physician on duty. He completed appropriate examinations and tests on Ms. A, and then discharged her home. The ER unit was Ms. A's closest option for medical attention, and was appropriate.

Her next visit was in November 2010 at 1:35 a.m. for back pain that was preventing her from sleeping. The nurse assigned her a triage score of 3, or urgent. Dr. Rai was the ER physician on duty. He assessed her problem, did appropriate investigations, and treated her muscular back pain with two medications that were given in the ER. Ms. A attended the closest hospital and the Committee viewed it as reasonable for Dr. Rai to treat her urgent problem when she was in pain.

Dr. Rai was the only ER physician on duty each time Ms. A attended the ER. The Committee heard no evidence to suggest that Ms. A's visits to the ER were orchestrated by Dr. Rai. She had legitimate medical problems, according to the clinical records. On two visits – October 2007 and March 2008 – Ms. A was attending at the ER to follow up on medical problems from previous ER visits. Of her remaining six ER visits from 2007 to 2010, Ms. A had medical issues that warranted medical attention, whether from Dr. Rai or someone else in the ER.

The Committee heard testimony about the criteria for calling in a second physician to the ER of Hospital 1. There was no testimony that this was even considered in these instances, or whether a second physician had been available on the roster. Although it was not optimal that Dr. Rai was examining and treating his spousal partner, the visits were legitimate visits to a small town ER. Even if he elected not to treat her and to instead send her elsewhere by ambulance or even private transportation, he had a duty as an ER physician to examine her and ensure she was in stable condition before sending her elsewhere.

Evidence was presented that Dr. Rai was working long hours, and that he covered five to six nights per week Hospital 1's ER at that time. Given the context of the small town ER, Dr. Rai had no choice but to attend to Ms. A's medical needs and to provide care for her problems.

The Committee finds that these ER visits constitute incidental care to a spouse, given the nature of the visits and the unique set of circumstances in this case. None of the visits were part of regular care, where appointments were made in an office, and none were part of ongoing care, as in the cases in *Leering* and *Rosenberg*. There is no indication that Dr.

Rai had the ER forms sent to him as her family physician or that he had a master chart for her in another location. Although some of the ER visits were not the highest level of urgency as shown by the CTAS score, they were nonetheless urgent in the patient's view. In the Committee's view on the clinical record, this is a distinguishing feature. The Committee does not find that Dr. Rai's treatments in the ER visits gave rise to a doctor-patient relationship in this context.

The Committee finds that the July 2008 visit to the ER for an immobile finger and the August 2007 visit for the Pap test constituted incidental care of a spouse. Although the Pap test may be considered more invasive and required a specialized table and instruments to perform, there was no evidence that it was repeated over the years. It was ill-advised of Dr. Rai to do this test at Ms. A's request. However, the fact this occurred one time only, and the fact that Ms. A had no family doctor, contributed to the Committee's finding that Ms. A and Dr. Rai were not in a doctor-patient relationship for these treatments. The Committee considers both of the above treatments to be incidental in nature. There is a marked difference between the contexts of these two clinical encounters with those reported in the *Leering* case.

Although College counsel argues that not finding an ER visit establishes a doctor-patient relationship would create an abyss and allow for doctors who treat patients in the ER to subsequently make sexual advances to the patient at the time or shortly thereafter, the Committee disagrees. If doctors are not given some latitude in treating their married or common-law spouse in the ER, if necessary, a pall would be cast over all the ERs in small-town Ontario. Doctors would be torn between treating their spouse in urgent situations and facing sexual abuse allegations. Common sense, therefore, must prevail.

In summary, the allegation that Dr. Rai committed an act of professional misconduct by engaging in sexual abuse with his patient has not been proved to the requisite standard. A prima facie case was not established on the evidence, and, accordingly, the Committee does not draw an adverse inference from the failure of the physician to testify.

The Committee finds that the single visit to a walk-in clinic for a Pap test and blood work, secondary to fatigue, is incidental care in the context of their intimate relationship.

There is no convincing evidence that Pap tests or other routine care were repeated, or scheduled. However, although Dr. Rai was relatively new to practice in Ontario at the time, he is not absolved of his responsibility with regard to treating family members.

The College's policy, "Treating Self and Family Members," states that physicians should not treat themselves or family members except for minor conditions or in an emergency situation, and only when another health care professional is not available. These conditions were not present when Dr. Rai did a Pap test and ordered blood work for Ms. A at a clinic visit in August 2007. As stated in the College's policy, when a physician treats someone with whom they have family relationship, there is a risk that the relationship will affect the doctor's ability to provide quality care. In general, physicians should refrain from treating family members or their partners. The Committee finds that, when examining Ms. A in a non-emergency situation for a Pap test and other blood work for fatigue, Dr. Rai engaged in behaviour that was disgraceful, dishonourable or unprofessional. Therefore, the allegation of professional misconduct is proved in relation to this single clinic visit.

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 January 19, 2016, and found that Dr. Rai has committed an act of professional misconduct in that he 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. After hearing evidence and submissions on penalty and costs on May 6, 2016, the Committee made an Order with written reasons to follow.

EVIDENCE AND SUBMISSIONS ON PENALTY

The following Agreed Statement of Facts Regarding Penalty was presented to the Committee and filed as an exhibit:

The College of Physicians and Surgeons of Ontario (the "College") and Dr. Sherapartap Singh Rai ("Dr. Rai") agree to the following facts:

1. Dr. Rai entered into an undertaking with the College effective September 30, 2015 with respect to his clinical practice. Among other things, Dr. Rai undertook to practise under the guidance of a clinical supervisor for twelve (12) months and to undergo a reassessment approximately six (6) months thereafter. Attached at Tab 1 of the Agreed Statement of Facts Regarding Penalty is an email report from Dr. David Clarkson, Dr. Rai's clinical supervisor, to Dr. Rai's counsel, dated April 28, 2016.

2. Dr. Rai voluntarily relinquished his prescribing privileges with respect to narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines, and other targeted substances as from June 24, 2011.

3. Attached at Tab 2 of the Agreed Statement of Facts Regarding Penalty is a report from Allison Hallman and Dr. Michael Kaufmann of the Physician Health

Program ("PHP") of the Ontario Medical Association regarding Dr. Rai's participation in PHP by way of a Substance Dependence Monitoring Contract since October 26, 2011. Dr. Rai undertook to the College to, among other things, fully comply with his PHP contract.

4. Attached at Tab 3 of the Agreed Statement of Facts Regarding Penalty is a report from Dr. Gerritt Veenman, who is Dr. Rai's addiction physician.

5. Dr. Rai is currently permitted as a term, condition, or limitation of his certificate of registration only to work at two specific family medicine clinics in Brampton, Ontario, for no more than 32 hours per week over four to five days. He is not permitted to work evenings, weekends, or on-call. He is not permitted to make house calls or engage in patient encounters at the home of the patient, at his own home, or in any non-clinical setting. Changes to these restrictions may be made on approval by the College upon the recommendation of his addiction physician and/or the PHP.

6. Dr. Rai made an assignment in bankruptcy on September 6, 2013. He was discharged from bankruptcy effective December 23, 2015 by the order of Master M. Jean, Registrar in Bankruptcy, dated November 23, 2015, attached at Tab 4 of the Agreed Statement of Facts Regarding Penalty. While in bankruptcy, Dr. Rai did not have the ability to set aside money for payment of any potential costs award.

DECISION AND REASONS ON PENALTY

Dr. Rai examined his romantic partner at a walk-in clinic on one occasion, and did a Pap test and blood work because she complained of fatigue. In doing so, he exhibited disgraceful, dishonourable, and unprofessional conduct.

While there was no convincing evidence that routine care was repeated and although Dr. Rai was relatively new to practice in Ontario at the time, he is not absolved of his responsibility with regard to treating family members.

The College's policy "Treating Self and Family Members" states that physicians should not treat themselves or family members except for minor conditions or in an emergency situation, and only when another health professional is not available. Dr. Rai's clinical care of his partner as described above did not fit into this category of care. When a physician does so, there is a risk that the familial or intimate relationship will affect the doctor's ability to provide the patient with proper care.

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and a costs order. The proposed order included terms requiring Dr. Rai to be reprimanded, that his certificate of registration be suspended for a period of two months, that he participate in the next available course on "Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship," and that he pay costs of the proceeding in the amount of $4,460.00.

The Committee considered the joint proposal for penalty. Although the Committee has discretion to accept or reject a joint submission on penalty, the case law is clear that the Committee should accept a joint submission unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

The Committee is also aware that the penalty proposed should address the principles of protection of the public, disapproval and denunciation of the wrongful conduct, maintenance of the public confidence in the integrity and self-regulating capacity of the profession, specific and general deterrence, and the rehabilitative needs of the member, if applicable.

The Committee decided to accept the joint submission on penalty since it fulfilled the principles outlined above. Dr. Rai's conduct was not acceptable and brought the practice

of medicine into disrepute. A suspension of Dr. Rai's certificate of registration will protect the public and serve to provide specific deterrence to the member. The general membership of the College will also be reminded that providing care to family members is not acceptable, except in exceptional circumstances. A reprimand will serve to denunciate the conduct on behalf of all of the profession. Maintenance of the public's confidence in the College's ability to regulate itself will be served by the totality of the penalty. It will serve to rehabilitate Dr. Rai. It will further ensure that he learns that his actions were outside of those considered professional and acceptable. The boundaries course will teach him how to approach the care of family members.

Dr. Rai's examination of his romantic partner in the walk-in clinic was in disregard of the College policy on treating family members. It was neither an urgent nor emergency situation. Dr. Rai could easily have had a colleague take care of his partner's needs. When a doctor treats a family member, other issues may cloud judgment.

There are mitigating factors in that Dr. Rai has been compliant with the PHP program and doing well with practice monitoring, terms and conditions that were not part of this matter. These positives lend weight to the view that Dr. Rai can be rehabilitated.

The Committee considered the precedents in the *Muhammed, Irvine, Karkanis* and *Aboulnasr* cases. Although none were exactly similar to this case, they nonetheless served to convince the Committee that the joint penalty proposed is proportional to the misconduct. The joint penalty brought forward here is reasonable, fair, and meets the penalty principles.

The proposed cost award against Dr. Rai was appropriate.

ORDER

Therefore, having stated its finding in paragraph 1 of its Order, the Discipline Committee ordered and directed on May 6, 2016 that:

2. the Registrar suspend Dr. Rai's certificate of registration for period of two (2) months, to commence at 12:01 a.m. on May 7, 2016;
3. Dr. Rai to appear before the panel to be reprimanded;
4. the Registrar place the following terms, conditions or limitations on Dr. Rai's certificate of registration:

    a. Dr. Rai shall participate in and successfully complete the next available course on "Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship" offered by Western University, or an equivalent program acceptable to the College, and shall forthwith thereafter provide proof of completion thereof to the College.

5. Dr. Rai pay the College its costs of this proceeding in the amount of $4,460.00, within one hundred and twenty (120) days of the date upon which the suspension of his certificate of registration is lifted.

At the conclusion of the hearing, Dr. Rai waived his right to an appeal and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND

Delivered May 6, 2016

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

And

DR. SHERAPARTAP SINGH RAI

THE CHAIRPERSON: You did a pelvic examine and lab work with respect to your romantic partner. Your actions revealed a significant lapse in judgment. Furthermore, you contravened the College policy on treatment of family members. This policy is in place so that the natural bond between the doctor and partner does not deprive the person of the best objective care.

Although you were relatively new to practice in Ontario at the time, that does not excuse your actions. The course "Understanding Boundaries and Managing the Risks Inherent in the Doctor Patient Relationship" will facilitate your rehabilitation in this regard.

From report that the Committee has received from the PHP program, it appears that you are compliant and doing it well with the practice monitoring. This Committee hopes that you will take the current order seriously, continue to learn from your mistakes and never appear before us again.