NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Mehdi Horri, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name or identity of Patient A or any information that could disclose the identity of Patient A under subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the Regulated Health Professions Act, 1991.

The Discipline Committee also ordered that there shall be a ban on the publication or broadcasting of the name or any information that could disclose the identity of Ms X including any reference to pregnancies, pursuant to s. 45(3) of the Code.

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… 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. Horri, 2019 ONCPSD 15

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. MEHDI HORRI

PANEL MEMBERS:

DR. P. CHART (Chair)
MR. P. GIROUX
DR. P. ZITER
MR. P. PIELSTICKER
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS E. WIDNER

COUNSEL FOR DR. HORRI:

MR. G. RAGAN
MS E. PAGE

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R.W. COSMAN

PUBLICATION BAN

Penalty Redetermination Hearing Date:	**November 7, 2018**
Penalty Redetermination Decision Date:	**March 29, 2019**
Penalty Redetermination Reasons Date:	**March 29, 2019**

PENALTY DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard submissions on the re-determination of penalty in this matter in Toronto on November 7, 2018.

BACKGROUND

The Committee initially heard this matter on September 26 and October 13, 2016. The Notice of Hearing alleged that Dr. Mehdi Horri committed an act of professional misconduct 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. The hearing proceeded by an Agreed Statement of Facts and Admission on Liability. At the conclusion of the liability phase of the hearing, the Committee stated its finding that Dr. Horri committed an act of professional misconduct as alleged in that he had engaged in a sexual relationship with Patient A too soon (two weeks) after the termination of the doctor-patient relationship.

The parties contested the penalty to be imposed. After hearing evidence and submissions, the Committee reserved its decision on the matter of penalty and costs. On March 24, 2017, the Committee released its penalty decision and ordered that Dr. Horri's certificate of registration be revoked. The Committee also ordered a reprimand and costs.

Dr. Horri appealed the penalty decision of the Discipline Committee to the Divisional Court. The Divisional Court heard the appeal on May 18, 2018. The Court granted Dr. Horri's appeal on May 30, 2018, and remitted the matter to the Discipline Committee for re-determination of the appropriate penalty.

FACTS and EVIDENCE

On the re-determination of penalty hearing, the parties called no witnesses.

The Committee had transcripts from the 2016 hearing of the testimony of Dr. Horri and Dr. Peter Collins, a forensic psychiatrist, who was called by Dr. Horri. The Committee refers to this testimony where relevant in our reasons.

In addition to the Agreed Statement of Facts and Admission which is set out below, the Committee also had the following documentary evidence: Dr. Peter Collins' report of February 15, 2016; CV of Dr. Peter Collins; the College's Policy Statement No. 4-08 [Maintaining Appropriate Boundaries and Preventing Sexual Abuse]; a post workshop appraisal and certificate of attendance at the Understanding Boundaries: Managing the Risks Inherent in the Doctor-Patient Relationship Course ("the Boundaries Course"); the December 2008 edition of Dialogue; and, resume of Dr. Horri.

AGREED STATEMENT OF FACTS AND ADMISSION

The following facts were set out in an Agreed Statement of Facts and Admission that was filed as Exhibit 2 at the hearing in 2016.

1. Dr. Horri is a 51 year old family physician who practises family medicine in Estevan, Saskatchewan. He graduated from the University of Tehran (Iran) in 1998 and obtained a certificate of Independent Practice in 2015.

Background

2. Patient A was [early 20's] years old when she became a patient of family doctor, Dr. X, in December of 2009. Dr. X's practice is located within the Pembroke Regional Hospital ("Hospital").

3. Dr. X met with Patient A on three occasions between December 2009 and January 2010.

4. During her first appointment with Dr. X, in December, 2009, Dr. X diagnosed Patient A with depression with major family stressors. She prescribed a trial of anti-depressants to Patient A.

5. During her second appointment with Dr. X, in December, 2009, Dr. X diagnosed

Patient A with depression with suicidal ideation. Patient A refused admission to the Hospital at that time. Patient A's anti-depressant dosage was increased.

6. During her last visit in January, 2010, Dr. X diagnosed Patient A with insomnia second to depression triggered by family dysfunction. Dr. X found that Patient A did not presently have suicidal or homicidal thought process and prescribed her a different anti-depressant and sleep medicine. Following this appointment, Dr. X began a maternity leave. When asked to describe the care provided to Patient A prior to her maternity leave, Dr. X indicated that she did not feel it was psychotherapy but more supportive in nature.

7. Patient A agreed to continue to attend for appointments with Dr. Horri who was acting as a locum during Dr. X's leave.

Doctor Patient Relationship

8. The first time Patient A met with Dr. Horri was in late January, 2010.

9. Dr. Horri continued the care plan commenced by Dr. X and provided Patient A with on-going support and medication management. The majority of the appointments with Dr. Horri were 30 to 45 minutes in length.

10. The appointments with Dr. Horri continued until the middle of June. Patient A describes that, because Dr. Horri was a medical professional whom she would not have to see again, she disclosed personal information to Dr. Horri that she had not previously disclosed to anyone. Attached at Tab "A" to the Agreed Statement of Facts and Admission is a copy of Patient A's medical chart together with a transcription of Dr. Horri's notes and Patient A's OHIP Record.

11. Patient A's chart reflects that during the doctor-patient relationship, Dr. Horri provided Patient A with support for on-going familial and relationship challenges; depression; anxiety and sleep difficulties. Dr. Horri renewed prescriptions to Patient A for anti-depressants and sleep medicine.

12. During her appointments, Patient A recollects that when she would share with Dr. Horri details of her familial challenges, Dr. Horri would tell her that he could relate to what she was experiencing given his own experiences with his family of origin.

Post Termination Sexual Relationship

13. Patient A's twelfth and final appointment with Dr. Horri was on a date mid-June, 2010. It was on this date that the doctor-patient relationship between Dr. Horri and Patient A ended.

14. After the last appointment, Patient A attended at Dr. Horri's office to drop off a thank you note for Dr. Horri.

15. Dr. Horri looked up Patient A's phone number in her medical chart and called her to thank her for the card and to offer his ongoing friendship. Dr. Horri suggested that Patient A call him if she needed a friend.

16. Patient A describes that at this point in her life, she was fairly isolated from her support network.

17. Dr. Horri and Patient A developed a friendship over the subsequent weeks. They met on a few occasions for coffee or walks together.

18. Approximately two weeks after Patient A's last appointment with Dr. Horri, Dr. Horri attended at Patient A's apartment. After watching a movie together, they had sexual intercourse. Patient A describes that she was scared and upset because they did not use a condom and she was worried about pregnancy. Dr. Horri left two hundred dollars on Patient A's nightstand, which Patient A found highly insulting. Dr. Horri intended this as a supportive gesture.

19. Dr. Horri left shortly thereafter for Thunder Bay where he entered the Family Practice anaesthesia program at the Northern Ontario Medical School on July 1, 2010.

20. After his departure, a long distance intimate relationship between Dr. Horri and Patient A continued on and off for approximately three years.

21. Patient A travelled to see Dr. Horri and on occasions Dr. Horri would travel to see Patient A. During and after the end of the sexual relationship, Dr. Horri provided Patient A with gifts including two $2000 e-transfers, a credit card in her name and a laptop.

22. When Dr. Horri moved to Sudbury in 2012, he began a new relationship with Ms. X.

Ms. X became aware of continued communication between Dr. Horri and Patient A and began sending unwanted and unsolicited emails, texts and phone calls to Patient A.

23. Dr. Horri and Patient A remained in contact after the sexual relationship until the spring of 2014. Attached at Tab "B" to the Agreed Statement of Facts and Admission is a copy of some of the e-mails and electronic messages exchanged between Dr. Horri and Patient A. The last contact was by telephone.

THE DECISION OF THE DIVISIONAL COURT

The Divisional Court found that the Committee's factual findings as to Dr. Horri's ongoing risk to patients were not reasonably supported by the evidence. The Divisional Court stated that proof of ongoing risk was not "clear and convincing and based upon cogent evidence."

The Court stated that "a penalty is unreasonable where it fails to provide a line of analysis that could reasonably lead from the evidence to the conclusion such that the reader can assess whether there has been an error in principle or whether a punishment has been imposed that is not rationally connected to the findings of misconduct." A number of cases were cited to illustrate this principle.

The Court found that the penalty imposed of revocation on Dr. Horri vastly exceeded the penalty imposed in similar circumstances in other cases. The Court stated that no rationale was given to support the vastly increased penalty and no conscious comparison with previous cases was undertaken.

The Divisional Court directed the Discipline Committee to re-determine the appropriate penalty bearing in mind the obligation to:

- provide a line of analysis that could reasonably lead from the evidence to a reasonable conclusion and punishment that is rationally connected to the findings of misconduct; and

- consider disciplinary penalties imposed in similar cases including the fact that this was Dr. Horri's first "offence", he conceded liability, he elected to seek help prior to the imposition of penalty and there was no clear prohibition against a physician entering a sexual relationship with a vulnerable patient shortly after treating her.

SUBMISSIONS OF COUNSEL

On the re-determination of penalty hearing, the College sought the following penalty and costs order:

1. a twelve-month suspension of Dr. Horri's certificate of registration;
2. the imposition of terms, conditions and limitations on Dr. Horri's certificate of registration including: individualized coaching in ethics, boundaries, informed consent and professional communications, as approved by and with reports to the College at Dr. Horri's expense, to be completed within six months of the date of the Order;
3. a reprimand; and
4. costs payable to the College within thirty days of the date of the Order.

Dr. Horri submitted that the following is the appropriate penalty and costs order:

1. a three-month suspension of Dr. Horri's certificate of registration;
2. completion of a course in medical ethics;
3. a reprimand; and
4. costs for one half day of hearing at the tariff rate applicable in October 2015.

LEGAL PRINCIPLES

The Committee is bound by the Divisional Court's finding that revocation of Dr. Horri's certificate of registration is not required as it vastly exceeds the penalty imposed in prior similar cases and the evidence did not reasonably support the finding that Dr. Horri is an ongoing risk to the public.

The jurisdiction of the Discipline Committee in respect of penalty is set out in section 51(2) of the Health Professions Procedural Code, which provides:

> 51 (2) If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:
>
> 1. Directing the Registrar to revoke the member's certificate of registration.
> 2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time.
> 3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.
> 4. Requiring the member to appear before the panel to be reprimanded.
> 5. Requiring the member to pay a fine of not more than $35,000 to the Minister of Finance.
> 5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.
> 5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1. 1991, c. 18, Sched. 2, s. 51 (2); 1993, c. 37, s. 14 (2).

The Committee is mindful of the well-established penalty principles which guide the determination of an appropriate order. First and foremost, the penalty must protect the public. The penalty should also provide specific deterrence to the member and general deterrence to the profession. In addition, the penalty should reflect the profession's disapproval of the misconduct. It should maintain public confidence in the College's ability to regulate the profession in the public interest. Where appropriate, the penalty should provide the potential for rehabilitation of the physician. In addition to these principles, the Committee must consider any aggravating or mitigating factors in determining the appropriate penalty. The penalty should also be proportionate to the finding given the circumstances of the particular case.

ANALYSIS

In reaching its decision on penalty in this matter, the Committee considered carefully the submissions of counsel, the evidence, the case law, the principles to be applied and the advice of Independent Legal Counsel.

The Committee determined that the appropriate penalty and costs order is:

1. a twelve-month suspension of Dr. Horri's certificate of registration.
2. the imposition of terms, conditions and limitations on Dr. Horri's certificate of registration to include that Dr. Horri complete instruction in medical ethics acceptable to the College within twelve months of the date of this Order and provide proof of successful completion to the College;
3. a reprimand; and
4. Dr. Horri pay costs to the College of one hearing day and one penalty hearing day.

In making this determination, the Committee considered the following to be relevant.

Evidence of Dr. Collins

Dr. Collins was retained by Dr. Horri as an expert in forensic psychiatry to give evidence on the motivation for Dr. Horri's behavior and his risk for future similar conduct. The Committee accepted Dr. Collins as an expert in forensic psychiatry and qualified to provide the assessments and opinions that are contained in his report (exhibit 10).

Dr. Collins assessment of Dr. Horri was based solely on a three-hour interview and a follow-up telephone call of less than one hour, several months later. The interview was carried out in 2016, just before Dr. Horri attended the Boundaries Course. Dr. Collins was cross-examined by counsel for the College on his affidavit before the hearing at a Special Examiner's office and not before the Committee. A transcription of his testimony was provided to the Committee (exhibit13).

Dr. Collins testified that he viewed Dr. Horri's conduct not as sexual misconduct or sexually deviant behavior, but as a breach in professional conduct. He did not view Dr. Horri as having a paraphilia.

Dr. Collins testified that he believed Dr. Horri "based on my clinical skills and the way he told it and his history" (Collins transcript, page 23). Dr. Collins further explained that by referring to "the way he told it," Dr. Horri was not externalizing blame on alcohol or drug use, or blaming the patient.

Dr. Collins agreed there were inherent limitations in relying solely on an interview. Dr. Collins further agreed that it was fair to assume that Dr. Horri had an interest in a positive report.

Dr. Collins indicated in his report that Dr. Horri's intent despite the age difference, was to make the relationship a permanent one "and we were both testing the situation." Dr. Collins concluded in his report that Dr. Horri had believed that since Patient A was no longer his patient, he would be able to develop and maintain a relationship with her. This, according to Dr. Collins, was in part cultural, and in part lack of education.

Dr. Collins testified that he believed Dr. Horri's motivation for the relationship with his former patient was that he was lonely, isolated and needed company and had a kind of inner drive or cultural drive that he had to have kids and had to be in a relationship (Collins transcript, pages 30-31).

Dr. Collins testified that Dr. Horri did not say in the interview that he was doing this for her benefit or that it was out of his control that he had sex with her. Dr. Collins testified that if Dr. Horri had said something like that, "he would be at risk" and he would be concerned about a lack of insight, as a lack of insight gives a licence to continue that type of behaviour (Collins transcript, pages 32-33).

Dr. Collins accepted Dr. Horri's explanation that he essentially did not know the rules. Dr. Collins testified that Dr. Horri portrayed the relationship as a dating relationship, which Dr. Horri now recognizes was wrong.

Dr. Collins testified that by virtue of this acknowledgement, he did not believe that Dr. Horri would act in a similar way in the future. In his report, Dr. Collins states "In my professional opinion, Dr. Horri has achieved insight that will ensure that he will not repeat the behavior that has led to this complaint."

Dr. Collins did not request a psychologist to conduct any psychological testing in coming to his conclusion. Dr. Collins testified "if there is not a presentation clinically that they are exaggerating or minimizing...I wouldn't ask for psychological testing" (Collins transcript, page 24, lines 4-7). When questioned further, his explanation was that there was no question of intellectual ability, major mental illness or thought disorder, so such tests were not indicated. Dr. Collins agreed that such tests can measure a tendency to give sincere, but overly favourable self descriptions and may also assist in ruling out narcissistic and psychopathic traits.

Dr. Collins testified that as a forensic psychiatrist, he would only refer a patient to a psychologist if there was a personality disorder. Dr. Collins did not feel this was the case with Dr. Horri or that he was exaggerating or minimizing. Dr. Collins came to this conclusion even though he was unaware of:

- the results of the evaluation of Dr. Horri's attendance at the Boundaries Course;
- the views of Dr. Horri's practice supervisor, ex-wife or office staff;
- Dr. Horri's testimony to the Committee regarding his motivation for pursuing a relationship with Patient A, which was different than what he had said to Dr. Collins;
- any longitudinal assessment of Dr. Horri's subsequent practice.

Dr. Collins was cross examined on these points.

Dr. Collins was taken to Section A of the Boundaries Course evaluation. It said that the assessment of Dr. Horri was "fair" in one section. Dr. Collins agreed that this was not a resounding endorsement and he would have expected a good or excellent. Dr. Collins was also not aware that the facilitator indicated it would take time for Dr. Horri to reach the goal of the course. While Dr. Collins and Dr. Horri discussed take away points in the post course telephone call, Dr. Collins had no knowledge as to what extent Dr. Horri incorporated the knowledge gained at the Boundaries Course into his practice.

Dr. Collins did not seek or rely upon any collateral information. He did not speak with medical office staff, colleagues of Dr. Horri or Dr. Horri's former wife. Dr. Collins testified that in the absence of a major mental illness or personality disorder, he did not think that was needed. Dr. Collins testified that he was unaware that Dr. Horri had a practice supervisor during the relevant time and agreed that it would have been relevant to interview that source (Collins transcript, page 22).

Dr. Collins agreed that rationalization and justification can affect risk. When asked in cross examination whether he would be concerned if Dr. Horri testified that engaging in unprotected sex or sexual intercourse with Patient A was beyond his control, Dr. Collins indicated that he would be concerned and that more questions would need to be asked. Dr. Collins agreed that it would be of concern if Dr. Horri said the relationship with Patient A was something he did for her benefit or that it was beyond his control when he had sex with her. Dr. Collins testified that he would not have reached the conclusion he did if that were the case (Collins transcript, page 32).

In respect of assessing future risk, after careful consideration of Dr. Collin's report and his testimony and the totality of the evidence before the Committee, the Committee did not accept Dr. Collin's opinion that Dr. Horri would not repeat the behavior that led to this complaint. Rather, the Committee concludes that there is an insufficient basis for Dr. Collin's opinion regarding future risk and the ability to reach any conclusion about future risk with reasonable certainty.

The Nature of the Doctor-Patient Relationship

The Committee considered Dr. Horri's description of his clinical care of Patient A, Patient A's medical record and the billing records of OHIP. In addition, the Committee looked at the frequency and intensity of the clinical care provided and the vulnerability of the patient. The Committee was alive to these factors in assessing the degree of trust Patient A invested in Dr. Horri.

Dr. Horri testified he was functioning as a locum physician when he attended Patient A. At that time, he was practising with a practice supervisor (he had completed a family practice residency at the University of Ottawa from 2007 to 2009 but had failed the CCFP exams; he was successful in 2014). Dr. Horri agreed that he saw Patient A weekly over four to five months (January, 2010 to mid-June, 2010). The majority of these visits lasted 30 to 45 minutes.

Dr. Horri testified that it was not an intense relationship, Patient A was just coming for support and he was a locum physician. He saw his role as ensuring she complied with medication and that she was okay. Dr. Horri testified that she was impulsive and a cutter, but was not suicidal. Dr. Horri further testified that Patient A disclosed personal issues to him as she felt comfortable with him. This included information she had not shared with her family doctor. Dr. Horri further testified that she was vulnerable at the beginning but towards the end, she was happy, had made plans to get on with her life and was much stronger.

Patient A's medical record confirmed that Patient A attended Dr. Horri frequently and regularly as noted above. Dr. Horri was following her for depression and anxiety. The medical record establishes that Patient A was vulnerable and documents a history of mental health problems involving family friction and work related issues. The medical record documents a refused admission for suicidal ideation predating Dr. Horri's care. The medical record also indicates Dr. Horri discussed family counselling and behavior therapy with Patient A. Further, it indicates Patient A disclosed personal information relating to her family, boyfriend relationships and work problems.

Dr. Horri recorded on a date in March, 2010, that Patient A expressed "some ideas of harming herself by sticking a needle in her arm." Dr. Horri made adjustments to her medication and by May 2010, her depression was recorded as improved.

OHIP billing records show a mixture of intermediate assessments and psychotherapy (first two visits). There was no formal cognitive behavioral therapy (CBT) plan. The Committee viewed Dr. Horri's explanation of the billing codes of psychotherapy on two occasions as reasonable, in that it reflected extended time spent with Patient A.

The Committee concludes that while not providing CBT in the ongoing traditional sense, Dr. Horri's relationship with Patient A was significantly more than a casual physician-patient relationship. Patient A shared intensely personal information with Dr. Horri, she saw him often and for lengthy periods and there was more repeated attention to her mental health. She shared more sensitive and personal details with Dr. Horri than with her regular family doctor. Dr. Horri would tell her that he could relate to what she was experiencing, given his own experiences with his family of origin. Patient A clearly relied upon Dr. Horri for her medical care during their physician-patient relationship.

In the Committee's view, Dr. Horri's characterization of the relationship as "supportive and not intense" minimized the true nature of his relationship with Patient A and minimized the degree of trust invested in him by Patient A.

Understanding Boundaries Course: Managing the Risks Inherent in the Doctor-Patient Relationship

Dr. Horri attended this course held October 16 and 17, 2015. Dr. Horri testified he was unaware prior to taking this course that he should not engage in sexual relations with a former patient too soon after the termination of the physician-patient relationship.

Dr. Horri testified that during the course, he reviewed the College's policy on Maintaining Appropriate Boundaries and Preventing Sexual Abuse. Section C of the Policy deals with sexual relationships following the termination of the doctor-patient relationship.

Dr. Horri testified that he completed two post-course correspondences, from which he received feedback (exhibit 6). The acknowledgement of the power differential, the importance of dealing with patients going forward and the need to achieve a work and life balance were addressed.

Dr. Horri's post workshop appraisal is mixed. While Dr. Horri achieved a 4/5 score (good), in attentiveness/contribution and a sense of responsibility, he achieved a score of only 3/5 (fair) in demonstrating awareness of personal strengths and limitations and accepting constructive feedback. The final lead facilitator's comments are noted:

> Your newly discovered insight into the power of maintaining balance in your life is good. Your next challenge will be to reassess yourself from time to time to avoid falling back into old habits. It's frustratingly easy to backslide.

At the time of the hearing in 2017, Dr. Horri testified that he was solely responsible for the harm caused to Patient A. Dr. Horri states that he now has an appreciation of the importance of respecting the power imbalance that exists in the doctor-patient relationship and why his relationship with Patient A was wrong. However, the Committee finds that Dr. Horri demonstrates a concerning lack of insight, which is more fully discussed in the section below entitled Insight.

Nature of the Misconduct

Dr. Horri's physician-patient relationship with Patient A ended on a date mid-June, 2010; however, his relationship with Patient A did not end on that date. There was no real break following the physician-patient relationship. After receiving a thank you note from Patient A, which she brought to the office and gave him within days of the last office visit, Dr. Horri looked up Patient A's contact details and called his [early 20's]-year-old former patient.

The Committee finds that Dr. Horri used the knowledge of Patient A that he had gained as her physician and the information he had acquired about her in confidence as her physician to offer her what he describes as an ongoing friendship. Dr. Horri testified his intention was to "be there for her to talk to. In case she has any issues in life, she would discuss them with me and avoid the situation she was in at the time." He made this overture knowing that he would be leaving Pembroke to go to Thunder Bay within days to commence a residency program on July 1, 2010.

Dr. Horri further testified "that after long walks and visits she invited me over." Within two weeks, he was in her apartment and had unprotected sexual intercourse with her after dinner, after cuddling and foreplay. No condom was used. He left her $200.00, which he intended as a supportive gesture and which she found insulting. This event left her frightened that she might become pregnant.

The relationship did not end when Dr. Horri moved away days later. The subsequent relationship between Dr. Horri and Patient A is described in the Agreed Statement of Facts, by emails and Facebook communication. Over the next three years, there was an on-and-off intimate sexual relationship. Dr. Horri sent Patient A money on two occasions and invited her to visit.

Selected e-mails illustrate that Dr. Horri continued to promote contact and, in the Committee's view, manipulate her to continue the relationship.

- On November 23, 2013, Dr. Horri writes "she (referring to a recent girlfriend who left him) is not in my life anymore." "i[sic] felt we should be in touch" "i[sic] felt bad stopping all correspondence with you" "I was hurt when you broke up with me and i[sic] think you have every right to cut all the strings."

- On February 17, 2014, Dr. Horri writes "Wanna come visit?" "What are you waiting for." To which Patient A responds "There are lots of reasons." "In one year, you told me twice you pick [woman's name] and that I was foolish to believe you would give up someone who was there, not someone you had to convince." "Then we had started talking on

Facebook then you disappear. Show back up today emailing me. I feel I am expendable to you." "I want a life, not a game. I feel you just want to keep playing."

- On April 1, 2014, Dr. Horri writes "I did not say you are not my first pick. If [woman's name] has left me and is dating others I should be free to date you. No one should complain. As for the mother of my child she knows I'm not going to be with her." Patient A responds "I'm just trying to figure out why you tell me this. Leave. Then contact me months later." Dr. Horri writes "But I want to try a long stay and see how it works."

- On April 4, 2014 Dr. Horri writes "We both need to make this effort and attempt this to find out how things will go beyond the third day. When can you take time off?"

- On April 23, 2014, Dr. Horri sends an e-transfer to Patient A for $2,000.00. He writes" I am pissed. I think I am being impulsive. I think this is the lowest form of relationship ever. I sent you money to help you and I'm asking for pictures" and later "I am not pissed at you! I'm pissed at myself." I don't want the money picture trade. I know you sent me pictures but I am paranoid, all the time. And I think I'm using you or something."

- On May 7, 2014, there is another $2,000.00 transfer from Dr. Horri to Patient A.

While it is important to understand that e-mails need to be appreciated in context, these e-mails paint a picture that illustrates how Dr. Horri continued to involve Patient A in his life and did so to meet his own needs. Patient A remained vulnerable to his advances. His ability to manipulate and exploit the relationship is clear. He remained in control up until 2014. In the Committee's view, his exploitation of Patient A was inconsistent with his responsibility as her former physician.

Motivation

In his testimony before the Committee, Dr. Horri offered two reasons why he acted as detailed above. First, he said he was naive and was not aware that having a sexual relationship with a

former patient was wrong. Second, he said to the Committee his motivation was to support Patient A.

While Dr. Horri testified he was naive at the time and did not know the rules, in the Committee's view, a plea of ignorance of expected professional behavior is no excuse. He was an older physician more than 20 years Patient A's senior, with recent Canadian residency experience. He should have known better. In the December 2008 edition of Dialogue, the new policy regarding maintaining appropriate boundaries and preventing sexual abuse was featured. Dr. Horri, who was a post-graduate resident at that time, would have been sent a copy of Dialogue. Dr. Horri testified that he could not recall receiving or reading this edition. The Committee notes that sexual abuse and maintaining boundaries were important topics in the profession at that time and that it would be unlikely for this not to be raised at all during the residency program. Information on the subject was certainly available.

To accept Dr. Horri's ignorance as an excuse for his sexual relationship with Patient A is not consistent with the acceptance of professional responsibility and flies in the face of protection of the public. Rules exist to deter such behavior and guide the profession; ignorance, or willful disregard of their existence, is not the motivating factor for sexual exploitation. Dr. Horri's professed naivety simply removed a barrier; it is not the reason why he acted as he did.

Dr. Horri repeatedly testified before the Committee that he contacted Patient A to offer a supportive friendship, notwithstanding the Committee's conclusion from the medical record that she did not need such support at the time. While Patient A was fairly isolated, Dr. Horri testified that towards the end of the physician patient relationship "She was happy. She had made plans for her life and she had decided to move on." (Transcript 1A-49) Furthermore, Dr. Horri knew he was planning to leave the area to commence a residency on July 1, 2010 in Thunder Bay, within days of the commencement of the sexual relationship. He left Patient A afraid of becoming pregnant. Dr. Horri agreed his actions were anything but supportive.

Dr. Horri's conduct is in stark contrast to his portrayal of the relationship to Dr. Collins as a dating relationship. Dr. Collins testified that it was not presented to him as though "I am going to

date her in order to help her" (Collins transcript, page 33). Dr. Collins opined that Dr. Horri acted as he was lonely, felt isolated and needed company and had a cultural influence or inner drive to have kids and to be in a relationship. We accept this as a reasonable conclusion based on what Dr. Horri reported to Dr. Collins during the interview. Dr. Horri did not state this in his testimony before the Committee. Dr. Horri, in response to counsel for the College, said he was unable to control that he had sex with Patient A. He testified "it happened" (Transcript 1-57). Dr. Horri did not express to Dr. Collins an inability to control the situation.

Taking into account Dr. Horri's testimony before the Committee and the evidence of what he said to Dr. Collins, the Committee concludes that Dr. Horri was less than fully honest in his testimony to the Committee, as to his motivation to commence and continue a sexual relationship with Patient A.

The Committee finds that Dr. Horri was inconsistent in what he said to the Committee as compared to what he said to Dr. Collins regarding his reasons for his relationship with Patient A. The Committee concludes that Dr. Horri tailored his explanation for his behaviour to his audience and in his self interest.

Dr. Horri held a position of trust and authority with Patient A, which clearly endured in the two weeks after her last office visit. In the Committee's view, Dr. Horri was not a passive player in the relationship. Rather, he actively pursued a relationship with Patient A. The Committee also finds that Dr. Horri's behavior in the ongoing relationship after leaving the area continued to be opportunistic and manipulative as evidenced in the email chain.

Even after Dr. Horri had the benefit of the Boundaries Course and consultation with Dr. Collins, the Committee finds that Dr. Horri did not come to grasp the role of his own personal needs and their influence on his behavior in pursuing a sexual relationship with his former patient.

The Committee finds Dr. Horri's conduct is egregious and that the the serious penalty of a twelve-month suspension is required to denounce the misconduct, achieve specific and general

deterrence and to uphold the integrity of the profession and public confidence in professional regulation.

Aggravating Factors

The Committee considered the nature of Dr. Horri's misconduct as described above to be the major aggravating factor.

Furthermore, Patient A was clearly a vulnerable [early 20's]-year-old patient.

Patient A was particularly vulnerable because of the mental health issues for which she sought care. She had little if any family support and few friends. Her Witness Impact Statement illustrates the profound effect that her experience with Dr. Horri has had on her personally and on her performance at work. Most troubling is her distrust of physicians and reluctance to seek help, which is a common theme in those who have suffered abusive behaviour at the hands of a physician.

A recent patient, who is young and vulnerable, should be able to rely on the integrity of her physician to act in her best interests and not to pursue his own needs. To exploit the enduring dynamic of the doctor-patient relationship, as Dr. Horri did within two weeks after termination of the doctor-patient relationship, is opportunistic and a serious breach of trust.

Mitigating Factors

The Committee accepts that the admission of liability by Dr. Horri and arriving at an Agreed Statement of Fact are mitigating factors. Dr. Horri saved Patient A from having to testify and spared the College the time and expense of a contested hearing.

Dr. Horri expressed remorse for his conduct and apologised publicly at the hearing. Further, Dr. Horri acted proactively prior to the hearing in completing the Boundaries Course. The

Committee accepts that this demonstrates that he has taken some degree of responsibility for his actions.

The Committee considered the fact that Dr. Horri had no prior history before the Discipline Committee but did not ascribe this significant weight. Dr. Horri had just completed his residency in family practice at the time of the misconduct. There is no past practice history to rely on. The locum he was doing was essentially his first job. He then took further training in Thunder Bay. His current practice is in Saskatchewan.

The Committee does not accept that simply seeing a psychiatrist for an assessment to be a mitigating factor, in particular, when the psychiatrist is not fully informed, or is given an account inconsistent with other evidence. That is what we found Dr. Horri did here.

Insight

Dr. Horri stated that he now understands that his relationship with Patient A was wrong. He said that he acquired this knowledge after the complaint and by attending the Boundaries Course. Simply knowing the rules and expressing remorse, however, does not mean that there is meaningful insight.

Insight, in the Committee's view, requires a conscious penetration of the reasons and a fulsome understanding of why the misconduct occurred. It further includes an understanding of the impact of behavior both on the victim and society, including the profession. Most important in this matter, insight requires examination of the personal factors that caused Dr. Horri to act as he did.

Dr. Collins testified that loneliness, isolation and cultural influence were the reasons why Dr. Horri acted the way he did. These were not addressed by Dr. Horri in his testimony before the Committee. These factors do not appear in Dr. Collins report and the extent to which they were discussed or acknowledged by Dr. Horri in the interview with Dr. Collins is unclear. This

Committee does not know if Dr. Horri has undertaken any therapy to understand or to gain insight. Dr. Collins did not know if he had done so (Collins transcript, page 34).

After hearing and watching Dr. Horri testify, the Committee concluded that Dr. Horri rationalized his behavior by asserting ignorance of the rules. Dr. Horri further rationalized his behavior when he testified that his intention was to support Patient A. Dr. Horri attempted to justify his participation in the sexual relationship with Patient A when he stated "the sexual relationship was not an intention - "It happened" - and that it was outside his ability to control.

Dr. Horri minimized the nature of his clinical relationship with Patient A when it served to downplay the nature of the care administered and her vulnerability, and over emphasized her needs when justifying providing ongoing friendship. He further minimized the relationship before the Committee, describing it as friendship, and not a dating relationship which is what he described to Dr. Collins.

In the Committee's view, as Dr. Horri was not forthcoming with Dr. Collins, rationalization and minimization, which Dr. Collins described as cognitive distortions, were not addressed and the issue of impulse control was not explored.

The Committee concludes that while Dr. Horri acknowledged before the Committee he was wrong in having a sexual relationship with his former patient, he has limited insight into his personal vulnerability. His inconsistent description of his motivation to Dr. Collins and the Committee indicates that he still has not resolved why he acted as he did. The Committee also finds that Dr. Horri does not fully understand the impact of his behavior on his former patient or on the public's view of the profession.

The opinion of Dr. Collins did not persuade the Committee that Dr. Horri was at low or no risk of future similar misconduct. The Committee view is that Dr. Collins based his conclusion on an incomplete assessment and a lack of awareness of critical factors (as noted earlier and listed under Dr. Collins evidence) which he said would have likely influenced his conclusions.

In the Committee's view, the evidence clearly demonstrates that Dr. Horri does not have meaningful insight into his misconduct. In Dr. Collins words, "if you have a lack of insight, that lack of insight is going to give you a license to continue that type of behavior."

Risk to the Public

The Committee concludes that the risk of future misconduct by Dr. Horri is indeterminate. The Committee understands there is an inferential gap between proof positive of increased risk and the conclusion of the Committee. Our concerns in regard to Dr. Horri include: limited insight; a lack of understanding of personal needs and vulnerabilities; inconsistency in Dr. Horri's evidence; and, rationalization and minimization of his behavior.

Even though Dr. Horri expressed remorse and was emphatic that he would never repeat such behavior, the Committee does not have sufficient evidence to find that his future risk is non-existent or low. When dealing with matters of public protection in the context of medical practice, a balance is required to achieve fairness to the physician and the need for public safety. This is all the more difficult when the probability of future misconduct, as in this case, is uncertain.

Case Law

Both parties brought considerable case law before the Committee. The Committee recognizes that it is not bound by prior decisions of the Discipline Committee. However, part of the diligence required in arriving at an appropriate penalty includes an assessment of the range of penalties imposed in similar cases. The Divisional Court in its decision underscored the need for the Discipline Committee to carry out a conscious comparison between Dr. Horri's case and similar cases in arriving at an appropriate penalty.

The Committee looked first to cases, in chronological order, where the nature of the misconduct and the context were somewhat similar.

In *CPSO v. Schogt*, 2004 O.C.P.S.D. No. 4, on the basis of an agreed statement of facts, the Committee made a finding of disgraceful, dishonourable or unprofessional conduct based on Dr. Schogt's engaging in intimate relations with a former patient. Dr. Schogt is a psychiatrist and had treated her patient for nine years with psychotherapy. The doctor-patient relationship ended in April 2001 and later in 2001, they began an intimate relationship. Since then, they had lived together as a family and co-parented. The patient did not complain (the matter came to the College's attention via mandatory reports). The patient retained independent counsel who informed the College the patient disapproved of the prosecution of Dr. Schogt. Dr. Schogt was cooperative and open with the College and provided the name of the patient, previously unknown, to the College. She closed her private practice in July 2002 and took a hiatus from practice in August 2003. The Committee accepted the parties' joint submission on penalty and ordered a nine-month suspension, a further three-month suspension to be suspended upon Dr. Schogt successfully completing College-approved courses in boundaries and ethics, and a reprimand.

In comparing the two cases, Dr. Schogt is a psychiatrist; Dr. Horri is not. Dr. Schogt engaged in a nine year doctor-patient relationship which included psychotherapy; this was not the case with Dr. Horri. Mitigating factors included an unblemished professional record and high esteem accorded to her by patients and colleagues. The Committee noted that Dr. Schogt demonstrated no inconsistency, rationalization or justification and no patient manipulation. The *Schogt* case was different in relation to the patient's opposition to the prosecution, Dr. Schogt's acceptance of it and her professional accountability for her misconduct and their co-parenting. The Committee found it of limited assistance in determining an appropriate penalty for Dr. Horri.

In *CPSO v. Doyle*, 2009 O.C.P.S.D. No. 26, the Committee found Dr. Doyle to have engaged in disgraceful, dishonourable or unprofessional conduct by having an intimate relationship with a patient too soon after ending the doctor-patient relationship. The matter proceeded on the basis of an agreed statement of facts and a joint submission on penalty. Dr. Doyle was a psychiatrist who had treated his patient with 45 psychotherapy sessions over one year and three months from April 2005 to July 2006. Dr. Doyle indicated in the patient's file that the end of the doctor-patient relationship was in July 2006. Their first date was in late summer 2006. There had been

no prior physical contact. A sexual relationship followed. The Committee ordered a twelve-month suspension, and terms, conditions and limitations on Dr. Doyle's certificate of registration, including that he remain in the Physician Health Program, continue in psychotherapy and be restricted from providing long term psychotherapy for patients. In addition, the Committee required a practice monitor for encounters with female patients, as well as clinical supervision of his ongoing care with a supervisor acceptable to the College.

As was the practice at that time, six months of the twelve-month suspension ordered was suspended providing Dr. Doyle successfully completed a number of remedial courses. The Committee has long ceased the practice of suspending a period of a suspension on the completion of remedial courses. The practice was to fix a period of suspension that was considered to be appropriate, and then allow a portion of it to be stayed if certain conditions were met. The period of suspension was not lengthened arbitrarily to achieve an objective. This was previously viewed as an incentive to the physician to complete remediation. However, it watered down the significance of the term of suspension ordered and gave (undue) credit for the completion of remediation that was required to address demonstrated misconduct. The Committee's view is that the 12-month suspension ordered, and not the 6-month remainder to be served, reflects the denunciation of the misconduct in Dr. Doyle's case.

The aggravating factors in *Doyle* included the length and nature of the doctor-patient relationship, violation of boundaries, contact very soon after terminating care, and the patient's vulnerability. These factors are broadly shared in Dr. Horri's case. Mitigating factors in *Doyle* included remorse and insight into his conduct. Dr. Doyle continued to engage in personal psychotherapy and had been in contact with the Ontario Medical Association's Physician Health Program (PHP). Dr. Horri is not a psychiatrist, but he had an established a trusting counselling relationship with Patient A, whom he saw for mental health problems. Dr. Horri demonstrated limited insight and has taken no measures [except the Boundaries course] to define or address his personal vulnerabilities. The *Doyle* matter is also instructive in that the penalty in its entirety needs to be considered, and not just the suspension alone.

After a contested hearing regarding the allegations, in *CPSO v. Karkanis*, 2010 O.C.P.S.D. No 15, the Committee found that Dr. Karkanis engaged in disgraceful, dishonourable or unprofessional conduct by engaging in sexual relations with a former patient approximately three months after the end of the doctor-patient relationship. Dr. Karkanis is an obstetrician gynaecologist and had operated on the patient in the past. Psychotherapy was not a part of the patient's care. The Committee accepted a joint submission on penalty and ordered a five-month suspension, monitoring of all professional encounters with female patients whether in the office or hospital, and additional courses in medical ethics, boundary violations and consent. Dr. Horri's matter is distinguished by the nature of the doctor-patient relationship and the nature and duration of the sexual relationship. The *Karkanis* case is notable in relation to the totality of the penalty, which provided added and necessary protection to patients through the imposition of terms, conditions and limitations on his certificate of registration.

In *CPSO* v *Weaver*, 2012 O.C.P.S.D. No. 4, the Committee found Dr. Weaver to have engaged in disgraceful, dishonourable or unprofessional conduct by engaging in a sexual relationship with a former patient within one day after ending the doctor-patient relationship. The patient had attended Dr. Weaver several times over a five month period from October 2007 to February 2008 for family and marital problems. Dr. Weaver told the complainant that he was attracted to her, that this was a conflict of interest for him and advised her to find another doctor. They began a sexual relationship the next day following the last office visit and then they lived together for three months.

The circumstances of Dr. Weaver's case are distinguished from that of Dr. Horri in a number of ways. Dr. Weaver did not attend or participate in the discipline hearing and was not represented by counsel at the hearing. Dr. Weaver's certificate of registration had expired, and it was not known if he would reapply. The Committee accepted the penalty proposed by the College of a six-month suspension to commence if and when his certificate of registration was reinstated. The Committee also ordered significant terms, conditions and limitations on Dr. Weaver's certificate of registration, including the requirement of a practice monitor for encounters with female patients and courses in boundaries and ethics at his own expense. Given the limited details in *Weaver*, it is difficult to find parallels beyond the complainant being a former patient, to assist in

making a penalty determination in relation to Dr. Horri. What is clear is that a six-month suspension on its own was insufficient and that significant practice restrictions, should Dr. Weaver ever return to practice, were also ordered.

In *CPSO v. Redhead*, 2014 ONCPSD 2, after a contested hearing, the Committee found that Dr. Redhead engaged in disgraceful, dishonourable or unprofessional conduct, in that he engaged in a three-month sexual affair with a former patient, Ms X, commencing approximately one month after he had attended her in-person on five occasions for mental health problems in the Emergency Department and hospital (twice on November 12, and then on December 27, 28 and 29, 2006). The sexual affair commenced either at the end of January or the beginning of February 2007 and had ended by May 2007. The Committee found that Dr. Redhead engaged in significant therapeutic interventions with Ms X, who was vulnerable, in that she suffered from depression and anxiety and required evaluation of her mental health status, including assessing risk of suicide. The Committee also found that although Dr. Redhead saw her while she was in the throes of her illness, his doctor/patient relationship with Ms X was sporadic and brief, with no evidence of intense counseling or psychotherapy. Ms X was not a regular patient of his and he saw her in the context of emergency department attendances, admitting her on two occasions to the care of her family doctor. From December 27 to 30, 2006, he followed her clinical course while she was a hospital patient, while he was covering for the doctors in town. The Committee also found that Dr. Redhead had provided Ms X with gifts of money and medications, which was exploitive of her vulnerability and augmented the power imbalance between them. Ms X had a family doctor whom she attended regularly and relied upon for care and a psychiatrist who treated her whilst in hospital. The College requested a six-month suspension and Dr. Redhead requested a four-month suspension. The Committee ordered a five-month suspension, a term, condition and limitation on Dr. Redhead's certificate requiring instruction in professional ethics, a reprimand and costs.

Dr. Horri's matter is similar in that he engaged in a sexual relationship with Patient A, who had mental health issues, soon after the end of a doctor-patient relationship. However, in the Committee's view, the nature of the doctor-patient relationship is an important distinguishing factor between Dr. Redhead's and Dr. Horri's cases. Dr. Horri provided significant frequent,

ongoing care to Patient A over a five month period. She relied on him totally for her medical care. Dr. Horri was Patient A's only physician during this time. Also, the degree of trust Patient A placed in Dr. Horri was quantitatively and qualitatively greater, than that of Ms X's in Dr. Redhead. Patient A disclosed information to Dr. Horri that she had not disclosed to anyone else. The Committee finds that Dr. Horri acted opportunistically in commencing and manipulating their ongoing relationship. Dr. Horri contacted Patient A within days and engaged in sexual relations with Patient A within two weeks of the end of the doctor-patient relationship and just prior to leaving town. His sexual relationship with Patient A went on for three years. Further, Dr. Horri claimed ignorance of his professional obligations to Patient A and the Committee has significant concerns with Dr. Horri's insight. In contrast, Dr. Redhead was fully aware of the profession's view on sexual misconduct and his insight was not an issue. While there is some common ground between the two cases (vulnerable former patients with mental health issues; gifts of money; harm caused; no agreement that Dr. Redhead was unlikely to reoffend, similar to the Committee's view regarding Dr. Horri), the Committee considers that the egregious nature and circumstances of the conduct in Dr. Horri's case substantially exceed that of Dr. Redhead and that this requires a significantly longer period of suspension.

In *CPSO v. Powell*, 2014 O.C.P.S.D. No. 4, the Committee made a finding of disgraceful, dishonourable or unprofessional conduct based on Dr. Powell having intimate relations with two long term former patients. A joint submission on penalty included a nine-month suspension and the imposition of terms, conditions and limitations on Dr. Powell's certificate of registration, including courses on boundaries and ethics. Dr. Powell was a psychiatrist and the prior treating relationships entailed long term psychotherapy. The sexual relationships were also of longstanding nature. Dr. Powell identified transference with the first patient, which led to ending the doctor-patient relationship in November of 1998. The romantic relationship began in February of 1999, with intercourse commencing in September of 1999. They planned marriage and the relationship lasted about five years. The second patient, after an out-of-office meeting and dinner, mutually agreed with Dr. Powell to end the doctor-patient relationship. They saw each other almost daily and sexual intercourse began four to six weeks later.

There are a number of similarities between the *Powell* matter and Dr. Horri's case. However, there are differences making each unique. Dr. Powell is a psychiatrist and Dr. Horri is a family doctor. Dr. Powell engaged in misconduct with two patients; Dr. Horri's misconduct involved one patient. On the other hand, Dr. Powell did not attempt to rationalize or excuse his behavior, or give inconsistent evidence regarding motivation. In addition, the *Powell* matter proceeded as a joint submission on penalty. There was no argument regarding the appropriate length of suspension. *Powell* was a serious case and Dr. Powell would likely have risked more serious sanction had he contested the penalty. As a consequence, the Committee takes little guidance from *Powell*.

In *CPSO v. Ghabbour*,2017 ONCPSD 38, the Committee made a finding of disgraceful, dishonourable or unprofessional conduct based upon Dr. Ghabbour having a long term intimate relationship with a former patient. Dr. Ghabbour is a psychiatrist and had an intense psychotherapeutic relationship with his patient. The Committee found Dr. Ghabbour to have a lack of insight and revoked his certificate of registration. As with Dr. Horri, there was agreement on liability and a contested penalty. Dr. Ghabbour sought a suspension of nine to twelve months and practice restrictions to include indefinite ongoing counselling. The College sought revocation. The Committee in *Ghabbour* ordered revocation noting the seriousness of the misconduct, the profound vulnerability of the patient and the lack of insight into the egregious nature of the misconduct. Expert opinion evidence indicated risk of recurrence at the low end of the spectrum, however, the need for ongoing psychotherapy. G*habbour* is a more recent case and while the specifics of *Ghabbour* are more serious than Dr. Horri's case, the case establishes that when indicated, revocation is an appropriate penalty in a case of sexual relations post termination of the doctor-patient relationship.

The above cases share boundary violations and misconduct of a sexual nature with former patients. As can be seen from the number of cases, this type of misconduct is a significant and recurring problem. These cases range from 2004 to 2017. A number of these cases proceeded with a joint submission on penalty (*Schogt (9 month-suspension), Doyle (12 month suspension net 6 month-suspension), Karkanis (5 month-suspension), Powell (9 month-suspension)*), which reflects a compromise between adverse parties. In addition to a suspension, the Committee

ordered terms, conditions and limitations on the physicians' certificates of registration, which in several of the cases (*Doyle*, *Karkanis*, *Weaver)* included monitoring, supervision, ongoing psychotherapy or practice restrictions.

None of these cases is identical to Dr. Horri's case. However, in view of the range of suspension in prior similar cases, the Committee concludes a twelve-month suspension is within the range and is appropriate in light of the penalty principles and the egregious nature and circumstances of Dr. Horri's misconduct.

The Committee also considered the following cases, although they were less similar to Dr. Horri's case.

CPSO v. Wyatt, 2000 O.C.P.S.D. No 10 is an earlier a case dealing with misconduct of a sexual nature dating back to 1992. The circumstances were unique involving a stable long term commitment. There was no patient complaint. There was a contemporaneous doctor-patient relationship where psychotherapy was involved. Dr. Wyatt made full and honest disclosure and the Committee did not find that she engaged in predatory or exploitive behavior. Even so, the Committee ordered a 24-month suspension, 20 months of which would be suspended on a number of conditions. Dr. Wyatt was prohibited from conducting psychotherapy and was required to attend for psychotherapy and counselling.

CPSO v. McNally, 2006, and *CPSO v. M.S.I.* 2000 as with *Wyatt* are early cases and do not reflect current thinking. We do not give them weight in light of more current cases.

In *CPSO v. Muirhead*, 2014, there were multiple boundary violations with current and former patients including financial dealings, familiarity with patients, hugging, gift giving, though sexual misconduct was not established. Dr. Muirhead further failed to maintain the standard of practice in a number of ways. Dr. Muirhead practised only psychotherapy. He exploited patients for his own benefit. The Committee ordered a suspension of 18 months, along with terms requiring a programme of graded supervision, remedial education and monitoring of all future encounters with female patients.

In *CPSO v. Minnes*, 2015 O.C.P.S.D. No. 3, and *CPSO v. Marshall* (2016), the Committee ordered revocation of the physicians' certificates of registration. The physicians were found to be in a position of trust in relation to underage, non-patient victims. Dr. Minnes, a pediatrician, was a camp doctor and the victim was a 17-year-old camp counsellor whom he had advised on a minor medical complaint. There was no physician-patient relationship established. The sexual acts included progressively intrusive, unwanted sexual touching. Dr. Minnes was also found to have engaged in disgraceful, dishonourable or unprofessional conduct with nurses, however, this did not enter into the Committee's decision to revoke his certificate of registration. The fact that the camp counsellor victim was underage was an important consideration in determining revocation as the appropriate penalty. In both *Minnes* and *Marshall*, the misconduct involved underage victims and the Committee determined revocation was appropriate. While there is a significant age differential between Dr. Horri and Patient A, Patient A was not a minor.

Societal Issues

Boundary violations in the context of the doctor-patient relationship have been a significant concern for the public and a significant problem for the College as regulator of the profession. As a consequence, the College in September 2008 approved a Policy (#4-08) Maintaining Appropriate Boundaries and Preventing Sexual Abuse, which was widely circulated to the profession in its regular Dialogue publication. The intention was two-fold: first, to ensure that physicians maintain appropriate boundaries in the doctor-patient relationship and second, to prevent sexual abuse.

As it relates to Dr. Horri, this Policy specifically addresses sexual relationships with former patients. The Policy, under section C – Sexual Relationships after Termination of the Physician-Patient Relationship, states that:

> Ending the physician-patient relationship does not eliminate the possibility that sexual contact between a physician and a former patient may be considered to be professional misconduct even though it is not sexual abuse as defined in the *RHPA*.

This is because there may be continuing trust, knowledge, or influence derived from the previous professional relationship.

…

In determining the propriety of a sexual relationship between a physician and a former patient, a number of factors will be considered, including:

- the length and intensity of the former professional relationship;
- the nature of the patient's clinical problem;
- the type of clinical care provided by the physician;
- the extent to which the patient has confided personal or private information to the physician; and
- the vulnerability the patient has in the physician-patient relationship.

For example, when the physician-patient relationship involves a significant component of psychoanalysis or psychotherapy, sexual involvement with the patient is likely inappropriate at any time after termination. However, if a physician saw a patient on one or two occasions to provide routine clinical care, it may not be inappropriate to have a sexual relationship with the former patient within a short time following the end of the physician-patient relationship.

At all times, a physician has an ethical obligation not to exploit the trust, knowledge and dependence that develops during the physician-patient relationship for the physician's personal advantage. A physician who is considering an intimate or sexual relationship with a former patient should act cautiously, making sure to consider the potentially complex issues. As well, a physician should ensure that the former patient has a good understanding of the dynamics of the physician-patient relationship and the boundaries applicable to that relationship. (*emphasis added*)

The Policy took a realistic approach. Factors, which need to be considered, were spelled out. Although there was no clear or absolute prohibition, the Policy states that: "when the physician-patient relationship involves a significant component of psychoanalysis or psychotherapy, sexual involvement with the patient is likely inappropriate at any time after termination". There was no traditional psychotherapy in this case. However, there was repeated attention to mental health issues and intense supportive counselling, the dynamics of which endured beyond the end of the physician-patient relationship. These contextual factors weigh against a sexual relationship with a former patient, such as Patient A.

As with many areas in medicine, it is not possible to address in a policy all possible situations, which may arise. Rather, a cautious path and a principled approach are needed. The degree of trust invested in the physician by the patient, the nature of the relationship and exploitation of the patient, are driving factors in weighing misconduct of a sexual nature. While it is accurate that sexual relationships with former patients are not explicitly prohibited, the fundamental principles of acting in the patient's best interest, putting the patient's needs first and not exploiting the power imbalance of the doctor-patient relationship, set a bar to precipitous sexual relations with vulnerable former patients. In the Committee's view, Dr. Horri can find no support in this Policy for his sexual relationship with Patient A.

Ten years after the inception of this Policy, sexual misconduct with former patients remains a problem. The body of case law cited in this matter provides the proof. Prior approaches, such as suspending a portion of an ordered suspension on certain conditions, have not been helpful and have been abandoned. In the face of heightened awareness of this continuing problem, there is a trend in recent years to imposing significant penalties. Support for this approach comes from the Supreme Court of Canada in the *Lacasse* case where it states "Maintenance of public confidence is a shifting standard, and the committee's penalties should remain in accordance with public standards and expectations." Penalties levied in the past have not had the general deterrent effect as intended. With Dr. Horri, specific deterrence is a factor to be considered in the penalty order, in addition to denunciation of the misconduct and general deterrence.

The importance to society of disavowing precipitous relationships of a sexual nature with vulnerable former patients is reflected in a recent legislative amendment, *the Protecting Patients Act*, 2017, S.O. 2017, c. 11, to the *Regulated Health Professions Act*, 1991 S.O. 1991, c. 18. Subsection 1(6) of the Code came into effect on May 30, 2018 and provides a definition of patient, which extends the period during which an individual is considered to be a patient by one year from the end of the physician-patient relationship. While Dr. Horri's case predates this legislative amendment, the legislation as it stands in 2018 clearly prohibits the misconduct admitted to by Dr. Horri and stipulates mandatory revocation for the very conduct he was found to have engaged in.

Revocation as compared to Suspension

The Committee raises this point to acknowledge that there is a significant difference between an order of revocation of a member's certificate of registration and that of a suspension regardless of length.

Once revoked, a physician is no longer a member of the profession. However, the doctor may apply for reinstatement after a specified period of time (after one year from the date of revocation as a result of a disciplinary proceeding, except in relation to a revocation for sexual abuse which can be made after five years). A reinstatement hearing takes place before the Committee and the costs are borne by the physician. The physician has the onus of proof to persuade the Committee that he or she is suitable to re-enter the profession.

When a suspension is ordered, the physician remains a member of the profession. When a suspension is completed, the member is free to resume practice, subject to any terms, conditions and limitation which may have been imposed on the member's certificate of registration.

Conclusion

The Committee considers that the suspension imposed is at the higher end of an appropriate range established by the case law. In our view, a penalty that includes a twelve-month

suspension is warranted in this case. It is commensurate with the egregious nature of the misconduct by Dr. Horri, the need to achieve specific and general deterrence, and the need to stop such behaviour in recognition of the evolution of social values.

The Committee took particular care to examine the case law to ensure fairness and proportionality. In the Committee's view, a twelve month suspension will maintain the public's confidence in the profession to fairly regulate the profession in the public interest, in addition to achieving appropriate denunciation of the misconduct, and both general deterrence and specific deterrence.

The Committee accepts that Dr. Horri is informed with respect to boundaries and is not imposing terms on his certificate of registration which would encumber Dr. Horri such as supervision or monitoring. To achieve rehabilitation and enhance public protection, the Committee is imposing terms, conditions and limitation requiring an ethics course with specific attention to professionalism, boundaries, and communication, which is anticipated to assist Dr. Horri going forward.

In determining the penalty in this matter, the Committee has had regard for the relevant facts, the submissions of counsel, the case law, direction of the Divisional Court and advice from Independent Legal Counsel. Factors which were most important include the following:

- The vulnerability of Patient A, which was enhanced by her mental health issues, for which she relied on Dr. Horri for care;
- Dr. Horri's characterization of the relationship as "supportive and not intense," which minimized the true nature of the relationship and minimized the degree of trust invested in him by Patient A;
- Dr. Horri exploited that trust and the knowledge derived from the doctor-patient relationship, by offering "friendship" and subsequently sexualizing the relationship in meeting or failing to control his own sexual needs;
- Dr. Horri rationalized his behavior by asserting ignorance of the rules and by saying he offered Patient A friendship which the Committee found to be an attempt to excuse his

behavior. This attempt to distance himself demonstrates a failure to take responsibility and is self-serving;

- Dr. Horri was not fully honest in his testimony before the Committee in regards to his motivation for contacting Patient A;
- The Committee concludes that the reasons Dr. Horri told Dr. Collins about why he acted the way he did were inconsistent with his testimony before the Committee;
- The Committee concludes that while Dr. Horri now acknowledges he was wrong, he has limited insight into to his personal vulnerability and the impact of his behavior;
- The Committee concludes that the risk to patient safety posed by Dr. Horri is indeterminate. The evidence of Dr. Collins did not persuade the Committee that Dr. Horri was at low or no risk of future similar misconduct.

The Committee accepts that Dr. Horri has admitted his misconduct, apologized, learned from this experience and states that this type of misconduct will never occur again. Nonetheless, Dr. Horri has a ways to go in gaining personal insight and taking full responsibility for his serious misconduct.

COSTS

The Committee has set costs payable to the College at $15,680.00, which reflects the costs of one hearing day at the rate of $5,500.00 and one penalty day at the current rate of $10,180.00. This takes into consideration that there was success on appeal of the first penalty order. We also considered the changes in the tariff rate for one day of hearing, which occurred between September 2016 and November 2018. After hearing and considering the submissions of the parties, as in *CPSO v. Garcia* (2017), the Committee ordered costs based on the per diem tariff rate that was in effect at the time of each of the hearing days. We find this approach to be fair and reasonable.

ORDER

The Discipline Committee orders and directs that:

1. The Registrar suspend Dr. Horri's certificate of registration for a period of twelve months, effective immediately;

2. The Registrar impose the following terms, conditions and limitations on Dr. Horri's certificate of registration:

    a) Dr. Horri shall complete an individualized course in medical ethics approved by the College to include professional responsibility, boundaries, and professional communication within 12 months of the date of this Order and will provide reports of successful completion to the College, at his own expense.

3. Dr. Horri appear before the panel to be reprimanded;

4. Dr. Horri pay to the College costs in the amount of $15,680.00 within 30 days of the date of this Order.