

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Albert Poh Soon Choong, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

Every person who contravenes an order made under ... section 45 or 47... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Choong,  
2018 ONCPSD 12**

**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. ALBERT POH SOON CHOONG**

**PANEL MEMBERS:**  
**DR. M. DAVIE (CHAIR)**  
**MAJOR A.H. KHALIFA**  
**DR. M. GABEL**  
**MR. J. LANGS**  
**DR. E. SAMSON**

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

**MS A. BLOCK**

**COUNSEL FOR DR. CHOONG:**  
**MR. M. SAMMON**  
**MS K. COSTIN**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR. R. COSMAN**

**Hearing Date:** February 5, 2018  
**Decision Date:** February 5, 2018  
**Release of Written Reasons:** March 13, 2018

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on February 5, 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. Dr. Albert Poh Soon Choong committed an act of professional misconduct:

1. under clause 51(1)(b.1) of the Health Professions Procedural Code which is schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the “Code”) in that he engaged in sexual abuse of a patient;
2. 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
3. under paragraph 1(1)33 of Ontario Regulation 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.

### **RESPONSE TO THE ALLEGATIONS**

Dr. Choong admitted that he engaged in professional misconduct as alleged in paragraphs 2 and 3 in the Notice of Hearing. The College withdrew the allegation in paragraph 1 in the Notice of Hearing.

## **THE FACTS**

The following facts are set out in the Agreed Statement of Facts, which was filed as an exhibit and presented to the Committee:

### **PART I - FACTS**

#### **A. Background**

##### **(i) Dr. Albert Poh Soon Choong**

1. Dr. Albert Poh Soon Choong (“Dr. Choong”) is an 81 year old family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario on October 10, 1972.
2. At the relevant time, Dr. Choong practised family medicine in Toronto, Ontario.

##### **(ii) Patient “A”**

3. Patient “A” became a patient in Dr. Choong’s family practice in the late 1990s when she first immigrated to Canada. In June, 2016, Patient “A” attended Dr. Choong’s office with complaints of pain in her rectum due to constipation and as a result of medication she was taking to relieve headache and muscle pain.
4. Given Patient “A”’s presentation, Dr. Choong offered to conduct a digital rectal examination (DRE), which the patient accepted.
5. Patient “A” was in the examination room alone with Dr. Choong. Dr. Choong did not offer the patient a chaperone.
6. Dr. Choong directed Patient “A” to take off her pants and undergarments. Dr. Choong failed to provide the patient any draping.

7. Dr. Choong asked Patient “A” to bend forward, and lean over the exam table, raising her rectum towards him. Dr. Choong’s positioning did not allow for adequate visual examination. Dr. Choong inadvertently inserted his finger in the patient’s vagina in a manner the patient experienced as forceful.
8. Patient “A” responded quickly stating “oh no not there”. Dr. Choong then released his finger and proceeded to insert it in her rectum to perform a digital rectal exam.
9. Following the examination, Dr. Choong recorded in his chart that the left lateral wall of the anus was tender but there was no induration and no blood. He found no clinical evidence of the abscess. Given Patient “A”’s presentation and finding, Dr. Choong believed she had an anal fissure and prescribed an analgesic cream.
10. The College retained Dr. Nancy Merrow to provide an opinion as to whether a digital rectal exam was clinically indicated in the circumstances and whether the digital rectal exam was performed to the standard of practice of the profession. A copy of Dr. Merrow’s opinion dated April 17, 2017 is attached at Tab 1 [to the Agreed Statement of Facts].
11. Dr. Merrow concluded that a digital rectal exam was clinically indicated in the circumstances. However, she offered the opinion that Dr. Choong failed to maintain the standard of practice of the profession in this case.
12. Dr. Merrow explained that the standard of practice for a female digital rectal examination is for the patient to be in the lithotomy position (on her back with legs open as for a pelvic examination) or lying on her left side. One would proceed in the lithotomy position if the patient was being evaluated for possible pelvic complaints and a rectal examination was also required. If only a rectal examination is indicated based on the complaint, the left side lying position is standard. Given that Patient “A” was complaining specifically of rectal pain and she was constipated, a side lying examination was indicated.
13. Dr. Merrow further concluded that Dr. Choong’s digital rectal examination technique

displayed a lack of judgment. Not only did he not employ the appropriate technique for female patients, he also failed to provide modesty draping, demonstrating a lack of judgment and a failure to maintain the standard of practice. Dr. Merrow noted that the examination which was “clumsily performed” may have a lasting negative effect on the patient’s experience.

## **PART II – ADMISSION**

14. Dr. Choong admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct:

- (a) under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”) in that he engaged in an act or omission relevant to the practice of medicine that having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and
- (b) under paragraph 1(1)2 of O Reg. 856/93 in that he has failed to maintain the standard of practice of the profession.

## **FINDING**

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Choong’s admission 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 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.

## **JOINT SUBMISSION ON PENALTY AND COSTS**

Counsel for the College and counsel for Dr. Choong made a joint submission as to an appropriate penalty and costs order. The joint submission included that Dr. Choong attend before the panel to be reprimanded and that he pay costs to the College in the amount \$5,500.00 within 30 days of the date the order becomes final.

In addition, the College filed, as exhibit 3, and as an attachment to the proposed order, Dr. Choong's undertaking dated January 30, 2018. Under this undertaking, Dr. Choong resigned from the College, effective January 30, 2018, and undertook not to apply or re-apply for registration to practise medicine in Ontario or any other jurisdiction.

In considering the appropriateness of the proposed penalty, the Committee was aware of the direction of the court that a joint submission on penalty should be accepted, unless the proposed penalty would bring the administration of justice into disrepute or is otherwise contrary to the public interest (*R v. Anthony-Cook*, 2016 SCC 43). The Committee is well aware that this test has been adopted and followed in previous decisions of the Discipline Committee.

Also, the Committee took into account that the primary consideration is protection of the public. Additional penalty principles are: denunciation of the conduct, general deterrence of the members of the profession, specific deterrence of the member, and maintaining public confidence in the profession, and the College's ability to regulate the profession in the public interest.

### **Aggravating Factors**

The facts underlying Dr. Choong's professional misconduct are set out in detail in the Agreed Statement of Facts. Although rectal examination was indicated in this case, it was performed in an inappropriate fashion and in a manner that displayed a lack of judgment, resulting in a violation of the patient's dignity and privacy. In addition, it was performed in a clumsy manner that caused embarrassment and physical distress to the patient. Dr. Choong failed to provide

modesty draping, demonstrating a failure to maintain the standard of practice of the profession.

An independent opinion by Dr. Nancy Merrow, dated April 17, 2017, indicated that the Digital Rectal Examination (DRE) performed by Dr. Choong did not meet the standard of practice of the profession. She described that the standard patient position for a female DRE is the left side lying position. As well, she opined that Dr. Choong's insertion of his examining finger into the vagina instead of the rectum demonstrates that his technique did not allow for adequate visual examination. Dr. Merrow concluded her report by opining on the question whether Dr. Choong's conduct exposed or was likely to expose his patient to harm or injury, stating: "Yes. I think one only has to imagine oneself with pants and underclothes off, bare backside not draped, standing bent over an examination table having a DRE which is clumsily performed to feel what a lasting negative effect the experience could have." The Committee was in agreement with her conclusion.

It is imperative that patients be shown the respect due to them by provision of a gown and privacy to change into it, and modesty draping, and to be properly examined with the least amount of exposure necessary to perform the examination. The patient must be able to expect that a DRE will be performed well, and not to have fingers inserted accidentally into the vagina for no clinical reason, as in this case. As well, offering the patient the presence of a chaperone would have been respectful of the patient's dignity and privacy.

Dr. Choong has clearly engaged in an act or omission that would reasonably be regarded by members as disgraceful, dishonourable and unprofessional by his actions, which demonstrated a lack of respect for his patient's right to dignity and a properly done examination. In his failure to provide modesty draping and in his performance of the DRE, Dr. Choong failed to maintain the standard of practice of the profession.

### **Mitigating Factors**

Dr. Choong has had no previous disciplinary history with the College. By agreeing to the Statement of Facts and entering into a joint submission on penalty, he saved the complainant



from having to testify about a stressful and embarrassing examination in a public forum. As well, he has saved the costs of a prolonged contested hearing.

### **Case Law**

In support of the jointly proposed penalty, College counsel relied on a number of prior cases. Although no two cases are identical, the Committee was satisfied that the parties' jointly proposed penalty order was consistent with orders imposed in similar cases: *CPSO v. Dubins* (2016); *CPSO v. Guindon* (2012); and *CPSO v. Roche* (2017).

These cases illustrate multiple ways that patients were treated without the respect due to them, and the physicians failing to maintain the expected standard of practice. In all three cases, public safety was accomplished by the resignation of the physicians of their membership in the College and each physician received a public reprimand.

It is unfortunate that Dr. Choong was not able to end a long and unblemished career with honour.

### **The Undertaking**

The Committee accepted that Dr. Choong's undertaking to resign from the College, and never to apply in Ontario or elsewhere to practise as a physician, provided assurance of the Committee's primary focus, which is protection of the public. The provision of a public reprimand served the purpose of expressing the dismay of the profession and the public at Dr. Choong's misconduct, and sends a message to the members of the profession of the importance of respecting the dignity and needs of patients at all times.

### **Costs**

The Committee finds this to be an appropriate case to assess against the physician the costs for one day of hearing, in the amount of \$5,500.00, as agreed upon by the parties.

**ORDER**

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of February 5, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Choong attend before the panel to be reprimanded.
3. Dr. Choong pay costs to the College in the amount of \$5,500.00 within 30 days of the date this Order becomes final.

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

**TEXT of PUBLIC REPRIMAND**  
**Delivered February 5, 2018**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. ALBERT POH SOON CHOONG**

The Panel is very disappointed that this is the way you end your long, unblemished career. Your misconduct reflects poorly on you and on the profession as a whole. The public must be able to trust that all physician encounters, and especially sensitive examinations, will be done in a completely professional manner, with proper attention to patient positioning and modesty draping. Even with patients you're familiar with after years of care, everyone deserves to be treated with dignity and respect.

We are reassured by your resignation and undertaking to never reapply in Ontario or any other jurisdiction; that the public will be protected going forward.

*This is not an official transcript*