NOTICE OF PUBLICATION BAN

In the matter of the College of Physicians and Surgeons of Ontario and Dr. Allan Selig Gordon, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the name and any information that could disclose the identity of the patient referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 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. Gordon, 2018 ONCPSD 67

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. ALLAN SELIG GORDON

PANEL MEMBERS:

MR. P. GIROUX (CHAIR)
DR. P. ZITER
DR. E. SAMSON
MAJOR A.H. KHALIFA
DR. P. CASOLA

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS C. SILVER

COUNSEL FOR DR. GORDON:

MR. J. LILLES
MR. K. COSTIN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS Z. LEVY

PUBLICATION BAN

Hearing Date:	**October 12, 2018**
Decision Date:	**October 12, 2018**
Written Decision Date:	**November 28, 2018**

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 October 12, 2018. 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 the Committee's penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Allan Selig Gordon committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

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

The Notice of Hearing also alleged that Dr. Gordon is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Gordon entered a plea of no contest to allegations 1 and 2 in the Notice of Hearing, that he failed to maintain the standard of practice of the profession, and that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances,

would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew allegation of incompetence.

THE FACTS

The following facts were set out in the Statement of Uncontested Facts, which was filed as an exhibit at the hearing and presented to the Committee:

A. FACTS

1. Dr. Allan Selig Gordon ("Dr. Gordon") is a 73-year-old physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College) on July 4, 1969.

2. Dr. Gordon holds Royal College of Physicians and Surgeons of Canada certification in neurology and practised at a Pain Management a Hospital in Toronto, Ontario until January 2018.

3. Dr. Gordon has expertise in the evaluation and treatment of widespread pain, neuropathic pain, and pelvic and genital pain.

Patient A

4. Patient A suffers from a complex and painful nerve condition in her feet and fibromyalgia. She was referred to Dr. Gordon by her family physician for investigation of her nerve pain.

5. On a date in March, 2016, Patient A presented at Dr. Gordon's office for an appointment. Her main concern at the March appointment was the pain in her feet. Patient A was in her 30's.

6. Prior to conducting a physical examination, Dr. Gordon reviewed Patient A's chart and

inquired into her medical history. He noted, among other things, widespread pain, foot pain, and pain with intercourse. She also complained of cold allodynia.

7. Dr. Gordon indicated that he wanted to do an examination and took Patient A to the examination room across from his office. He left her alone to gown. Dr. Gordon did not offer or provide Patient A with a chaperone for the examination.

8. When Dr. Gordon returned to the examination room, he began by testing Patient A's reflexes and did a strength assessment. He proceeded to conduct an examination with a cotton swab. Dr. Gordon ran the swab along Patient A's arms, legs and feet. Without asking and without an adequate explanation to Patient A, he slightly exposed Patient A's breast and touched it with the swab. He also tested various areas with a cold tuning fork (looking for cold allodynia) and a pointed object.

9. Dr. Gordon asked Patient A to stand and face the wall, and stood behind her. He examined various muscles for strength, tenderness and pain. Without asking and without an adequate explanation to Patient A, he pulled up the back of Patient A's hospital gown to expose her buttocks. He began touching various spots on her buttocks with the cotton swab, to test for tenderness. Patient A felt uncomfortable and "creeped out."

10. Dr. Gordon asked Patient A to lie down on the bed to check for vulvar pain. He wondered if she had provoked vestibulodynia as a cause for her intercourse pain. Patient A felt uncomfortable. She has a history of sexual abuse. She attempted to avoid the exam by telling Dr. Gordon she had her period, but Dr. Gordon said he was fine to proceed if she agreed. She complied. She removed her underwear and lay down on the examination table. Dr. Gordon did not explain to Patient A why he wanted to examine her vagina or what he was about to do.

11. Without an explanation adequate for Patient A, Dr. Gordon used a cotton swab to lightly touch various parts of Patient A's labia, including her internal labia and around where her

tampon was. Patient A indicated that this did not hurt. The experience left Patient A feeling caught off guard and very upset.

12. After the physical examination concluded, Dr. Gordon left Patient A to dress and returned to his office. Patient A dressed and joined him in his office. Dr. Gordon felt that a small fibre sensory neuropathy could account for the foot pain. He asked if Patient A had ever experienced any emotional or physical trauma. Patient A did not understand how this was relevant to the assessment. She explained that she had been sexually abused as a child, but that she didn't remember the details. Dr. Gordon commented it was probably better she didn't. Patient A reiterated that her main concern was the pain in her feet. He offered a variety of other evaluations, tests and treatments to her including psychological therapy, rhythmic sensory stimulation therapy, and a promise to explore virtual reality therapy. He wrote her doctor and copied Dr. Vera Bril for information on the small fibre testing. Patient A left the appointment with Dr. Gordon feeling extremely upset but made no mention of this to Dr. Gordon.

13. In April 2016, Patient A complained to the College regarding her experience with Dr. Gordon.

14. The College retained the services of Dr. Neil Hagen to review the care provided by Dr. Gordon to Patient A. Dr. Hagen opined, in part, as follows:

> Ms. [Patient A] was evaluated by Dr. Gordon once, [in] March, 2016. Written assessment tools indicate she described pains in her feet including marked sensitivity to cold and to touch; pains in the back, buttocks and legs; pain with intercourse, and other pains…
>
> *Question: Was the patient inappropriately examined in that the skin of her breast, buttocks and her external genitalia were touched by a cotton applicator ("Q-tip") when examination of those areas was not warranted?*

Based on the information provided to me and with familiarity with the kind of scenario that this patient presented with, it is my opinion that the patient was indeed appropriately examined.

The use of a cotton applicator to systematically search for mechanical allodynia is a ***routine part of the pain physical examination***. It is routinely taught to Residents and other pain trainees. The use of a cotton applicator has particular importance in a patient with chronic pelvic pain, whether the patient has an isolated regional pain, or whether there is also a concurrent generalized pain disorder (as was the case for the patient who has lodged the present complaint). The use of a cotton applicator has been validated as a bedside provocative maneuver in chronic pelvic pain, to look for the presence of pain sensitization. It is relevant in assessment of patients who likely have neuropathic pain and also can be present in pelvic pains which have other mechanisms... Importantly, whether for assessing pelvic pain or for assessing pain elsewhere such as in the feet, patients do not always understand why they would be examined in this peculiar manner with a cotton applicator, even in this instance where the patient presented with, using her own description, “allodynia”.

On examination it is common that the physician finds either greater or less mechanical allodynia than what might be anticipated based on the history, and often in a pattern of distribution different than what is expected. Thus, a systematic approach to the use of a cotton applicator during the physical examination of a chronic pain patient is standard practice in pain medicine.

Question: Did the patient undergo a breast, buttocks and a pelvic

examination without the patient's explicit consent?

It is my opinion that a competent pain physician will directly ask the pain patient for consent to examine them.
Further, the physician should be attuned to *ongoing consent*, for example: to alert the patient that an upcoming part of the exam might be uncomfortable; to ask for feedback about any discomfort that arises in the course of the exam; to ask again, "can I examine you *here* to look for tenderness?"

Breast Examination. It is unclear whether there was in fact any breast exam performed. "He slightly exposed my breast, but not the nipple", the patient reported in her letter of complaint. Dr. Gordon's June 6 report indicates the patient described bilateral axillary pain ... It is my opinion that exposing an area where there was a report of tenderness is ***standard practice*** in examining a pain patient. There appears however to have been miscommunication about what Dr. Gordon was going to do during the examination…

Buttocks Examination ... It is however ***standard practice*** to directly inspect the back and buttocks, including the skin, when there is chronic pain in those regions. Scars from some forgotten major surgery, birth defects, muscle atrophy, evidence of spondylolisthesis or scosoliosis, and many other serious contributing factors can often be discerned only by direct observation. Further, it is clear from the consultation that Dr. Gordon was assessing for the presence of tender points. Examination of the buttocks by pressing specific areas where tender points are found, is ***standard practice*** in the assessment of a pain patient who might have fibromyalgia.

...

> *Summary: Did the care Dr. Gordon provided to the patient meet the standard of practice of the profession?*
>
> My opinion: Yes, the care Dr. Gordon provided to the patient met the standard of practice of the profession... There was clearly miscommunication in that the patient did not understand why the physical examination of the axilla, buttocks and perineum was conducted in the way it was, and that is in my opinion the crux of the matter.
>
> ...
>
> The patient wrote in her complaint that she did not understand what examination was going to be performed and why. This implies a ***serious breakdown in communication.***

15. Dr. Gordon also retained an expert, Dr. John Jarrell, to review the care he provided to Patient A, who agreed with Dr. Hagen that the tests done were clinically indicated.

16. Dr. Gordon does not contest that he similarly did not provide adequate explanations to some other patients before proceeding with sensitive examinations and inquiries.

RULE 3.02 OF THE DISCIPLINE COMMITTEE'S RULES OF PROCEDURE

Rule 3.02 of the Discipline Committee's Rules of Procedure 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.

FINDING

The Committee accepted as true all of the facts set out in the Statements of Uncontested Facts. Having regard to these facts, the Committee accepted Dr. Gordon's plea and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession, and in that has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

AGREED STATEMENT OF FACTS ON PENALTY

The following facts were set out in the Agreed Statement of Facts on Penalty, which was filed as an exhibit at the hearing and presented to the Committee:

1. On January 26, 2018, the Inquiries, Complaints, and Reports Committee ("ICRC") made an interim order under section 25.4 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, directing the Registrar to suspend the certificate of registration of Dr. Alan Selig Gordon ("Dr. Gordon"). Dr. Gordon has not practiced since that Order took effect.

2. Dr. Gordon has undertaken to resign his certificate of registration effective immediately and not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Gordon made a joint submission as to an appropriate penalty and costs order.
A joint submission on penalty should be accepted by the Committee unless to do so would bring the administration of justice into disrepute, or is otherwise not in the public interest. Counsel for Dr. Gordon reviewed in his submissions the Supreme Court of Canada's decision in *R v Anthony-Cook* (2016) and emphasized the import of this principle.

In arriving at its decision, the Committee first considered the applicable penalty principles. Those principles include protection of the public, so one measure of the appropriateness of an order is whether it is adequate to protect the public. General deterrence of the profession is another important purpose of any order. Further, the order should provide specific deterrence, discouraging the practitioner from engaging in the conduct in the future. Another penalty principle is maintaining public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest. Where relevant, consideration is also given to rehabilitation of the practitioner. These general considerations, and consideration of the parties who would be affected by the order, including the public, the profession, and the practitioner, informed the Committee's decision on penalty.

Facts Relevant to Penalty Assessment

As set out in the Statement of Uncontested Facts, Dr. Gordon is a neurologist who practised pain medicine at the Pain Management Centre at a Hospital in Toronto. The complaint brought against Dr. Gordon leading to this hearing related to the manner in which he approached his patient, and his failure to obtain consent for the examination he conducted. The Committee finds that the examination conducted of the patient was clinically indicated, based on the evidence of the two independent experts, one retained by the College and the other by Dr. Gordon. However, Dr. Gordon conducted his examination without explanation to the patient of what he was doing, and

without seeking even informal consent from the patient. In so doing, he failed to show sensitivity to the patient.

Patient A presented to Dr. Gordon with the primary complaint of foot pain. She was caught off guard and was upset that Dr. Gordon's clinical examination included a total body assessment, including her genitourinary area, for pain. This required the patient to disrobe. While the patient acknowledged that she had pain symptoms associated with multiple other areas of her body other than her feet including her genitourinary area, she had not expected the examination conducted by Dr. Gordon, and did not understand why Dr. Gordon conducted a general body examination. By failing to explain in advance and obtain consent from the patient for a full body examination, where her chief complaint was foot pain, Dr. Gordon caused confusion on the part of the patient. Dr. Gordon's intrusion into this patient's sphere of intimacy without the patient understanding the reason for it left her feeling scared, threatened, and embarrassed.

Meaningful communication and obtaining informed consent for the doctor's clinical actions is integral to a healthy doctor-patient relationship. Patients need to be informed of the rationale for a physician's clinical actions in advance, so they can understand the procedure(s) to be performed. This allows the patient to prepare for the procedure(s) and provide informed consent to proceed. It is not sufficient that the clinician is aware of the rationale for an examination. The patient must also be informed by the clinician.

Beyond the general requirement for informed consent, the Committee notes the fundamental importance of proper and respectful boundaries in dealing with subjects of an intimate nature or performing intimate examinations. It is of particular importance that patients be informed, that spatial boundaries be respected, and that physicians refrain from inappropriate comments during these moments. Failure to act appropriately undermines public trust in the profession. The patient's comment to Dr. Gordon that she had been sexually abused should have been a "red flag" to him to be even more cautious about potential boundary violations that may be perceived by this patient. His comment to her that it was best that she not recall the abuse was inappropriate and insensitive. Equally, his failure to communicate properly with her about the nature and need

for the examinations conducted was inappropriate and insensitive, which together with the uncontested statement of fact that Dr. Gordon did not provide adequate explanations to some other patients before proceeding with sensitive examinations and inquiries, suggests a pattern of insensitive behaviour.

The Committee has no doubt that Dr. Gordon is a proficient clinician and that his clinical examination of the patient as described by the two independent assessors was appropriate. The Committee is also aware that the pain management and treatment is a challenging field, and can be a difficult area of medicine in which to practice. However, the insensitivity Dr. Gordon manifested in his approach to and working with the patient stands in marked contrast to his clinical skills, and in that way failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct.

Application of General Penalty Principles

As set out above, general penalty principles include remediation, specific deterrence, general deterrence, public protection, and maintaining public confidence in the integrity of the profession and the College’s ability to regulate the profession in the public interest. Mitigating and aggravating factors should be considered.

On January 26, 2018, the ICRC made an interim order under the Code to suspend Dr. Gordon's certificate of registration. Dr. Gordon has not practised since that time. Dr. Gordon has undertaken to resign his certificate of registration effective as of the date of the hearing. Therefore, remediation is not applicable in this case, and the principle of specific deterrence is satisfied.

Given Dr. Gordon's resignation and undertaking not to practise medicine in Ontario or any other jurisdiction, public protection is achieved. The principle of general deterrence is also satisfied as it sends a message to the profession that this behaviour will not be tolerated.

Mitigating factors in this case include that Dr. Gordon did not contest the allegations, thus sparing the complainant from having to testify before this Committee. This also saved the College the time and expense required for a contested hearing. Further, the Committee recognizes that Dr. Gordon has never been before the Discipline Committee previously.

The aggravating factor here is that the Committee accepted as true that, as set out in the Uncontested Statement of Facts, Dr. Gordon similarly did not provide adequate explanations to some other patients before proceeding with sensitive examinations and inquiries.

In consideration of those factors, the factual background set out above, and the general penalty principles also set out above, the Committee concluded that the jointly proposed penalty is appropriate in this case.

The Committee also found that this was an appropriate case in which to order costs to the College in the amount of $6,000 for a half day hearing.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of October 12, 2018. In that order, and in light of Dr. Gordon's undertaking to resign and to not re-apply, the Committee ordered and directed on the matter of penalty and costs that:

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

3. Dr. Gordon pay costs to the College in the amount of $6,000 within thirty (30) days from the date of this Order.

TEXT of PUBLIC REPRIMAND

Delivered October 23, 2018

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. ALLAN SELIG GORDON

Dr. Gordon,

In the practice of medicine in today's environment, a physician is not only obligated to provide an accurate medical diagnosis as a result of a patient encounter but also to appropriately inform the patient as to the nature and extent of the consultation.

Public expectations have changed over time and physicians are obligated to not only keep appraised of technical education but also with societal norms.

You had many opportunities in the course of your patient encounter to explain to your patient how you were going to proceed but you failed to do so.

The Committee regrets that you are appearing before us today after a long and distinguished career.