

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Clarence Edwin Clotey, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients 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 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. Clottey,  
2020 ONCPSD 6

**DISCIPLINE COMMITTEE  
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**  
which is Schedule 2 of the ***Regulated Health Professions Act, 1991***,  
S.O. 1991, c. 18, as amended.

**B E T W E E N:**

**COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. CLARENCE EDWIN CLOTTEY**

**PANEL MEMBERS:**

**DR. C. CLAPPERTON (CHAIR)  
MR. M. KANJI  
DR. R. SHEPPARD  
MR. P. GIROUX  
DR. P. POLDRE**

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

**MS S. DHAMRAIT**

**COUNSEL FOR DR. CLOTTEY:**

**MS J. McKENDRY and MR. S. DARROCH**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR G. FORREST**

**Hearing date and Decision Date:**

**January 10, 2020**

**Release of Reasons Date:**

**February 25, 2020**

**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 January 10, 2020. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

## **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Clotey 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 engaged in sexual abuse of patients; 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.

## **THE FACTS**

The following facts were set out in a Statement of Uncontested Facts and Plea of No Contest which was filed as an exhibit and presented to the Committee:

## **BACKGROUND**

1. Dr. Clarence Edwin Clotney (“Dr. Clotney”) is a fifty-nine (59) year old physician who practices family medicine in Oakville, Ontario. He received his certificate of independent practice in 2010.

2. At all relevant times, Dr. Clotney practiced at Bristol Family Physicians located at 2315 Bristol Circle, in Oakville, Ontario (“Bristol Family Physicians”).

3. In 2016, Dr. Clotney was arrested and charged with six (6) counts of sexual assault contrary to s. 271 of the *Criminal Code of Canada*, R.S.C., 1985, c. C-46, in relation to six (6) of the seven patients (7) on the Notice of Hearing, dated February 8, 2017, May 17, 2017, and October 24, 2018 (the “Notice of Hearing”, Exhibit 1).

4. Between November 2017 and July 2018, a four-week criminal trial took place before Justice Stephen D. Brown (“Justice Brown”) in the Ontario Court of Justice in Halton. The six (6) patients testified at the criminal trial, as did Dr. Clotney and three expert witnesses, the latter testifying about the appropriateness of various medical examinations carried out by Dr. Clotney.

5. In an oral judgment delivered on July 12, 2018, followed by a 180-page written decision on August 7, 2018, Justice Brown acquitted Dr. Clotney on all counts.

6. The six (6) patients from the criminal trial and one (1) additional patient all complained to the College about Dr. Clotney.

## **DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT**

### **Patient A**

7. Dr. Clotney was Patient A’s family physician between approximately October 2014

and June 2016. Patient A attended medical appointments with Dr. Clotney at his office at Bristol Family Physicians. Patient A was in her late 40's at the time of the appointments.

8. Over the years, Patient A had multiple physical examinations from Dr. Clotney including a full physical examination in February 2015.

9. In June 2016, Patient A attended Dr. Clotney's office for a pre-booked annual physical examination. Patient A undressed and changed into a gown.

10. Dr. Clotney did not have a chaperone in attendance during the examination.

11. During the breast examination, Dr. Clotney examined and applied pressure to Patient A's nipples. Patient A did not understand the purpose of this type of examination or expect this type of examination. After he examined Patient A's nipples, Dr. Clotney told her that he was looking for discharge.

12. Prior to conducting the breast examination of this patient, Dr. Clotney:

- Failed to explain to Patient A the rationale for the application of pressure to the nipples;
- Failed to explain what the examination would involve, specifically failing to explain to her that part of his examination including applying pressure to the nipples to check for discharge; and
- Failed to obtain Patient A's informed consent before proceeding with the examination.

13. During the internal examination, Dr. Clotney's thumb made contact with Patient A's

clitoris. Patient A found this uncomfortable and told Dr. Clotney to stop touching her clitoris. Dr. Clotney removed his thumb and apologized. Dr. Clotney conducted the internal examination in a careless manner by failing to show sensitivity to his patient in allowing his thumb to make contact with Patient A's clitoris.

14. Dr. Clotney's method in conducting the internal examination was overly long, causing Patient A to experience distress and pain.

15. At the end of the examination, Dr. Clotney stayed in the examination room while Patient A got dressed. Although he was not looking at her and was writing his notes, Patient A was nervous and stressed that Dr. Clotney remained in the room.

16. Patient A did not return to see Dr. Clotney after this appointment.

17. Patient A experienced significant distress due to the absence of a chaperone, Dr. Clotney's failure to explain or obtain informed consent for the application of pressure to Patient A's nipples and his failure to show sensitivity and care in his thumb positioning during the internal examination.

### Patient B

18. Patient B saw Dr. Clotney on two (2) occasions in 2012 when she attended for medical appointments with him at his office at Bristol Family Physicians. Patient B was in her late 30's at the time of the appointments.

19. Patient B's initial appointment with Dr. Clotney was a "meet and greet" that took place in October 2012. There was no physical examination done at this appointment. During this appointment, Dr. Clotney told Patient B to schedule a physical examination with him which would include a Pap test and breast examination. Patient B asked Dr. Clotney whether a female physician could conduct the Pap and breast examinations

as she would feel more comfortable. Dr. Clotney responded dismissively, stating, “we’re all the same”. Dr. Clotney’s reaction made Patient B feel ashamed for suggesting she preferred a female physician for the Pap and breast examination. She agreed to proceed with Dr. Clotney and enrolled as a patient in Dr. Clotney’s practice.

20. At Patient B’s next and last appointment, in December 2012, Dr. Clotney conducted a physical examination of Patient B including a Pap test, an internal examination and a breast examination. Patient B felt uncomfortable during the appointment because there was no chaperone present in the room.

21. During the breast examination, Dr. Clotney examined and applied pressure to Patient B’s nipples to look for discharge. Patient B did not understand the purpose of the examination or expect this type of examination.

22. Prior to conducting the breast examination of this patient, Dr. Clotney:

- Failed to explain to Patient B the rationale for the application of pressure to the nipple;
- Failed to explain what the exam would involve, specifically failing to explain to her that part of his examination including applying pressure to the nipples to check for discharge; and
- Failed to obtain Patient B’s informed consent before proceeding with the examination.

23. As a result of Dr. Clotney’s conduct, Patient B felt confused and violated. She did not return to see Dr. Clotney again and did not obtain her Pap test results.

### Patient C

24. Patient C was a patient of Dr. Clotney between approximately 2012 and 2013. Patient C attended medical appointments with Dr. Clotney at his office at Bristol Family Physicians. Patient C was in her late 20's at the time of the appointments.

25. In April 2013, Patient C attended for an appointment with Dr. Clotney for a physical examination which included a breast examination and internal examination. She undressed and changed into a gown prior to Dr. Clotney entering the exam room.

26. Dr. Clotney did not have a chaperone in attendance during the examination.

27. Prior to conducting the breast examination of this patient, Dr. Clotney:

- Failed to explain to Patient C the specific rationale for the breast examination;
- Failed to explain what the exam would involve; and
- Failed to obtain Patient C's informed consent before proceeding with the examination.

28. During the internal examination, Dr. Clotney's thumb made contact with Patient C's clitoris. Patient C found this uncomfortable and confusing. Dr. Clotney conducted the internal examination in a careless manner and failed to show sensitivity to his patient by allowing his thumb to make contact with Patient C's clitoris.

### Patient E

29. Dr. Clotney was Patient E's family physician for approximately four and a half years, between 2012 and 2017. Patient E attended medical appointments with Dr. Clotney at his office at Bristol Family Physicians, seeing him about twenty (20) times in total. Patient E was in her early 40's at the time of the appointments.



30. Dr. Clotney conducted annual physical examinations of Patient E which included breast and internal examinations. Patient E would undress and wear a gown prior to Dr. Clotney entering the examination room.

31. Dr. Clotney did not have a chaperone in attendance during these examinations.

32. During her first annual physical examination with Dr. Clotney, Dr. Clotney examined and applied pressure to Patient E's nipples to check for discharge. Patient E did not understand the purpose of the examination or expect this type of examination.

33. Prior to conducting the breast examination of this patient, Dr. Clotney:

- Failed to explain to Patient E the rationale for the application of pressure to the nipples;
- Failed to explain what the examination would involve, specifically failing to explain to her that part of his examination including applying pressure to the nipples to check for discharge; and
- Failed to obtain Patient E's informed consent before proceeding with the examination.

34. During a number of internal examinations, Dr. Clotney's thumb made contact with Patient E's clitoris. This made Patient E very uncomfortable. Dr. Clotney conducted the internal examinations in a careless manner by failing to show sensitivity to his patient in allowing his thumb to make contact with Patient E's clitoris.

35. As a result of Dr. Clotney's conduct, Patient E felt shocked and upset. However, Patient E continued to see Dr. Clotney for her care as he was treating her for other

health concerns and she did not want to start all over with another physician.

### Patient F

36. Dr. Clotney was Patient F's family physician between July 2015 and January 2016. Patient F attended medical appointments with Dr. Clotney at his office at Bristol Family Physicians. Patient F was approximately thirty (30) years old at the time of these appointments.

37. Patient F first met Dr. Clotney in July 2015 for a "meet and greet". She had a couple of subsequent appointments to obtain prescriptions and for a post-natal follow-up visit.

38. In December 2015, Patient F attended for an appointment with Dr. Clotney for a full physical examination. A nurse provided Patient F with a gown. Patient F removed all her clothing and put on the gown prior to Dr. Clotney entering the exam room.

39. Dr. Clotney did not have a chaperone in attendance during the examination.

40. At this appointment, Patient F discussed with Dr. Clotney that she thought she had hemorrhoids after having recently given birth. Dr. Clotney conducted a physical examination of Patient F including an internal examination and rectal examination. Patient F expected a rectal examination, following discussion of hemorrhoids, but did not expect the internal examination and was uncomfortable and surprised when he began to conduct an internal examination.

41. Prior to conducting the internal examination of this patient, Dr. Clotney:

- Failed to advise Patient F that he was going to conduct the examination;
- Failed to explain to Patient F the rationale for the examination;

- Failed to explain what the examination would involve; and
- Failed to obtain Patient F's informed consent before proceeding with the examination.

42. Patient F felt that the examination was unnecessarily long and this caused her to be upset.

43. During the rectal examination, Dr. Clotney's thumb made contact with Patient F's clitoris. Patient F found this confusing. Dr. Clotney conducted the rectal examination in a careless manner by failing to show sensitivity to his patient in allowing his thumb to make contact with Patient F's clitoris during the rectal examination without any explanation.

44. Patient F had concerns about what occurred in the December appointment. She returned for one more appointment with Dr. Clotney in January 2016 to obtain results from a test, but ultimately did not see him. Patient F told someone at Dr. Clotney's reception that she would no longer be Dr. Clotney's patient.

## **PLEA OF NO CONTEST**

45. Dr. Clotney does not contest the facts specified above in paragraphs 1-44, and does not contest that, based on these facts, he engaged in professional misconduct by engaging 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.

**RULE 3.02 – PLEA OF NO CONTEST**

Rule 3.02 of the Rules of Procedure of the Discipline Committee regarding a plea of no contest states as follows:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

- a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
- b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
- c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

**WITHDRAWAL**

The College withdrew the allegation of sexual abuse.

**FINDING**

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts and Plea of No Contest on Liability.

On reading the Notice of Hearing dated February 8, 2017, the Statement of Uncontested Facts and Plea of No Contest on Liability, and on hearing the submissions of counsel for the College and counsel for Dr. Clottey, the Committee found that Dr. Clottey committed an act of professional misconduct under paragraph 1(1)33 of O. Reg.

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.

## **PENALTY AND REASONS FOR PENALTY**

### **THE POSITION OF THE PARTIES**

Counsel for the College and counsel for Dr. Clottey made a joint submission as to an appropriate penalty and costs order. Counsel submitted that the fair and appropriate penalty was an Order that Dr. Clottey attend before the panel to be reprimanded, and directing the Registrar to suspend Dr. Clottey's Certificate of Registration for a period of 12 months effective immediately. It was further submitted that several terms, conditions and limitations be placed on Dr. Clottey's Certificate of Registration, including that he complete the Saegis course on Professionalism and Communications within six months, and that he not conduct breast, pelvic or rectal examinations with any patient, with signage to be placed in all of his practise locations to inform them of this restriction.

### **EVIDENCE ON PENALTY**

The evidence on penalty which the Committee considered consisted of the Statement of Uncontested Facts and Plea of No Contest (Exhibit 2) which describes the professional misconduct which Dr. Clottey engaged in, Witness Impact Statements of two of the complainants in this case (Exhibit 3), and a Brief of Letters in support of Dr. Clottey, submitted by his counsel (Exhibit 4). The Committee also considered several previous decisions of the Discipline Committee in somewhat similar cases, contained in the Brief of Authorities jointly submitted by counsel.

**DECISION ON PENALTY**

The Committee accepted the submission of the parties, and made the Order jointly proposed by counsel.

**REASONS FOR DECISION**

The Committee is aware that the threshold for rejecting a joint submission is high. As stated by the Supreme Court of Canada in *R. v. Anthony-Cook* (2016), a joint submission should be accepted unless to do so would bring the administration of justice into disrepute, or would be otherwise contrary to the public interest.

It is nevertheless required that the Committee impose a penalty which properly expresses the recognized principles which guide the imposition of penalty in disciplinary proceedings. First and foremost is the protection of the public. The penalty imposed should also denounce wrongful conduct, assist in maintaining public confidence in the integrity of the profession and in the College's ability to regulate the profession effectively in the public interest, serve as a specific deterrent to the member and as a general deterrent to the membership as a whole and, where applicable, attempt to address the rehabilitative needs of the member. The penalty imposed should be proportionate to the misconduct committed, and should generally be consistent with previous decisions in similar cases.

**Aggravating factors**

The nature of Dr. Clotney's misconduct is of great concern to the Committee. Intimate examinations, by their nature, place patients in a very vulnerable position. All physicians have a professional obligation to place their patients at ease by communicating what is being done and why, and by performing these examinations with care, sensitivity, and respect for patients' comfort and privacy. Dr. Clotney failed to do these things. His patients were left feeling confused, upset, violated, and traumatized. Two of the

patients were sufficiently disturbed by the manner in which Dr. Clotney examined them that they did not return to see him again. Dr. Clotney's actions had a lasting effect on these patients' ability to place trust in male physicians.

The Committee considers the nature of Dr. Clotney's conduct, whereby he subjected his patients to traumatic experiences due to his callous and insensitive approach to intimate examinations, to be an aggravating factor. A further aggravating factor is that this conduct occurred with multiple patients over the course of a number of years. This was not an isolated lapse in judgement on the part of Dr. Clotney. Rather, it amounted to persistent deficiencies in communication and in awareness of and respect for his patients' sensitivities.

### **Mitigating factors**

The Committee accepts that Dr. Clotney's plea of no contest prevented the need for a lengthy hearing, and the need for complainants to testify. Dr. Clotney's plea also suggests a willingness to take responsibility for his deficiencies, indicating that he has gained some insight. Furthermore, the Committee notes that he has no prior history with the College. The Committee considers these to be mitigating factors.

### **Criminal acquittal**

Counsel for Dr. Clotney submitted that the fact that Dr. Clotney was charged criminally and acquitted is a mitigating factor. The Committee disagrees, and places no weight on the evidence that Dr. Clotney was criminally charged as a result of the allegations of the complainants in this case, and ultimately acquitted after a lengthy trial. The fact that criminal charges were laid is not an aggravating factor, and Dr. Clotney's acquittal is not mitigating. The Discipline Committee often hears of physician conduct which is not criminal in nature, but which is unacceptable and intolerable in the regulatory context,

where the purpose and nature of the proceedings is much different. Dr. Clottey's acquittal by the Court is neither an aggravating nor mitigating factor.

### **Letters of Support**

The Committee considered the letters of support for Dr. Clottey. By its nature, this evidence is generally accorded little weight in disciplinary proceedings, as the authors of the letters have no direct knowledge of the facts and issues which are before the Committee. The Committee notes that Dr. Clottey appears to be very highly regarded by some of his patients. This does not diminish the Committee's concern that, with other patients on some occasions, he committed serious professional misconduct.

### **Previous Decisions of the Discipline Committee**

The Committee reviewed the decisions of the Discipline Committee pertaining to past cases which bore some similarity to that of Dr. Clottey.

The Committee is satisfied that the length of the suspension proposed for Dr. Clottey, 12 months, is within the range of previous penalties for similar misconduct. None of the previous cases reviewed bears a strong similarity to the current case, but each does involve some degree of privacy violation, lack of respect for appropriate boundaries, and insensitivity to patient vulnerabilities. Previous suspensions have ranged from four months in *CPSO v. Wilson (2016)*, to effective revocation, as the Committee would have revoked the physician's certification had the physician not resigned and undertaken not to reapply, as in *CPSO v. Thicke (2019)*, for misconduct much more egregious and longstanding than that of Dr. Clottey.

A 12-month suspension is a very significant sanction. This suspension will be a very significant deterrent to Dr. Clottey and, further, will send a strong message to the profession and to the public that the College will not tolerate insensitive and callous



violations of the privacy interests of patients. Public confidence in the integrity of the profession, and in the principle of effective governance by the College of its membership, will hopefully be strengthened.

The public reprimand will serve as an expression of disapproval of Dr. Clotney's actions, making a statement to the profession and the public that misconduct of this nature is unacceptable.

The Committee is of the view that the terms, conditions, and limitations which will be imposed on Dr. Clotney's Certificate of Registration will be important in upholding the principles of penalty. The public will be protected as much as possible by the requirement that Dr. Clotney no longer perform intimate examinations, and that he inform the public of this restriction by signage to be posted in his office. We note that Dr. Clotney signed an Undertaking with the College in 2017, and has abided by the conditions in this regard and, hence, we are optimistic that he will comply with the terms and conditions imposed by this Order. The Saegis course on Professionalism and Communications, or a similar course approved by the College, will ideally allow Dr. Clotney to gain better insight into his previous deficiencies, and prepare him to return to practise at the conclusion of his suspension.

Finally, the Committee finds that this is an appropriate case for a costs Order and agrees with the joint position of counsel that Dr. Clotney be ordered to pay costs to the College in the amount of \$6,000 within 30 days of the date of this Order.

## **ORDER**

The Committee stated its findings in paragraph 1 of its written order of January 10, 2020. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Clotney to attend before the panel to be reprimanded.

3. The Registrar suspend Dr. Clotney's certificate of registration for a period of twelve (12) months, commencing immediately.
4. The Registrar place the following terms, conditions or limitations on Dr. Clotney's certificate of registration:
  - (i) Dr. Clotney shall comply with the College Policy "Closing a Medical Practice;"
  - (ii) Dr. Clotney shall complete the Saegis course on professionalism and communications (or other similar course approved by the College) within six (6) months from the date of the Order, at his own expense, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Clotney will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it;
  - (iii) Dr. Clotney shall not conduct breast, pelvic or rectal examinations of any patient;
  - (iv) Dr. Clotney shall provide a referral to another physician for any patient who seeks and/or may in his judgment require a breast, pelvic, or rectal examination and shall record the referral and reasons for referral in the patient's chart;
  - (v) Dr. Clotney shall post a sign in all waiting rooms, examination rooms, and consultation rooms in each and

every location where he practises, in any jurisdiction (collectively "Practice Location(s)"), in a clearly visible and secure location in the form set out in Schedule A of the Order, that states:

"Dr. Clotney shall not conduct breast, pelvic, or rectal examinations of any patient for any reason.

Dr. Clotney shall provide a referral to another physician for any patient who seeks and/or may in his judgment require a breast, pelvic, or rectal examination.

Further information may be found on the College website at [www.cpsso.on.ca](http://www.cpsso.on.ca)"

- (vi) Dr. Clotney shall inform the College of each of his Practice Location(s) within fifteen (15) days of the Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;
- (vii) Dr. Clotney shall consent to the College making enquiries of the Ontario Health Insurance Program , the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor his compliance with the Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions;
- (viii) Dr. Clotney shall co-operate with unannounced inspections of his office practice and patient charts by the College for

the purpose of monitoring and enforcing his compliance with the terms of the Order;

(ix) Dr. Clotney shall notify any employer, or any hospital at which he may have privileges, about the Order;

(x) Dr. Clotney shall be responsible for any and all costs associated with implementing the terms of the Order.

5. Dr. Clotney pay costs to the College in the amount of \$6,000.00 within thirty (30) days of the date of the Order.

At the conclusion of the hearing, Dr. Clotney 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 January 10, 2020**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. CLARENCE EDWIN CLOTTEY**

Dr. Clottey:

We are dismayed, distressed and disappointed in your callous disregard for your patient's dignity and comfort. There are many ways you did not show respect for your patients:

- you failed to communicate appropriately to your patients the nature of the examination you were doing;
- you showed a lack of sensitivity to one patient's request for a female physician to complete her examination;
- you were careless in the manner of your intimate examinations causing patients to feel violated and distressed, as demonstrated by the victim impact statements.

It is clear that the long term effects of your misconduct has been significant with some of your patients. They no longer trust male physicians. Your actions besmirch the reputation of the whole profession and that affects us all.

We expect that when by the time you return to practice you will have gained a deeper understanding of how your deficiencies traumatized some of your patients. We hope you will have gained knowledge regarding respect for all of those in your care.