NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Wameed Ateyah, this is notice that the Discipline Committee ordered a ban on the publication, including broadcasting, of the name of the complainant and any information that could identify the complainant whose testimony is in relation to allegations of misconduct of a sexual nature involving the complainants, under subsection 47(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

> 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 and 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. Ateyah, 2019 ONCPSD 31

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 Surgeon 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. WAMEED ATEYAH

PANEL MEMBERS: **DR. P. TADROS (CHAIR)**
MR. P. PIELSTICKER
DR. C. CLAPPERTON (Dissenting)
MR. P. GIROUX
DR. P. BERGER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:
MS E. WIDNER

COUNSEL FOR DR. ATEYAH:
MR. J. KOZIEBROCKI
MS L. YERMAKOVA

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. MCALEER
MR. B. SELLS

PUBLICATION BAN

Hearing Dates: **May 14 to 18, 2018**
Decision Date: **July 19, 2019**
Written Decision Date: **July 19, 2019**

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 May 14 to 18, 2018. At the conclusion of the hearing, the Committee reserved its decision on finding.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Wameed Ateyah 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;

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

3. 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.

The Notice of Hearing also alleged that Dr. Ateyah is incompetent as defined by subsection 52(1) of the Code.

RESPONSE TO THE ALLEGATIONS

Dr. Ateyah denied the allegations in the Notice of Hearing. College counsel advised in closing submissions that the College was not pursuing the allegation of incompetence.

CONCLUSION

The Discipline Committee finds that: the allegation of failing to maintain the standard of practice of the profession is proven; the allegation of disgraceful, dishonourable or unprofessional conduct is not proven; and the allegation of sexual abuse is not proven.

Dr. Clapperton, dissenting, finds that: the allegation of failing to maintain the standard of practice of the profession is proven; the allegation of disgraceful, dishonourable or unprofessional conduct is proven and the allegation of sexual abuse is proven.

The Discipline Committee agrees with and adopts Part A of Dr. Clapperton's decision - Background, Issues, Evidence and Law. The analysis and findings of the Discipline Committee commence at page 61, following Dr. Clapperton's decision and reasons.

DECISION AND REASONS OF DR. CLAPPERTON (Dissenting on allegations of sexual abuse, disgraceful, dishonourable or unprofessional conduct and failing to maintain the standard of practice of the profession, except regarding failing to adequately explain the intended examination)

PART A: BACKGROUND, ISSUES, EVIDENCE AND LAW

BACKGROUND

It is alleged that during a medical appointment in October 2016, Dr. Ateyah placed his hand over Patient A's pubic bone and labia twice while she was lying on the examination table, once with his hand over her underwear and once with his hand under her underwear. She testified that his hand remained there for five to six seconds each time. When she got off the table and while he purported to examine her back, it is alleged that Dr. Ateyah pulled down Patient A's capri pants and again cupped her pubic bone and labia for five to ten seconds with his hand and rocked her back and forth. Patient A testified that Dr. Ateyah also made comments about her age and appearance and then rubbed her arm during the appointment.

Dr. Ateyah does not recall Patient A's appointment and denies the allegations.

The College alleged that Dr. Ateyah's actions constitute professional misconduct by: engaging in sexual abuse of Patient A; by engaging in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable and unprofessional conduct; and by failing to maintain the standard of practice of the profession in his care of Patient A.

THE ISSUES

This case raised three issues:

1) Did Dr. Ateyah sexually abuse Patient A, specifically by touching of a sexual nature (placing his hand over her pubic bone and labia on one or more occasions) and/or by remarks of a sexual nature (about her age and appearance) during a medical appointment?

2) Did Dr. Ateyah engage in an act or omission that would reasonably be regarded by members of the profession as disgraceful, dishonourable, or unprofessional, specifically by (i) touching Patient A in an inappropriate manner (placing his hand over her pubic bone and labia on one or more occasions and/or rubbing her arm), (ii) by making inappropriate comments to her (about Patient A's age and appearance) during a medical appointment, or (iii) by pulling down Patient A's pants?

3) Did Dr. Ateyah fail to maintain the standard of practice of the profession in his care of Patient A?

FACTS AND EVIDENCE

Summary of the Evidence

The Committee heard testimony from Patient A, Dr. Ateyah and from two expert witnesses, Dr. Faulds and Dr. Stanton, on the standard of practice of the profession. In addition, Dr. Krakowski, an expert in urology and sexual function, testified with respect to Dr. Ateyah's sexual health.

Several documents were entered as exhibits, including a copy of Dr. Ateyah's clinical chart for Patient A, the ultrasound requisition that Dr. Ateyah gave Patient A, Dr. Ateyah's day sheet from the day of Patient A's visit, a video and photographs of the office lay-out, a schematic diagram of the lymphatic system of the abdomen and upper legs, medical information related to Dr. Ateyah's health and a copy of CPSO policy 4.08 Maintaining Appropriate Boundaries and Preventing Sexual Abuse.

Patient A's Evidence

Patient A is in her early 50's. Patient A testified that on her drive to work the morning of a date in October, 2016, her back bothered her when the car stopped and started and when her back pressed into the lumbar support on her seat. Patient A testified that she had had pain in her right back area for two weeks prior to that date.

When Patient A arrived at work that day, she decided to seek medical attention. Patient A testified that she believed that she might have a bladder infection. Patient A testified that she called her own family doctor and told her family doctor's receptionist that she had back pain. Patient A also complained of vaginal itchiness. Patient A had discussed vaginal itchiness with her family doctor in the past and felt that it was likely a yeast infection. She knew how to treat a yeast infection with over the counter medication.

Patient A's family doctor would not be able to see her for two days. The receptionist suggested that given her symptoms, she might have a bladder infection. Patient A found this concerning and inquired whether it would be appropriate to visit another doctor at a walk-in clinic. The receptionist told Patient A that this would be appropriate. Patient A then called Dr. Ateyah's office, a doctor she had previously seen on other matters, to see if he could take her as a walk-in patient that day. Dr. Ateyah's office is conveniently located across the street from the place where Patient A works. Patient A was able to make an appointment with Dr. Ateyah for 10:50 a.m. that morning.

Patient A testified that that day, it was a Toronto Sports Team's Day at work and she was wearing the Toronto Sports Team's t-shirt with a pair of capri jeans. Patient A testified that the jeans were a relaxed fit and sat low on her waist, just on top of her underwear line and about an inch below her belly button.

When Patient A arrived for her appointment at Dr. Ateyah's office, she needed to use the washroom. Patient A asked Dr. Ateyah's receptionist if she should provide a urine sample, which she subsequently did. After returning the urine sample to the receptionist, she was led into Examination Room 3. It was a few minutes later that Dr. Ateyah entered the room and closed the door.

Patient A testified that Dr. Ateyah inquired about the nature of the visit and she described her back pain. She was asked if it burned when she urinated and she told him no but that she did have some itchiness. He also asked her if she had any discharge and whether it hurt when she had sex. She replied "no" to both questions. Patient A testified that Dr. Ateyah did not ask her about her sexual history.

Patient A testified that Dr. Ateyah asked her questions about her menstrual periods, including when her last cycle was. In response, Patient A testified that she laughed and said that her periods were every 20 days as she was going through menopause. Patient A testified that Dr. Ateyah laughed in response, and said it was not possible as she could not be old enough. Patient A testified that Dr. Ateyah asked her how old she was and she stated her age (in her early 50's). Patient A testified that Dr. Ateyah then went over to his computer and came back and said that she looked so young she could not possibly be that age. Patient A testified that Dr. Ateyah then rubbed her arm up and down and said, "Whatever you're doing, keep it up. You look fabulous." In referring to this incident, Patient A also described Dr. Ateyah's action as rubbing her shoulder.

Patient A testified that she was not offended by Dr. Ateyah's comments about how young she looked. She was, however, offended by Dr. Ateyah's rubbing her arm. Patient A felt that Dr. Ateyah had invaded her personal space.

Patient A testified that Dr. Ateyah tested her urine by inserting a strip in the urine sample. Dr. Ateyah told Patient A that her urine sample was normal. Patient A testified that Dr. Ateyah then told her that he thought her problem “was very serious” and something had travelled from down there up to her kidney area. Patient A thought he meant an infection. Patient A testified on cross examination that when Dr. Ateyah said several times that he thought she had a “serious problem”, it scared her.

Patient A testified that Dr. Ateyah then told her to lie down on the bed in the examination room, and undo her pants. She testified that he said, “I’m obviously not going to do an internal”, but he did not explain what he was going to do. Patient A testified that she expected him to touch her abdomen as part of the examination. Dr. Ateyah asked her to bring her knees up and place her feet on the table. Patient A testified that she was not given a gown or drape. Patient A testified that she did not undo the zipper on her pants, but when she lifted her knees up her jeans would have opened more. Patient A testified that Dr. Ateyah asked her to open her legs outward and she did not. She testified that she resisted and was very tense.

Patient A testified that Dr. Ateyah put his ungloved hand under her jeans and over top of her underwear and cupped her “whole vaginal area, not to the rectum, but before that”, and asked her to move her legs back and forth open and shut. Patient A testified that her legs were never clenched together. Patient A testified that Dr. Ateyah’s hand rested on her pubic bone and labia for five to six seconds. Patient A testified that Dr. Ateyah said that she was very tense and that she needed to relax. Patient A testified that she did not know which hand Dr. Ateyah was using, as she was looking up at the ceiling. She testified that she knew he used his hand because she knows what a hand feels like between her legs.

Patient A testified that Dr. Ateyah then took his hand out and re-inserted his ungloved hand under her underwear. Patient A testified that she felt her pubic

hair being pulled as his hand slid down. Patient A testified that she said nothing. Patient A explained that one leg was pressed against the wall and Dr. Ateyah was manipulating the other leg back and forth and open and shut. Dr. Ateyah's hand was again resting from the top of her pubic bone to her vagina and over the whole vaginal area. Patient A testified that the touch lasted five to six seconds and was a "light pressure". Patient A testified that she was concerned Dr. Ateyah was going to put his fingers in her vagina, although he did not. According to Patient A, Dr. Ateyah did not explain what he was doing, nor did he make other comments besides stating that she was tense and needed to relax.

On cross-examination, Patient A answered "no" when asked if Dr. Ateyah, in any way, did any examination of her abdominal region.

When it was suggested to Patient A on cross-examination that she had not previously described Dr. Ateyah's hand placement between her legs as "cupping", and the first time she used that word was in her testimony, she disagreed. Patient A went on to say that she did not know when she first used the word "cupping". Upon review of the transcript of her College interview, Patient A agreed that she used the word "cupping" during her College interview in relation to Dr. Ateyah touching her while she was standing up. When asked why she hadn't described the other incidents as "cupping", Patient A said that it was the same movement: "His hand was between my legs, right on top of my vagina and my pubic area."

On cross–examination, Patient A said that the first time Dr. Ateyah touched her genitals, it felt as if he was coming from the right side, as he brushed against the outside of her leg. The second time, the hand felt as if it came from the left side, she said as she felt more pressure on the left side. However, when he touched her vaginal area, "it was the same movement, or the same motion or the same feel".

After Dr. Ateyah took his hand out of her underwear, Patient A testified that she jumped off the table and her pants were a bit lower, perhaps halfway down her bottom, as a result of getting up. She testified that Dr. Ateyah told her that he needed to do “one more thing”. Patient A stated that she was holding onto the top of her jeans with her left hand to pull them up. Patient A testified that she then told Dr. Ateyah, “But the pain is here,” and used her right hand to show him where the pain was on the right side of her back.

On cross-examination, Patient A stated that she was in a bit of shock and her head was spinning when Dr. Ateyah said he had to do one more thing. She assumed he was going to touch her back. Patient A testified that Dr. Ateyah told her that it was very important and said, “It’s very serious. I think you’re really sick.” Patient A testified that Dr. Ateyah asked that she lower her pants. On cross-examination, Patient A acknowledged that she did not report that Dr. Ateyah asked her to lower her pants in her letter to the College, but she did mention this in her interview with the College. Patient A testified that the letter was just a summary and she did not realize that she had to put every single thing in it.

Patient A testified that she did not want to lower her pants and as she was trying to pull up her pants, Dr. Ateyah came from behind and pulled her pants down. Patient A testified that Dr. Ateyah was standing behind her to the right and his right hand came around her and went down between her legs. Patient A testified that Dr. Ateyah’s thumb was outside of her underwear, and his hand was cupping in between her legs. On cross-examination, Patient A stated that it was Dr. Ateyah’s right hand that cupped her genital area and she did not know where his left hand was because she was concerned about the hand that was between her legs. Patient A testified that Dr. Ateyah rocked her back and forth from behind for six to seven seconds. Later, on cross-examination, Patient A testified that the rocking lasted for five to ten seconds. Patient A testified that she did not know

what part of Dr. Ateyah's body was touching her when he rocked her back and forth, whether it was his stomach or leg. On cross examination, Patient A confirmed that during the examination from behind, no clothing was removed nor did her underwear come down.

Patient A testified that she repeatedly told Dr. Ateyah that the pain was in her back. Patient A testified that as she said, "It is in my back," she pushed back behind her and Dr. Ateyah let go. Patient A demonstrated her right arm motioning back with her elbow.

While she was doing up her pants, Patient A testified that Dr. Ateyah told her that the pain was due to a female problem and he was writing her an ultrasound requisition, which he gave to her.

When she left Dr. Ateyah's office, Patient A testified that she felt shaky and as if "something wasn't right". She went back to work.

Patient A testified that she did not get the ultrasound done that was ordered by Dr. Ateyah, as she did not believe it was necessary. When Patient A saw her family doctor two days later, her family doctor ordered a kidney ultrasound and a chest x-ray. Patient A testified that she had the tests that her family doctor ordered. Patient A testified that her back pain was muscular and it resolved.

Patient A testified that she wrote her letter of complaint to the College three days after the appointment, and she was interviewed by College investigators two weeks later.

Patient A testified that she did not go to Dr. Ateyah due to the itchiness in her vaginal area as she has yeast infections a couple of times a year and she treats them herself with something she can buy over the counter. Patient A testified

that she did not expect to be examined for the problem she had with itchiness or a yeast infection.

Despite the appointment being about 20 minutes in length, Patient A testified that she would not have recognized Dr. Ateyah. Patient A testified that she was “shooken up” and after his hands were between her legs, she never looked at him again.

Patient A testified that she did not know if Dr. Ateyah’s touch on her genitals was sexual, as she did not know what the physician was thinking, but she thought it was inappropriate.

Patient A agreed that at no time did she say stop to Dr. Ateyah. When she was asked if there was a reason why she did not tell Dr. Ateyah to stop or complain about what he was doing, Patient A testified that Dr. Ateyah was a doctor and she trusted him to do the right thing. Patient A testified that she had no prior concerns about seeing Dr. Ateyah on previous occasions or on the day of this appointment.

Dr. Ateyah’s Evidence

Dr. Ateyah is a 47 year old family physician practising in Schomberg, a small community north of Toronto. He was born in southern Iraq, and immigrated to Canada in 2000. He is married with an adult son. Although English is not his first language, Dr. Ateyah had no difficulty understanding and responding to questions.

Dr. Ateyah received his medical training in Baghdad, Iraq. He graduated in 1994 and interned at different hospitals in Iraq until permanently immigrating to Canada in 2000. In Canada, Dr. Ateyah initially practised as an observing

physician in Toronto. However, to practise independently, and make a reasonable income, Dr. Ateyah relocated to the Northwest Territories, leaving his wife and son in Toronto from 2001 to the spring of 2004. In 2003, during his assignment in the Northwest Territories, Dr. Ateyah was involved in a serious accident while on a remote location call, which left him with significant injuries and chronic health conditions. Dr. Ateyah testified that he returned to Toronto for three months to recover from his accident. Once he was physically able, Dr. Ateyah returned to practise in the Northwest Territories and also spent six months practising in Nanuvut. Dr. Ateyah then returned to Ontario.

Dr. Ateyah testified that beginning in approximately March 2004 and continuing for “about a year-and-a-half”, he practised under a restricted licence in a clinic in Innisfil. Dr. Ateyah testified that in January 2006, he received his full licence to practise in Ontario and worked with a physician in the Innisfil/Barrie area. He opened his practice as a sole practitioner in 2007 in Schomberg where he currently practises in a building that houses an adjoining pharmacy. Dr. Ateyah testified that in October 2016, he had 2,300 rostered patients and now has 1,850 patients, being one of two family practices in Schomberg. Dr. Ateyah also accommodates walk-in patients. His rostered patients are a representative cross section of the local population from newborns to the elderly. His patients also come from surrounding communities including Barrie, Innisfil, Schomberg and Bradford.

Dr. Ateyah explained the layout of his office. He testified that Examination Room 3 is the first door down the hall from the reception desk. Dr. Ateyah’s clinical note for Patient A’s October, 2016 visit indicated that she was seen in Examination Room 3.

Dr. Ateyah testified that he “absolutely” did not have any recollection of Patient A and her visit on the date in October, 2016. Upon review of the day sheet for that

day, Dr. Ateyah testified that Patient A was seen at 10:50 and “UTI” was noted after her name, indicating that was what Patient A told the front desk staff as the reason for her visit. UTI stands for a urinary tract infection. Dr. Ateyah had 20 minutes allocated for Patient A’s visit, but testified that he may not have actually had that much time.

Dr. Ateyah reviewed his medical records for Patient A and noted that he had seen her four times before the date in October, 2016, but he had no recollection of her. Dr. Ateyah advised that since he had no recollection of Patient A or the appointment, his testimony would be based on his interpretation of his clinical note and his normal procedures.

Dr. Ateyah uses the SOAP (Subjective Objective Assessment Plan) format for his EMR (Electronic Medical Record). Dr. Ateyah reviewed his clinical note, which he testified indicated that Patient A was seeing him for vaginal discomfort and burning for many days when urinating. He testified that this is what he had recorded as the subjective complaint of the patient.

The next three lines of the subjective portion of the medical record indicated, “No pain during sex,” “No increased urinary frequency,” and “Normal BM’s”.

Dr. Ateyah testified that the next entry of the patient chart was “lower abdominal discomfort and back pain”, which indicates that this was an area of concern for the patient.

Dr. Ateyah testified that he did not recall having a conversation with Patient A in which he told her she could not possibly be menopausal and asked how old she was. He had no recollection of saying, “Oh my God, you look so young,” as alleged by Patient A. However, Dr. Ateyah agreed that he might say to a patient that she looked young or that she looked great and “good for you”. Dr. Ateyah

denied that he would have said Patient A looked “fabulous” as that that is not a word he uses in daily language as English is his second language.

Dr. Ateyah testified that he has no recollection of the appointment at all but it is possible that he touched Patient A’s shoulder. He testified that he might touch a patient’s shoulder to reassure them. He denied rubbing the patient’s shoulder.

Dr. Ateyah testified that his clinical note said “urinalysis negative”, but he did not know from his note whether he or his staff tested the urine sample. He explained that a negative urinalysis indicates that it was unlikely that the patient had a UTI.

Dr. Ateyah then testified about the notes he made under the “Objective” part of his clinical note. As he could not recall Patient A’s appointment, he indicated that his testimony was a recitation of ‘best practices’.

The clinical record for Patient A noted, “back tender bilaterally above iliac crest”. He testified that this note indicated that he examined the back above the iliac crest bone and it was tender on both sides. Dr. Ateyah went on to explain that if it is tender on the flanks and the iliac crest it could be a muscle problem, but it could still be a gynecologic problem or a kidney problem. Dr. Ateyah described in detail what an examination of the back would entail. His note in the patient’s chart indicated, “No back restricted ROM”, which meant there was no restricted range of motion in the back on “flexion and extension.” Dr. Ateyah denied using the word “rock” to describe the movement he asks the patient to do when examining their back. He never uses the word “rock”, he said.

Dr. Ateyah testified that a patient would never have their pants around their knees or ankles while he was doing a range of motion examination of the back. It would be “absolutely inappropriate”, Dr. Ateyah testified. He also testified that he would

not cup a patient's genital area during this type of examination or physically move the patient himself.

Dr. Ateyah described an abdominal examination. After examining the abdomen, he would then palpate the inguinal area looking for lymph nodes and tenderness to the upper part of the pubic bone.

Dr. Ateyah testified that if a patient was seeing him for a general physical examination, they would be undressed and wearing a gown, but if they were not there for a physical examination, they would be dressed "for sure".

Dr. Ateyah testified that it was his standard practice to have the patient unbutton her pants before he examines the abdomen and pelvis, and he would do the same for a rostered patient or a walk-in patient. He does not offer a gown or draping, unless it is a physical examination and it depends on the situation and the circumstances with a walk-in patient, he said. If the patient needs to be given a gown, he provides one and the patient is also able to ask for a gown

Dr. Ateyah agreed that the set up in Examination Room 3 was not suitable for doing pelvic examinations as he has a five foot long massage table in that room with no space to do this type of examination. If a walk-in patient required a pelvic examination, they could be moved to another room.

The clinical record for Patient A has an entry "No PV done", which Dr. Ateyah testified meant that he explained to the patient that no pelvic examination was going to be done. He also stated that it was important to know that, "I've discussed this with the patient that there wouldn't be any pelvic exam and, hence, I am not having any chaperone."

Dr. Ateyah testified that he did have two chaperones available in the office, so the fact that there was no chaperone was not the reason he did not do the pelvic examination. Dr. Ateyah gave several reasons why he did not do a pelvic examination:

- Patient A was not his patient and it is only appropriate for her to have such a "gynecological important exam" by her family physician with whom she has built trust. He testified that Patient A was "hoping" she would have this examination with her family doctor.
- He did not think Patient A's problem was "something really serious and important".
- He would not be saving her life by doing a pelvic examination and ordering an ultrasound would show him what he needed to know.
- A pelvic examination was not something he would do for a walk-in patient.

When asked why he told the patient *before* he examined her that he was not going to do a pelvic examination, Dr. Ateyah stated:

- He thought it was important for the patient to know in advance that he was not going to do a pelvic examination, in case she was uncomfortable.
- It would reassure her if she was nervous about a pelvic examination to make it clear to her that it was not going to be done. Dr. Ateyah testified that he did not think Patient A was nervous, then added that he did not remember the visit.
- He testified that from the history, he did not think Patient A's problem was serious or important. He agreed that PID (pelvic inflammatory disease) is serious, but indicated that he did not think he was dealing with that.
- If he thought a pelvic examination was needed after the examination, he could take the patient to another room and call in a chaperone.
- He was not her family physician.

- Dr. Ateyah agreed that the patient should have a pelvic examination but he did not think it was urgent as it did not need to be done “at that moment for that reason,” and he ordered an ultrasound instead.

Dr. Ateyah testified that his entry “Bilateral groin area pubic bone slight tenderness”, indicates that he examined this area to see if there was a large lymph node in the groin area since he was not going to do a pelvic examination. He was looking for infection. Dr. Ateyah testified that a tender pubic bone could indicate that there was an inflamed organ underneath, which required checking the inguinal area for tenderness and/or large masses. This is done with the ends of four fingers. The tested area would be the iliac crest and pubic bone.

Dr. Ateyah testified that he would ask the patient to undo the top of her pants and roll them down so he could look at the area. The patient’s underwear would stay on as long as it was not obstructing anything. The patient may need to pull the underwear down a bit lower so he can see the inguinal area. He testified that he never pulls the patient’s pants down for them.

Initially, Dr. Ateyah testified that he conducts an inguinal examination under the underwear. However, based on his notes, he could not determine whether he examined Patient A’s inguinal area, over or under her underwear. Dr. Ateyah then testified that he usually examines the inguinal area from under the clothes, but above the underwear if possible. Dr. Ateyah explained that he made sure that the underwear is removed to expose the area he wants to examine. He continued: “So, if the area is exposed fully, then I would do the exam with the underwear on. If the underwear covers the exam area, then I would ask the patient to lower the underwear just to expose the inguinal region.”

It would not be possible to come in contact with the patient’s labia with this examination, but it would be possible to come in contact with the patient’s pubic

hair, Dr. Ateyah said. He went on to explain that it is possible to touch pubic hair when his hand touches from the iliac crest to the pubic bone.

Dr. Ateyah testified that if he was doing a complete physical examination on a patient, he would wear gloves from the beginning, but for a walk-in patient and simply doing an abdominal examination and inguinal area examination, he would not be gloved. Based on his notes, he does not believe he wore gloves, as it was his routine practice not to wear gloves. Dr. Ateyah stated that if the patient was uncomfortable with him doing the exam with no gloves, she should have mentioned that and he would note that the patient felt uncomfortable with no gloves for the examination.

“A” means Assessment in Dr. Ateyah’s clinical notes and he testified that this means he made an assessment of the case and his differential diagnoses. Dr. Ateyah testified that his first entry is “Ovarian pathology” as there was a bit of tenderness above the iliac crest area and a urinary tract infection was unlikely with the negative urine test. Dr. Ateyah listed various possibilities of pathology related to the ovary.

Dr. Ateyah explained that DDX means differential diagnoses. He included “PID” or pelvic inflammatory disease, and “renal stones” under that list. He was considering the things that could lead to the back pain and discomfort the patient was having.

Dr. Ateyah testified that “P” referred to plan. In his note, he wrote “reassured” and he explained that he told the patient there was nothing serious going on. His next entry was “Precautions discussed”, which Dr. Ateyah testified meant that he told the patient if her symptoms got worse, or if she developed new symptoms, to seek more urgent care.

Dr. Ateyah testified his clinical note indicated that the patient was “sent for abdominal and pelvic ultrasound” since he did not think she had a UTI and he did not do an internal examination. An ultrasound would give information about the differential diagnoses. On his ultrasound requisition, which was in evidence, Dr. Ateyah testified that he recorded, “right flank pain with discomfort to pelvic area”. He also recorded “irregular cycles” on this form. The patient told him that her cycles were getting closer together so he wanted to see if there was any pathology of the ovaries.

Continuing in the clinical notes, Dr. Ateyah stated that he wrote “to be contacted when results are back significant”. Dr. Ateyah testified that this meant he would contact Patient A if anything of significance was found. Dr. Ateyah testified that Patient A’s ultrasound results were not in his file for her, indicating that she did not have the ultrasound. Dr. Ateyah testified that he charted “support” in his notes to indicate that he’d offered Patient A support, that the patient would be contacted if anything significant was found, and that if there was a need to communicate with Patient A’s family doctor, he would do so.

Dr. Ateyah testified that he did not make arrangements for Patient A to see another doctor for a pelvic examination, or make any suggestion that she should see her family doctor for a pelvic examination.

Dr. Ateyah’s notes included the entry “hygiene discussed”. Dr. Ateyah explained that he was not sure what this entry meant, other than he would have told the patient how to clean themselves, to clean their abdomen, how to wash themselves, how to wipe themselves. He also wrote “increase fluid” in the clinical note, and he explained that the patient sometimes would forget to hydrate themselves when they are in pain and he would have reminded the patient to hydrate. According to his clinical record, Dr. Ateyah testified that he never saw Patient A again.

Dr. Ateyah denied that he ever touched Patient A in a sexual manner. He denied touching her with any sexual intention. He testified that he might have touched her shoulder reassuringly, but he denied cupping her genital area or asking her to rock back and forth.

Dr. Ateyah testified that he was notified of Patient A's complaint less than two weeks after her appointment with him. Accompanying the letter from the College, dated in October, 2016, was Patient A's letter of complaint.

Dr. Ateyah agreed that he might tell a patient in certain circumstances that they are very tense and they should relax. He said he had no recollection of saying that to Patient A but it is possible that he did. He did not address that part of Patient A's complaint in his letter of reply to the College.

Dr. Ateyah agreed that removing a patient's clothing could be seen as a boundary violation and was inappropriate, but denied that he removed her clothing as alleged by Patient A. He agreed that when doing a stethoscope examination he would lift a patient's clothing.

Dr. Ateyah agreed that in a physician-patient relationship, the physician always holds the power.

Dr. Ateyah denied placing his hand over the patient's labia either over or under her underwear while she was lying on the table. He also denied pulling her pants down and placing his hand over her labia when she was standing.

Dr. Ateyah testified that he was diagnosed in January 2016 with a prolactinoma, which is a tumour of the pituitary gland that causes his prolactin to be high and suppresses his other hormones, such as cortisol and testosterone.

Dr. Ateyah testified about his symptoms related to the prolactinoma, including decreased libido for four years before diagnosis. He testified that he was experiencing all of the symptoms in October 2016 when he saw Patient A. Dr. Ateyah testified about his medical treatment for the prolactinoma and his medical records were entered as exhibits. Surgical treatment was ruled out, Dr. Ateyah testified, and he was treated with medication. He remained on the medication for a few months and it had the effect of lowering the prolactin levels but did not raise the testosterone level. Dr. Ateyah was on this medication at the time of Patient A's appointment with him. His sexual libido remained low and he had not had sexual relations with his wife for four years before the October 2016 appointment with Patient A.

Dr. Ateyah testified that the medication he was taking for his prolactinoma caused nausea, vomiting and abdominal discomfort, but no cognitive or memory problems.

Dr. Cathy Faulds' Evidence

Dr. Faulds is a family physician practising in the London area. Dr. Faulds has been a family physician for about 30 years. Currently, she practises in her clinic with another physician and cares for about 3,000 patients. She is involved with the South West Local Health Integration Network. Dr. Faulds is the Chief Clinical Quality Lead for that organization and she is also its Vice-President Clinical. In that capacity, she is responsible for forming clinical teams of five physicians for various sub-regions in the area. She is responsible for developing programs, integrating the system and transitions of care and providing a clinical voice as needed in terms of policy and funding. She has been on the board and executive and President of the Ontario College of Family Physicians.

Dr. Faulds was involved in teaching third year medical students in the past during their rotations in family medicine, although she currently is on sabbatical. She lectured medical students at the university on common family medicine problems. Dr. Faulds also taught courses including ethics, introduction to clinical care and clinical examination to first and second year students. Dr. Faulds has been an assessor for the College of Physicians and Surgeons of Ontario and has been retained by the College's Investigations and Resolutions Department to assess complaints against family physicians. She has assessed eight cases in that capacity. She has been a member of the Primary Care Advisory Committee for the Ontario Medical Association. She was called by the College and accepted by the panel as an expert with respect to the standard of practice of a family physician, specifically in the area of accepted norms for a physical examination of a patient.

Dr. Faulds had been given Patient A's clinical record from Dr. Ateyah, the ultrasound requisition, Patient A's complaint letter, Patient A's interview transcript with the College investigators, Dr. Ateyah's response letter and the College Policy No.4-09 entitled Maintaining Appropriate Boundaries and Preventing Sexual Abuse, and College Policy No. 3-16, entitled Physician Behaviour in the Professional Environment. Dr. Faulds provided her report on January 15, 2017, in which she expressed her opinion that Dr. Ateyah did not maintain the standard of practice of the profession. The Committee did not have a copy of her report.

Dr. Faulds testified about several areas where in her view, Dr. Ateyah did not maintain the standard of practice of the profession.

(i) Failure to Identify the Patient's Chief Complaint

Dr. Faulds testified that the standard of practice requires the physician to identify the patient's chief complaint. Based on the facts she was asked to assume, Dr. Faulds indicated that the very essence of the chief complaint is different between the doctor and the patient in this case. The patient expected one examination, based on her chief complaint, which was back or flank pain and some vaginal itching. The physician provided a different examination. Dr. Ateyah's clinical record indicated that he focused on vaginal discomfort, burning when urinating, lower abdominal discomfort and then back pain. Dr. Faulds testified that at the end of the history taking, there needs to be an agreement between the patient and physician about what the chief complaint is. Dr. Faulds testified that the physician needs to establish consent regarding where the examination is going to go, by reflective listening of the patient's complaint. Dr. Faulds opined that this did not happen, and that Patient A expected one examination and Dr. Ateyah provided a different examination because the patient's chief complaint was not established.

(ii) History-taking and Examinations did not align with Differential Diagnoses

Dr. Faulds was of the opinion that although there was a differential diagnosis of pelvic inflammatory disease (PID), there was an inadequate sexual history taken with no questions about sexual partners, unprotected sex, and a past history of sexually transmitted diseases. In Dr. Faulds' opinion, the history taken by Dr. Ateyah was not extensive enough for Dr. Ateyah to arrive at the differential diagnosis of PID. Dr. Faulds noted that although Dr. Ateyah listed PID as one of his differential diagnoses, which is a potentially very serious problem, and even though Dr. Ateyah asked questions related to pain during intercourse and vaginal discharge that may be related to that diagnosis, he failed to elicit answers to other very important questions that were very relevant to this differential diagnosis.

Dr. Faulds agreed that a diagnosis of ovarian pathology is reasonable to entertain in this scenario, but it was her opinion that to include a diagnosis of ovarian pathology in the differential diagnosis when there was not a complete history taken or a physical examination done is not reasonable. She testified that a pelvic examination needed to be completed if ovarian pathology or PID is part of the differential diagnoses.

Further, Dr. Faulds comments that there was no history taken with regard to a previous history of renal stones, family history of renal stones, medications, including over the counter medications and calcium, all of which are related to renal stones. There was no reference to any such history having been taken based on the clinical notes.

Dr. Faulds was of the opinion that Dr. Ateyah did not conduct a clinical history or physical examination that would support the differential diagnoses of PID, renal colic or ovarian pathology that he recorded. She was of the view that his deficiencies in this regard did not meet the standard of practice.

(iii) Preparation for the Examination

Dr. Faulds testified that if Dr. Ateyah made the decision that an examination of the abdomen and pelvis was required, she would have expected that he articulate that to the patient clearly and the reason why an examination of that type was needed. She testified that the standard of practice is that he should leave the room after giving instructions to the patient to change from the waist down and giving her a drape and gown if he was going to do a pelvic and abdominal examination. He should then return with a chaperone to do the examination and should tell the patient throughout what he was doing to gain consent from the patient. She testified that the consent is what allows the patient to feel comfortable during the examination. Dr. Faulds explained how the examination of

the abdomen and pelvis should proceed with proper draping, taking care not to expose private areas needlessly for prolonged periods of time. Dr. Faulds was aware that Dr. Ateyah's note indicated that he did not conduct a pelvic examination; rather, his note indicated that he conducted an abdominal examination and an examination of the pubic and inguinal areas. Dr. Faulds testified on cross-examination that a physician would need to drape the patient for a proper examination of the inguinal canal.

Dr. Faulds testified that for an examination of the back, the patient would leave their underwear on and be provided with a gown and drape so that the back can be inspected and the patient can drape their bottom.

Dr. Faulds testified that gender does play a role in whether or not a chaperone is needed for an examination. Dr. Faulds opined that male physicians always require a chaperone for a private or sensitive examination of women, including a pelvic examination. Dr. Faulds testified that a male physician would not be required to obtain a chaperone for an abdominal examination. However, a male physician would be required to obtain a chaperone if the abdominal examination extended to the groin or inguinal area and pubic bone as these are private and sensitive areas for a patient. Her opinion was that an examination of these areas requires a chaperone when a male physician is examining a female patient.

(iv) The Examination

Dr. Faulds testified in detail about an examination of the abdomen and what that would entail. She testified that doing an abdominal examination without gloves is acceptable. Dr. Faulds indicated gloves would be worn for a pelvic examination and described how that would be done. The standard of practice would require gloves for a pelvic examination but not for an abdominal examination.

Dr. Faulds agreed that the lower limit of the abdomen is the pubic bone and the inguinal canals are part of the abdomen. Dr. Faulds testified that an examination of the inguinal canals would not necessarily be completed with an examination of the abdomen, unless there was an indication of an inguinal or femoral hernia. Nor would an examination of the pubic bone be required, she said. It would be required if there was severe localized pain or inflammation, as in osteomyelitis.

Dr. Faulds testified that sometimes the pubic bone is tender following delivery of a baby, but that was not a factor in this case. The pubic bone and the inguinal area would not be considered part of the genitals. Dr. Faulds testified that even though the inguinal area and pubic bone are part of the abdomen, she would expect the physician to have a chaperone present if these areas are examined, and to wear gloves as the pubic bone and inguinal area are private and sensitive areas for the patient. This would be the standard of practice in Dr. Faulds opinion whenever any sensitive or private area is examined.

Dr. Faulds testified that the standard of practice would be to use a stethoscope in the four abdominal quadrants followed by palpation. This would then be followed by a vaginal examination, keeping in mind proper sterile technique, such as the use of gloves, and maintaining the presence of a chaperone. This would be an important part of the examination and by omitting to do this, Dr. Ateyah did not meet the standard of practice.

If ovarian pathology and PID were in Dr. Ateyah's differential diagnoses, Dr. Faulds testified that she would expect the physician to conduct a pelvic examination with a speculum examination, and to take cultures and a urine sample for Chlamydia. Dr. Faulds opined that a sexually transmitted disease workup would have been expected. Dr. Faulds stated that there should be no difference between how a walk-in patient is treated as compared to a regular patient. There should be no difference in whether a gown or drape is provided,

nor any reason not to do an internal examination because someone is a walk in patient, versus a regular patient.

Dr. Faulds testified that there was no clinical indication for Dr. Ateyah to put his ungloved hand over top of Patient A's labia and vagina, as alleged by Patient A.

In the hypothetical patient scenario of a patient with a complaint of vaginal discomfort, burning for many days when urinating, but no increase in urinary frequency and a normal urinalysis, and right sided flank pain and menstrual cycles getting closer together, Dr. Faulds agreed that a bacterial urinary tract infection was unlikely. Dr. Faulds agreed that an abdominal examination would be reasonable. She testified, however, that an examination of the inguinal canal would not be reasonable, as that would be looking for a hernia. There was no indication from the history that a hernia was a potential problem. She agreed an examination of the groin or inguinal area was reasonable, to look for lymphadenopathy as a sign of infection in the pelvis.

Dr. Faulds further testified that a differential diagnosis of renal stones would have been reasonable if there had been percussion of the flank area, but there was no note that this was done, although there was a notation in Dr. Ateyah's record of flank tenderness and back pain. Dr. Ateyah gave detailed testimony of how he would have examined the flanks for tenderness, although he could not recall whether he did that with Patient A. Dr. Faulds testified that an ultrasound was an appropriate test to order to assist the physician in arriving at a diagnosis.

Dr. Faulds testified that it was a boundary violation to ask a patient to lie on the table without proper preparation by way of consent from the patient, as well as appropriate draping or a gown. To then ask the patient to undo a button and for the physician to put his hand down the patient's pants to her lower groin without explaining to the patient in advance is also a boundary violation. Dr. Faulds did

not expressly testify that doing an examination of the abdomen or groin area in this way failed to maintain the standard of practice.

(v) Comments and Shoulder Rubbing

Dr. Faulds testified that she had concerns about a physician making comments about a patient's physical appearance and accompanying those comments with rubbing the patient's shoulder. She stated that it is very important to maintain professional boundaries in a physician-patient relationship as it keeps trust with the patient. Dr. Faulds testified that the alleged comments made by Dr. Ateyah to Patient A, "Whatever you're doing, keep it up. You look fabulous" and rubbing the shoulder, are examples of violations of the professional boundary.

Dr. Faulds agreed that it might be appropriate for a physician to touch a patient's shoulder in certain circumstances. She also agreed that comments about the patient's age and the dynamics of the situation in the examining room would determine whether or not comments about age were a boundary violation or were not a boundary violation.

(vi) Back Examination

In Dr. Faulds' opinion, a back examination was required in this case based on Dr. Ateyah's note and the patient's complaint. Dr. Faulds described the method by which it should be done, including having the patient change into a gown but leaving her underwear on. She testified that there is no clinical reason for a physician to cup the patient's labia and vagina with his hand, as alleged by Patient A, when doing a back examination. She also testified that removing an article of clothing on a patient would be a boundary violation.

Dr. Faulds was of the opinion that Dr. Ateyah did not meet the standard of practice.

Dr. Tom Stanton's Evidence

Dr. Stanton was called by Dr. Ateyah to provide expert opinion evidence on the standard of practice in family medicine. Dr. Stanton has been a family physician since 1991. He has about 3,000 patients in a group practice in Oakville. Dr. Stanton works at the local hospital looking after his patients, delivers babies and also does shifts in the local Emergency Department. Although he has no formal appointment with a university, in the last 10 years, he has had three placements for medical training of students, one medical student and two medical residents for a period of two to four weeks. Dr. Stanton has been qualified by the courts to give evidence in emergency medicine and family medicine. The Committee accepted Dr. Stanton as an expert in family medicine.

Dr. Stanton reviewed Dr. Ateyah's clinical record for Patient A as well as a copy of the ultrasound requisition. He did not review any details of the complaint against Dr. Ateyah, nor did he know the allegations against him.

Dr. Stanton testified that when a patient presents with vaginal discomfort and burning for many days, he would consider a differential diagnoses related to the genitourinary tract, that is, anything related to the bladder, external genitalia, the vagina, and including the kidneys and ureters.

Dr. Stanton testified that it would be appropriate to have a discussion about a patient's age in the context of a discussion of menopause and the patient's periods.

Dr. Stanton testified that the entry of “no pain during sex” would lead away from a potential diagnosis related to vaginitis or a disease of the external genitalia and point more towards other diagnoses, such as those involving the bladder, uterus, ovaries, pelvic organs, bowel, or kidneys.

He stated that the entry of “lower abdominal discomfort and back pain”, along with a report of vaginal discomfort and burning means that the patient’s problem is likely related to the pelvic area as sometimes back pain is associated with pelvic and abdominal complaints. The organs that might be involved include the uterus, ovaries, kidneys, ureter and bladder.

Dr. Stanton testified that a negative urinalysis suggests a bladder infection is not the problem.

The notation “Flanks right tender more”, was interpreted by Dr. Stanton to mean that the physician observed this on examination as it was entered under the “Objective” part of the clinical note and would point to the kidneys as potentially being involved.

Dr. Stanton interpreted “Back tender bilaterally above iliac crest”, as similar to the note above indicating the flanks were tender. Dr. Ateyah again documented that the back was tender on both sides above the iliac crest in the flank area. This notation would point to a disease process in either the kidneys or the musculature of the back.

Dr. Stanton testified that in his opinion, “No back restricted range of motion, flexion and extension” would mean that the patient’s range of motion was tested in flexion and extension and there was no restriction or pain associated with the movements. Dr. Stanton said that if the patient had a full range of motion, in both flexion and extension, it would point away from the pain being of muscular origin.

The entry “Abdominal no tenderness and no masses” suggests that there was nothing acute related to the abdomen, according to Dr. Stanton.
“No PV done” means that the physician did not do an examination of the vagina and Dr. Stanton assumed there was no examination of the external genitalia either. Dr. Stanton testified that in his opinion, in a patient with this presentation, “best practices” would be to do a vaginal examination. Dr. Stanton outlined the circumstances when it would be reasonable to defer a vaginal examination with a plan, and they included:

- if the patient’s abdominal examination reflected a non-acute abdomen;
- it was not in an emergency situation;
- if the physician was uncomfortable doing the vaginal exam;
- if the patient was uncomfortable having a vaginal exam done; or
- if there was no chaperone present or who could be present.

Dr. Stanton interpreted the entry “Bilateral groin area pubic bone slight tenderness,” to mean that the inguinal area and pubic bone are tender. He did not think an examination of the pubic bone constituted part of an abdominal examination, although he testified that an examination of the inguinal canals where they meet at the top of the pubic bone was reasonable based on the clinical note. This notation suggested to Dr. Stanton that the lymph nodes in the area might be tender or inflamed and swollen. This suggests some kind of infection or inflammation in the pelvic area or lower abdominal area.

Dr. Stanton testified that the presentation in this case does not point to any specific diagnosis that stands out above any other. Localizing the problem to the ovaries could explain all of the symptoms, and it would be reasonable to have this as the number one on a differential diagnoses list. Dr. Stanton’s view was

that PID (pelvic inflammatory disease) and renal stones are also reasonable differential diagnoses in this case.

When examining the inguinal area, Dr. Stanton testified that it is reasonable to do the inguinal area examination with the patient draped or by having the patient undo her pants and having them pulled down to expose this area, while keeping the genitals covered. It is also reasonable to have the patient pull down her pants a short way to conduct this examination, he said. Dr. Stanton testified that he would ask the patient to undo her pants, and he would only help her if she had a dexterity problem or if she needed assistance. He would tell her he was going to assist.

Dr. Stanton testified that this part of the examination may be done with or without a glove, and it was appropriate to do the examination without a chaperone if the genitals are not being examined too. Whether or not the examination of the inguinal area is done over or under the underwear depends on the type of underwear the patient is wearing. He went on to say that it would be appropriate to pull down one side of underwear to examine one side of the abdomen and then the other side. He also testified that sometimes the physician will slide his hand under the underwear to do the lower part of the abdominal examination if the patient wants to keep her underwear pulled up.

Dr. Stanton thought that the plan that Dr. Ateyah charted, that is, an ultrasound of the pelvis, and a plan to call the patient if anything significant was reported, along with reassurance, hygiene teaching, hydration, and support was reasonable. He also testified that he thought after reviewing the entire clinical note, and taking into account the presentation of the patient as described in the clinical note, the differential diagnoses recorded by Dr. Ateyah were reasonable

Dr. Stanton agreed that based on the clinical chart for Patient A, he would not know that the patient's main complaint was back pain.

Dr. Krakowsky's Evidence

Dr. Ateyah testified about his diagnosis of a prolactinoma, which is a benign tumour in the brain that causes elevation in prolactin hormone that lowers other hormone levels, including testosterone. Because of the tumour, Dr. Ateyah testified that he experienced several symptoms including low libido. He testified that he has not had sexual relations with his wife for four years because of this condition.

Dr. Ateyah called the evidence of Dr. Krakowsky, an expert in the field of urology and specifically in the field of men's sexual function, to provide evidence on Dr. Ateyah's sexual function and motivation.

College counsel objected to any evidence on Dr. Ateyah's sexual health and function on the basis it was not relevant and that evidence from Dr. Krakowsky on this issue was inadmissible. College counsel and Dr. Ateyah's counsel agreed that Dr. Ateyah could provide evidence on this issue and Dr. Krakowsky could testify by way of *voir dire*, if the issue of relevance and admissibility could be argued in closing submissions. The Committee agreed with this process.

THE LAW

The civil standard of proof of balance of probabilities applies in professional misconduct proceedings (*F. H. v McDougall).* The College must establish that it is more likely than not that the alleged professional misconduct occurred. It is the College's burden to prove the allegations; it is not Dr. Ateyah's responsibility to disprove them. In all civil matters, regardless of the nature of the allegations, the

evidence must be clear, cogent, and convincing in order to satisfy the balance of probabilities test.

In this case, there are three allegations of professional misconduct. It is alleged that Dr. Ateyah engaged in professional misconduct by:

1. engaging in sexual abuse of Patient A;
2. engaging in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional; and
3. failing to maintain the standard of practice of the profession.

Sexual abuse of a patient by a member of the College is defined in subsection 1(3) of the Code as follows:

> "sexual abuse" of a patient by a member means,
>
> a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
> b) touching, of a sexual nature, of the patient by the member, or
> c) behaviour or remarks of a sexual nature by the member towards the patient.

The Code specifies that conduct of a "sexual nature" does not include touching, behaviour or remarks "of a clinical nature appropriate to the service provided." Accordingly, in order to establish sexual abuse, the Committee must find that the touching, behaviour or remarks complained of were of a "sexual nature", and not of a "clinical nature appropriate to the service provided."

In determining whether the conduct in issue is of a "sexual nature", the Committee may consider the principles articulated by the Supreme Court of

Canada in *R. v Chase,* [1987] 2 S.C.R. 293. The test to be applied is an objective one: “Viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer.” The Committee may consider the part of the body touched, the nature of the contact, the situation in which it occurred, the words and gestures accompanying the act and all other circumstances surrounding the conduct. Whether the alleged perpetrator derived sexual gratification or had a sexual purpose is a relevant factor, but the absence of sexual motivation would not necessarily preclude a finding that the behaviour in question was sexual in nature.

The second allegation of professional misconduct is of disgraceful, dishonourable or unprofessional conduct. The elements of sexual abuse and disgraceful, dishonourable or unprofessional conduct are different, and there can be a finding of misconduct on both grounds arising from the same set of facts if the different elements of each allegation are proven. However, the Committee may find that a physician’s actions or remarks were inappropriate and amount to disgraceful, dishonourable or unprofessional conduct, although it is not satisfied that the actions or remarks were of a sexual nature.

The third allegation is of failure to maintain the standard of practice. A failure to maintain the standard of practice of the profession is an act of professional misconduct under paragraph 1(1) 2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*. The standard of practice is defined as the standard that is reasonably expected of the ordinary, competent practitioner in the member’s field of practice. It is not necessary to find that there has been harm in order to find that there has been a failure to maintain the standard of practice.

The Committee recognizes that the standard of practice may be established on the basis of evidence from experts, publications from the College, or guidelines published in particular areas of practice.

Assessment of Credibility and Reliability

The Committee must assess the credibility and the reliability of each witness. Credibility refers to the witness's sincerity and willingness to speak the truth as he or she believes the truth to be. Reliability relates to the witness's ability to accurately observe, recall and recount the events in issue. That is, the witness's honesty must be assessed along with whether his or her evidence is reliable or can be counted on to be accurate. There is no legal requirement that a complainant's testimony in respect of an allegation of sexual abuse be corroborated.

There is no rule governing when inconsistencies in a witness's evidence will render the evidence not credible or unreliable. When assessing the credibility of the witness, inconsistencies on minor matters or matters of detail are normal and are to be expected and must be considered when weighing all the evidence. The Committee must not consider a witness's evidence in isolation, but should consider all the evidence and assess the impact of the inconsistencies on the witness's credibility and reliability as it pertains to the core issue in the case.

PART B: ANALYSIS AND FINDINGS OF DR. CLAPPERTON

(1) Overview

After scrutinizing the testimony of all of the witnesses and having regard for the totality of the evidence, for the reasons that follow, I find that the allegation of sexual abuse is proven. I further find that the allegation of disgraceful, dishonourable or unprofessional conduct is proven, on the basis of the same conduct that supports the finding of sexual abuse and on the basis of the remarks made regarding Patient A's age and appearance and rubbing her arm. I do not find that the arm rubbing and comments constitute sexual abuse although

I find that they are acts of professional misconduct that would be viewed by members of the profession as unprofessional. I would not necessarily find all touching of a shoulder or arm, or all comments about appearance to be an act of professional misconduct. Context is important. In this case, the comments and action of rubbing the shoulder preceded acts of sexual abuse and therefore, must be viewed in that context. Finally, I find that Dr. Ateyah failed to maintain the standard of practice of the profession. My reasons follow.

(2) Credibility and Reliability of the Fact Witnesses

(a) Credibility and Reliability of Patient A

Patient A gave her testimony in a very straightforward fashion. Patient A displayed no apparent animus towards Dr. Ateyah. She testified that she trusted him. She had seen him before. She testified that she had no problem going to see male doctors. She also testified that she did not know if his actions were sexual, as she did not know what was in his mind, but she thought that they were inappropriate. There was an absence of evidence of any motive to fabricate the allegations, which, while not determinative, is one factor I took into consideration in assessing her credibility.

Counsel for Dr. Ateyah asked Patient A more than once whether or not she said “No” to Dr. Ateyah when he was cupping her genital area. She testified that she did not. When she was asked in re-examination why she did not speak up, Patient A responded that he was the doctor and she trusted him to do the right thing. It is an old stereotype and myth that people who are being sexually abused would voice their objection at the time and / or try to fight off the perpetrator. I place absolutely no weight on the fact Patient A did not say “no” or be more assertive with Dr. Ateyah. He had already increased her vulnerability and likelihood of compliance by flattering her and by telling her that something more serious was

going on. Further, Dr. Ateyah is a person in a position of authority whom Patient A trusted based on the position he held as a physician. Even if she immediately recognized that his actions were not appropriate, it is an error to assume that she would articulate her objection at the time. There is no typical response to being sexually abused. Some people speak out at the time; others do not.

Similarly, the fact that Patient A testified that she returned to work after the appointment is of no significance. It is a false stereotype that a victim of sexual abuse will be so distraught that she can't return to work or function after the abuse. The fact that she returned to work following the appointment does not assist in determining whether or not she was sexually abused.

Further, the fact that Patient A provided her evidence in an unimpassioned and straightforward manner does not detract from the veracity of her allegations. Demeanor is an unreliable factor in credibility assessments and placing too much weight on demeanor is not appropriate. The fact that Patient A did not break down during her testimony does not mean she was not sexually abused. It would be subscribing to stereotypes or myths to assume that a victim of sexual abuse must demonstrate an emotional response and appear to be deeply disturbed by what happened to her. It would be an error to ascribe less credibility to her testimony because she was not outwardly emotional or distraught when she gave it. Again, there is no typical response to being sexually abused.

There were several aspects of Patient A's testimony that were corroborated by Dr. Ateyah or his office records:

- The day sheet listed UTI as the reason for her appointment and she thought she had a bladder infection;
- A urinalysis was performed, which is consistent with the patient's complaint of back pain, and her concern that she had a bladder infection;

- Patient A testified that Dr. Ateyah asked her if it burned when she peed and she told him no but it was itchy and this is consistent with his chart;
- Dr. Ateyah and Patient A both agree that he told her he was not going to do a pelvic examination prior to her examination;
- Both Patient A and Dr. Ateyah agree that she was seen in Examination Room 3 (although it was not at the end of the hall as she said but close to the reception desk);
- Dr. Ateyah and Patient A both agree that she was given an ultrasound requisition;
- Dr. Ateyah and Patient A both agree that she was seen on the morning she called the office;
- Patient A testified that the appointment lasted about 20 minutes and that is the length of time available to Dr. Ateyah according to his day-sheet;
- Dr. Ateyah and Patient A both agree that no gown or drape was provided;
- Dr. Ateyah agreed that he might say that a patient looked young and "good for her" or touch her shoulder, although he had no specific recollection of making these comments with respect to this specific patient or touching her shoulder.

Dr. Ateyah's counsel submitted that there were several areas of inconsistencies in Patient A's testimony that undermined her credibility and reliability. I will address each of these alleged inconsistencies.

(i) The Reason for the Visit

Patient A denied that she attended Dr. Ateyah due to vaginal itchiness. She maintained that she attended because she had back pain and was concerned she may have a urinary tract infection. Patient A was confronted with the fact that she told the College investigators that she mentioned to her own family doctor's receptionist, before her appointment with Dr. Ateyah, that she had back pain and

vaginal itchiness. She explained that she knew vaginal yeast infections cause itchiness and had seen her family doctor for yeast infections in the past. Patient A had a yeast infection a couple of times a year and she knew how to treat them with over the counter medication. She maintained that this was not the reason she attended Dr. Ateyah's office.

Dr. Ateyah's counsel submitted that Patient A was confused about why she was seeing Dr. Ateyah and this was a material inconsistency in her evidence as a large part of the case turns on exactly why Patient A went to see Dr. Ateyah. Dr. Ateyah's counsel submitted that it would be unlikely that Patient A would be confused about whether she was seeking medical attention for back pain or a suspected UTI and this undermines her credibility. Dr. Ateyah's counsel submitted that it was an attempt by Patient A to downplay the vaginal itchiness as a symptom she was experiencing at the time of the appointment in order to substantiate her claim that it was her back and not her genital or urinary organs for which she was seeking medical attention. Counsel submitted that it would be unlikely that a patient would forget such information if something out of the ordinary occurred during the subsequent appointment.

In my view, Patient A's evidence was not inconsistent. She was very clear that she thought the back pain was a sign of a bladder infection. Patient A knew how to treat a yeast infection, which she thought was the cause of the vaginal itchiness. She did not need to see a physician for that problem, although she may have mentioned to her own family doctor's receptionist that she thought she had a yeast infection again. She thought that the back pain signified she had a bladder infection. Her daughter had had a bladder infection recently. Patient A testified that when she was asked by Dr. Ateyah about whether or not it burned when she peed, she testified that it did not, but she was itchy. Her testimony is consistent with Dr. Ateyah's note on this point. Dr. Stanton also gave evidence

that back pain could be associated with the bladder. I find that none of Patient A's evidence on her reason for the visit is inconsistent.

(ii) Cupping

Counsel for Dr. Ateyah submitted that Patient A did not use the word "cupping" to describe Dr. Ateyah's putting his hand on her pubic bone and labia while she was lying on the examination table until her examination in chief at the hearing. Patient A says that she had used the term "cupping" prior to her testimony during the hearing. It was revealed that in her interview with the College she did use that word "cupping" when she described Dr. Ateyah touching her genital area while she was standing. Whether or not Patient A consistently used the word "cupping", she testified that the term "cupping" meant the same thing as the conduct she described during the examination, namely, Dr. Ateyah's hand on her pubic bone and labia on each of the three times she described.

I find that Patient A's use of the term "cupping" in her testimony was not an attempt to embellish her version of events, but simply, as she said, a way to explain what happened. I further find that her failure to use the term "cupping" on each occasion she described what happened to not be an inconsistency. A witness may use different language at different times to describe a series of events or an act without that language giving rise to any material inconstancy in her description of what happened.

(iii) Toronto Sports Team's Shirt

It was a Toronto Sports Team's day at the place where Patient A works on the day of the appointment with Dr. Ateyah. Patient A did not mention that she was wearing the Toronto Sports Team's shirt in either her complaint letter or interview with College investigators. Patient A testified that she did not realize that she had

to include everything in her original complaint letter and had simply mentioned that she was wearing a t-shirt and capri jeans.

I find Patient A's explanation for omitting this detail in her letter of complaint reasonable and nothing turns on the added detail to Patient A's account of the incident. The fact she had not previously mentioned that her t-shirt was the Toronto Sports Team's t-shirt is not an inconsistency and is irrelevant.

(iv) Location of Examination Room 3

Patient A testified that she was seen in Examination Room 3 and that it was down at the end of a hall-way. The clinical record confirmed she was seen in Examination Room 3. Photographs of Dr. Ateyah's office clearly indicated that Examination Room 3 was close to the Reception Desk and not at the end of a hall. Patient A was wrong on this point. Visual-spatial perceptions may vary and the fact that she did not accurately recall the location of Examination Room 3 does not undermine her credibility or the reliability, more generally, of her evidence in my view. There is no link between the location of the Examination Room and the alleged misconduct such that an error with respect to the location of the room would undermine the accuracy of her recollection or the veracity of her evidence with respect to the misconduct she described.

(v) Words "Fabulous" and "Fantastic"

Patient A testified that Dr. Ateyah used the word "fabulous" in his comment to her regarding her age and youthful appearance. Dr. Ateyah testified that "fabulous" is not a word he uses.

Patient A agreed that she had not used the word "fabulous" in relation to comments made to her by Dr. Ateyah in either her letter of complaint to the

College or her interview with the College investigators. In re-examination, Patient A confirmed that the words she used in her letter of complaint were: “He checked the computer screen and exclaimed that I looked young and rubbed my shoulder telling me how great I looked and good for me”. She confirmed that the words she used in her College interview were: “And he got on the computer and he made a great big deal about it: “Oh my God, you look so young”, and he rubbed my shoulder up and down and said, “Whatever you’re doing, keep it up. You look fantastic.”

The words “fabulous” and “fantastic” are very similar in meaning in the context in which the words were alleged to have been used. I do not consider the fact that Patient A used the terms interchangeably to be a material inconsistency. I do not find her use of either term to be an embellishment of her version of events and the inconsistency does not affect her credibility. The fact that Patient A may be unsure as to whether the word “fantastic” or “fabulous” was used does not undermine her reliability with respect to the fact that she recalls Dr. Ateyah being surprised by her age and making a comment that complimented her on her physical appearance.

The issue is whether such a comment, whether it be “fabulous” or “fantastic”, was appropriate and, if not, whether it rises to the level of professional misconduct.

(vi) Nervousness of Patient A

It was put to Patient A that she was nervous when she was seeing Dr. Ateyah and that as a result, her recollection of events could not be relied upon. Because of being scared, confused and seeing a male doctor instead of her own family doctor, counsel for Dr. Ateyah submitted that Patient A mistakenly believed that Dr. Ateyah touched her inappropriately.

Patient A testified that she was not nervous when she went to the appointment. When she found out during the appointment that the urinalysis tested negative, she knew her problem was not a UTI. Dr. Ateyah told her that he was concerned that she had something serious before he examined her on the table. She became scared, she said. Before he touched her, when she was standing, she testified that he told her that he thought it was serious and he thought she was really sick.

In my view, the fact that Patient A may have become scared or nervous does not mean that she misperceived Dr. Ateyah's actions. I do not find that Patient A's nervousness or concern about her health (a concern that was deepened by Dr. Ateyah's comments) influenced her detailed description of the manner in which she was touched by Dr. Ateyah. Patient A's evidence, which I accept, was that Dr. Ateyah was the one who said he thought she had something serious going on and caused her to be fearful. He told her words to that effect before she was on the examination table and again when he had her stand up so that he could do one more thing.

I find, for the reasons stated above, that none of the foregoing alleged inconsistencies impugn the credibility or reliability of the evidence of Patient A. Her evidence was clear, consistent and cogent. Her evidence was internally consistent. She was credible and her version of events was plausible. She was without animus. She had seen Dr. Ateyah previously and had felt comfortable with him. There was no evidence of any reason for her to fabricate her version of events. There was also no basis in the evidence to suggest that she misperceived Dr. Ateyah's hand on her genitals. She testified that she knew what a hand between her legs felt like. I find this to be a reasonable statement.

(b) Credibility of Dr. Ateyah

Dr. Ateyah presented in a matter of fact way and appeared to be earnestly trying to answer questions. His command of the English language was good and did not appear to be an impediment to testifying. He appeared to take the allegations very seriously and was adamant in his denial of the allegations. For the reasons that follow, however, I did not find Dr. Ateyah to be credible.

(i) Did Dr. Ateyah remember Patient A?

Dr. Ateyah testified that he "absolutely" and "definitely" did not recall Patient A's appointment. Dr. Ateyah received the College letter enclosing Patient A's complaint letter less than two weeks after Patient A's appointment with him. It stretches credulity that he would not recall a single thing of that visit despite the detail in Patient A's letter, which one would expect to jog his memory of the visit. Dr. Ateyah testified that the medication he was on at that time for the prolactinoma did not affect his memory.

There are indications in his testimony that he did, in fact, recall some details of Patient A's visit on the date at issue. Dr. Ateyah testified, "I was hoping that she could go for a proper internal exam with her family doctor," despite the fact that there was no notation to this effect in his clinical record. If Dr. Ateyah did not recall Patient A, how would he recall that he was "hoping" she would see her own family doctor? Dr. Ateyah noted potentially serious conditions in his differential diagnosis, yet his plan was rather generic, benign and vague, consisting of follow-up advice regarding hygiene, an increase in fluids, and reassurance, along with an ultrasound. He did not note, "follow up with her family doctor" as part of the plan. If he recalled hoping she would follow-up with her family doctor, he must recall the patient.

Dr. Ateyah testified, “I did not think I am dealing with pelvic inflammatory disease.” , yet Dr. Ateyah wrote “PID” as one of his differential diagnoses. Dr. Faulds described PID as a fairly serious condition, even an emergency one. If Dr. Ateyah did not remember Patient A, then why would he testify that he didn’t really think she had PID? He clearly wrote PID in his list of differential diagnoses. If he did not recall Patient A, one would expect that Dr. Ateyah would say words to the effect of, “Apparently, I was very concerned she had PID as it was one of my differential diagnoses.”

Dr. Ateyah testified that he did not think the patient was nervous, and then quickly added, that he did not recall the visit. I find that Dr. Ateyah did not misspeak when he said she was not nervous. This testimony belies Dr. Ateyah’s evidence that he had no recollection of Patient A. If he did not think she was nervous, he must have remembered her.

I find that Dr. Ateyah was not credible in his testimony about whether or not he remembered Patient A. I find that Dr. Ateyah recalls at least some of Patient A’s appointment with him.

(ii) Dr. Ateyah’s Clinical Note for Patient is Unreliable

I find Dr. Ateyah’s clinical record unreliable for several reasons.

(a) Failure to establish principal or chief complaint

Patient A was very clear in her testimony that she went to see Dr. Ateyah because she had right flank pain that was bothering her on her drive to work and she was concerned that she had a UTI. She testified that she showed the doctor where the pain was in her back and when he asked if it hurt when she urinated, she said it didn’t, but “that it was a bit itchy”. She also testified that she told Dr. Ateyah

several times that she was there for back pain. In Dr. Ateyah's medical record for this visit, back pain is mentioned lower down in a list of subjective responses to questions. It is listed after normal BMs.

Patient A testified that she told Dr. Ateyah several times she had right flank pain, yet Dr. Ateyah's note for the appointment does not indicate that he took a further history of that pain by asking, for example: How long had she had the pain? What kind of pain was it? Did the pain radiate anywhere? Did movement or anything make it worse? It is puzzling to me that Dr. Ateyah was focused on issues related to the pelvis when this was not what Patient A came to see him about. His lack of attention to her main complaint, and the lack of agreement between Dr. Ateyah and Patient A with respect to the presenting problem, undermines Dr. Ateyah's testimony about his attention to the clinical care of Patient A's presenting problem and suggests that the clinical notes do not accurately reflect what Patient A actually told Dr. Ateyah.
Dr. Faulds noted that Dr. Ateyah failed to determine what Patient A's chief complaint was. I agree and find that the lack of focus on Patient A's chief complaint raises issues with respect to the reliability of Dr. Ateyah's note for the appointment.

(b) The chest and abdominal examination

I am not convinced that a chest and abdominal examination were completed, although Dr. Ateyah charted that he did them. Dr. Ateyah described in his testimony how he examined the flank area, which involved one hand on the front and one hand on the back of the patient. After asking the patient to take a deep breath, he would try to "grab" the kidney as it was pushed down with the respiration. Dr. Ateyah testified that he thinks, based on his note, that he likely did this examination. However, when Dr. Ateyah wrote his response to the College after receiving the complaint, he did not describe doing a chest and abdominal

examination at all. When he responded to Dr. Faulds' expert report in February 2017, he did not mention it either. Patient A testified that she did not have an abdominal examination. It was not put to Patient A that she had a chest examination, nor was she asked about the examination of the kidney area specifically. I find that Patient A's evidence is more credible and reliable on the nature of the examination that was conducted. I expect that she would have remembered if Dr. Ateyah had done an examination of the kidney the way he said he did.

(c) The inguinal area and pubic bone examination

The table in Examination Room 3 is not a conventional examination table but a massage table that the visiting physiotherapist used. It is only five feet long and Dr. Ateyah testified that a patient would have to bend their legs to lie on it.

Dr. Ateyah gave varying versions of how he would examine the inguinal area. First, he said he would do it under the underwear, then over the underwear but under the clothes and then he said he would have the patient push down their underwear a little so he could feel the area with his hand. He stated, "I feel more comfortable to do the exam with direct contact of my skin with the patient's skin. Make me feel better." He then went on to explain why that was important because contact with the skin would inform him of any roughness, eczema or skin problem. This explanation was not credible as there was no reason for him to be focused on these skin problems. He was dealing with a walk-in patient who was seeing him for a specific complaint of back pain.

There was no dispute that Patient A's legs had to be bent when she was on the table. She is 5 feet 6 inches tall. The massage table was five feet long. She testified that Dr. Ateyah told her to bend her legs and that she thinks her pants

zipper undid more when she bent her legs. Patient A testified that her pubic hair did not protrude outside her underwear.
In order for Dr. Ateyah to do an inguinal exam as he said he preferred to do with skin on skin, he would either have to insert his hand under the underwear or have the patient push her underwear down so her inguinal area was not covered. It would then be very difficult for Dr. Ateyah to examine the inguinal area with the patient's knees bent and the underwear rolled down to expose that area. If he inserted his hand under her underwear, it is plausible that Patient A's pubic hair was pulled as Patient A testified. It is difficult to imagine how the inguinal area could be adequately examined when the legs are bent with either scenario, with the underwear rolled down or the hand under the underwear. This is an examination that would be more easily performed with the legs straight, especially when Dr. Ateyah testified that he did this examination with the flat part of four fingers.

Dr. Ateyah charted "bilateral groin area pubic bone slight tenderness." Dr. Ateyah testified that he decided to do the pubic bone examination to see if there was any inflammation of organs underneath this bone, since he was not going to do a pelvic examination. Dr. Ateyah did not chart whether or not Patient A had enlarged lymph nodes. In light of the fact that Dr. Ateyah found the pubic bone tender, noting a negative finding of 'no lymphadenopathy' would have been important since he testified that pubic bone tenderness may indicate a problem with an infection in the organs beneath it.

Both Dr. Faulds and Dr. Stanton testified that it was not necessary to fully palpate the pubic bone as part of an abdominal examination. Dr. Ateyah's note that the pubic bone was tender suggests that he touched the pubic bone. Dr. Faulds testified that examination of the pubic bone would be important if there was pubic bone pain and a suspicion of inflammation or osteomyelitis or the patient

had a fever. There was no reason for Dr. Ateyah to examine the pubic bone based on the presenting complaint or differential diagnoses.

Patient A stated that she was told she was tense and she needed to relax and to open and close her legs when Dr. Ateyah's hands were in this area. Patient A testified that nothing more was said. Given Patient A's evidence that Dr. Ateyah did not question her when his hand was in the area of Patient A's pubic bone and inguinal area, and the difficulty in doing an examination of the inguinal area with bent legs and with the underwear either pushed down or the hand under the underwear, I find Dr. Ateyah's clinical note "bilateral groin area pubic bone slight tenderness" to be unreliable.

I find that Dr. Ateyah did not do an inguinal or a pubic bone exam as he said he did. His note to that effect is not reliable and his evidence on this point is not credible. I find that Dr. Ateyah covered up his sexual touching of Patient A by writing a note to provide a clinical reason for his hand being in the pubic area.

(d) Ovarian pathology differential diagnosis

Although Dr. Ateyah listed ovarian pathology as his first differential diagnosis, he did not elicit other history related to that potential diagnosis, raising further doubts about the reliability of his note.

(e) PID differential diagnosis

Dr. Ateyah charted PID (pelvic inflammatory disease) as one of his differential diagnoses, yet as Dr. Faulds noted, there was no history other than asking about pain on intercourse and vaginal discharge that would be related to this differential diagnosis. If he thought that PID was a serious consideration, a more

complete sexual history should have been done, as Dr. Faulds testified, including questions about Patient A's sexual partners, etc.

Furthermore, Dr. Ateyah contradicted himself when he said that he did not think the patient had PID, thus calling into question the reliability of his clinical note.

In summary, I find that the chart note for Patient A by Dr. Ateyah on this visit is not reliable. The fact that the note of the examination is not reliable, along with evidence that points to Dr. Ateyah in fact remembering Patient A, leads me to conclude that Dr. Ateyah is not credible. There is almost no history to support the three differential diagnoses Dr. Ateyah listed. There is no history of the back pain of which Patient A complained. While there is no expectation that the history taking under the subjective part of the note would be exhaustively recorded, there is very little in the way of history to substantiate that Dr. Ateyah even asked about the potential diagnoses he listed. The diagnoses were fairly serious problems, yet the plan as outlined by Dr. Ateyah included rather benign and generic advice. It would be difficult to perform the inguinal examination he said he did with bent legs, and Dr. Ateyah's description of how he did it varied, whether over or under the patient's underwear.

For the reasons stated above, I find that Dr. Ateyah's testimony on key issues was not credible. For this reason, where Dr. Ateyah's evidence is inconsistent with the evidence of Patient A, I prefer the evidence of Patient A, who I have found to be a credible witness for the reasons expressed above.

(3) The Expert Evidence

(a) Dr. Faulds' Evidence

I found Dr. Faulds to be knowledgeable and experienced. I also found that she gave her evidence in an impartial way. Dr. Ateyah's counsel submitted that Dr. Faulds was a biased expert and critical of every aspect of Dr. Ateyah's practice. In my view, this is not an accurate characterization of her evidence as on several points, Dr. Faulds evidence and Dr. Stanton's evidence was consistent. For example, both experts thought Dr. Ateyah should have completed a pelvic examination based on his differential diagnoses. Both experts thought that an abdominal examination did not require the use of gloves. Both experts indicated that an abdominal examination did not involve an examination of the pubic bone. I found Dr. Faulds' evidence of assistance in determining the standard of practice of the profession and I will have more to say about her opinion when reviewing the allegation that Dr. Ateyah failed to maintain the standard of practice of the profession.

Dr. Ateyah's counsel also contended that Dr. Faulds' evidence was biased because she appeared to engage in an assessment of Patient A's credibility by noting that Patient A was consistent in her story, in her complaint letter and in her statements to the College investigator. In my view, Dr. Faulds was not commenting on the credibility of Patient A in making that statement, but simply stating what information she was working with and stating that the information was consistent. I did not find her opinions and conclusions biased.

(b) Dr. Stanton's Evidence

I found Dr. Stanton to be knowledgeable and experienced. Although Dr. Stanton did not have the complainant's letter and her transcript from her interview with the College investigators, he did his best to interpret Dr. Ateyah's clinical notes and relate this to the standard of practice. I found his opinions helpful for establishing the standard of practice of the profession and assessing whether or

not Dr. Ateyah maintained the standard of practice. Again, I will have more to say with respect to evidence below.

(c) Dr. Krakowsky's Evidence

Counsel for the College argued that Dr. Krakowsky's evidence was not relevant and therefore inadmissible. It was agreed by the parties that the Committee could hear the evidence of Dr. Krakowsky and then make a subsequent determination as to its relevance and admissibility.

In order for evidence to be relevant it must have some tendency as a matter of logic and human experience to make the proposition for which it is advanced more likely than the proposition would be in the absence of that evidence. Whether or not something is relevant is also a matter of experience and common sense.

What constitutes touching of a sexual nature is an objective inquiry viewed from the perspective of an objective observer (*R v. Chase*). Sexual motivation on the part of the perpetrator is but one factor to be considered. The absence of sexual motivation, or in situations where the offender's motivation is unknown, does not preclude a finding that the behaviour in question is sexual in nature.

The College submitted that since sexual motivation is not necessary to establish touching of a sexual nature, it must follow that evidence going to this issue is not relevant. Dr. Ateyah submitted that the College's position confuses relevance with the constituent elements of the allegation. Dr. Ateyah's counsel submitted that both direct and circumstantial evidence of the facts in issue are relevant and that general circumstances surrounding the incident, so long as that evidence tends to prove or disprove whether a fact in issue occurred, is relevant. Dr. Ateyah's counsel accepted that a finding that Dr. Ateyah did not experience

sexual desire is not a complete defence to the allegation. He submitted it is one piece of evidence, which the Committee is entitled to consider as part of evaluating all of the facts of the case.

Dr. Ateyah relied on the case of *R. v. Labrecque,* 2002 CanLII 2668 (ON SC). The issue in that case was whether the defendant touched the two complainants in a sexual manner. The defendant denied this occurred. The defendant had various physical ailments including an enlarged prostate and a very low testosterone level, which his expert testified, would virtually eliminate any sexual desire or the ability to have an erection or to ejaculate. One complainant alleged, among others, that the defendant masturbated and ejaculated in her presence, the other alleged he digitally penetrated her vagina.

In *Labrecque*, the trial judge stated with respect to the expert evidence at para 95:

> I accept the evidence of Dr. Levers that a low level of free testosterone would have the affect of attenuating a male person's sexual desire. His evidence on this point is based primarily on findings that watching erotic movies does not sexually arouse males with a low free testosterone level. That may be so, but the touching of a female person on a part of her body that deems the touch to be sexual in nature may, or may not, be made with the intent of his sexual gratification. The Crown's theory in part, is that knowing he had sexual problems for which he was referred to a specialist, and, not being aroused sexually by his partner, the defendant may be motivated to experiment with his young employees. This would be in an attempt to stimulate his sexual desire and not out of sexual desire. At the time of his alleged offences the defendant had not yet seen Dr. Levers and would not have known that his sexual desire was attenuated for chemical reasons.

The Court in the *Labrecque* went on to conclude that the evidence of the accused's low testosterone did not raise a reasonable doubt as to whether or not he had engaged in sexual touching of the complainant, because the accused was still capable of touching the complainants in a sexual manner for other reasons.

Counsel for Dr. Ateyah submitted that even though the Court in *Labrecque* was not persuaded that the expert evidence raised a reasonable doubt, the Court did not rule that the expert evidence was inadmissible. College counsel points out that there is no indication from the decision that the Crown ever raised an objection to the expert evidence on the basis of relevance.

It is a settled principle in law that sexual assault does not require sexual motivation or gratification. As stated by the Ontario Court of Appeal in *R. v V (K.B.)* CanLII 7503 (ONCA); affirmed, [1993] 2 SCR 857, the absence of sexual motivation is not determinative.

In the *R. v V (KB)*, the Court relying on *R v. Chase*, said at p. 7:

> "What elevates an assault to a sexual assault will depend on the circumstances of each case. A sexual assault does not require sexuality and indeed, may not even involve sexuality. It is an act of power, aggression and control. In general, sexual gratification, if present, is at best a footnote."

The question is whether the touching and remarks were objectively sexual in nature, not what Dr. Ateyah's motivation may have been at the time. This does not mean, however, that evidence with respect to sexual motivation, arousal or gratification is not relevant. Evidence of the absence of sexual motivation, arousal or gratification alone, however, is not determinative.

College counsel points out that in *R. v Labrecque*, the Court relied on the evidence of low testosterone to the extent that it showed that the accused experienced erectile dysfunction and inability to ejaculate. The Court, however, rejected any connection between the evidence of low testosterone and the likelihood that the accused had engaged in sexual touching of the complainant.

Evidence tending to show sexual motivation or gratification is always relevant. But the obverse is not true. Evidence of a lack of sexual gratification, desire or libido does not reduce the likelihood that sexual abuse occurred. The parties are entitled to lead evidence of general circumstances surrounding the incident, so long as the evidence tends to prove or disprove whether a fact in issue occurred. Evidence regarding Dr. Ateyah's sexual desire or libido and the lack of sexual gratification does not tend to prove or disprove any fact regarding the allegations in this case, and thus, is not relevant. Sexual abuse is not necessarily about sexual gratification, and may be about power and control or violating someone's sexual integrity, as the Courts have stated.
Consequently, I find that Dr. Krakowsky's evidence is not relevant.

(4) Findings

(a) Sexual Abuse

For the reasons provided below, I find that the allegation that Dr. Ateyah engaged in the sexual abuse of Patient A is proven.

(i) The First Improper Touch

I find that Dr. Ateyah touched Patient A by placing his hand over her underwear on her pubic bone and vagina area for five to six seconds as Patient A testified. Patient A was credible and her evidence reliable. Cupping the pubic bone and

labia to just before the rectum is touching in a sensitive and private area. I do not see how Patient A could have misinterpreted Dr. Ateyah's examination of the inguinal area on the lower abdomen with his hand on her genitals as she described. Patient A's testimony that she knew what a hand between the legs felt like was credible and makes sense. There was no legitimate clinical purpose for this touch and it constitutes sexual abuse.

(ii) The Second Improper Touch

I also find that Dr. Ateyah put his hand under Patient A's underwear and cupped his hand over her pubic bone and vagina for five to six seconds. Patient A's recollection that she was concerned that Dr. Ateyah was going to put his finger in her vagina was a detail that added to the credibility of her version of events. This is not the description of a hand on the lower part of the abdomen examining for tender lymph nodes. Similarly, there would be no reason for pubic hair to be pulled if a hand was simply on the abdomen feeling for lymph nodes. The action of putting the hand lower over the genitals under the underwear would more likely pull pubic hair as Patient A described. In addition, although Dr. Ateyah charted that the groin and pubic area were tender, I find that this note was made to provide clinical justification for touching her in this area. I find that Dr. Ateyah cupped Patient A's pubic bone and labia while she was lying on the table, as Patient A described, without clinical justification. As with the first improper touch, I find that Patient A did not misinterpret or mistake an appropriate examination of her abdomen and inguinal area as Dr. Ateyah's touching of her genitals in the manner described.

(iii) The Third Improper Touch

Dr. Ateyah's counsel submitted that Patient A's description of what happened the third time Dr. Ateyah touched Patient A, when she was standing, lacks an air

of reality, because Patient A did not know which body part of Dr. Ateyah was touching her and because of the difficulty in doing the manoeuver Patient A described. For the reasons below, I do not agree.

Patient A testified that Dr. Ateyah stood to her right or behind her and cupped her pubic bone and labia and rocked her back and forth into him for about five to ten seconds. She could not recall what part of Dr. Ateyah's body she touched when he rocked her back and forth. Patient A recalled seeing Dr. Ateyah's hand between her legs with the thumb sticking out during this incident. She had her underwear on but her pants had been pulled down. Dr. Ateyah testified he was 6 feet tall and weighs 260 lbs. Patient A is 5 foot 6 inches and appeared to be of an average weight.

Given the size differential, I do not consider it implausible at all that Dr. Ateyah could perform this manoeuver. He was taller and bulkier and could easily reach around Patient A as she described. The fact that Patient A did not know which part of his body touched her as he rocked her while holding her genital area is not surprising. Dr. Ateyah was behind her, she could not see what part of his body was touching her. The action was short-lived, and she was significantly stressed by the situation in which she found herself.

I find that Dr. Ateyah touched Patient A's genital area in the same way as she described when she was standing. Her statement that Dr. Ateyah told her it was serious and that he thought she was really sick, at a time when she was already feeling "shooken up" and scared was most likely a way to ensure she stood still. Patient A continued to tell Dr. Ateyah the pain was in her back and eventually elbowed her way free. Patient A is credible and I find that Dr. Ateyah did, in fact, cup Patient A's pubic bone and labia as she said he did, without clinical purpose. I find that the third incident of touching occurred as described by Patient A, that

this was touching of a sexual nature and that this touching constitutes sexual abuse.

(b) Disgraceful, Dishonourable or Unprofessional Conduct

(i) The Vaginal Touching of a Sexual Nature

I have already concluded that each of the three touchings of Patient A's vaginal area by Dr. Ateyah were without clinical justification and constitute sexual abuse. I also find that each of these touchings of a sexual nature under the guise of purported examinations would be viewed by members of the profession as disgraceful, dishonourable and unprofessional.

(ii) The Comments and Arm / Shoulder Rubbing

Dr. Ateyah testified that he might tell a patient that they look young and 'good for you'. He also testified that he might touch a patient's shoulder as reassurance. He testified, however, that he does not recall making any such comments to Patient A or touching her shoulder.

Patient A's testimony with regard to the comments that Dr. Ateyah made are credible and align with what Dr. Ateyah said he might do. Patient A's evidence that Dr. Ateyah rubbed her arm is also believable. Dr. Ateyah said he might touch a patient's shoulder. Patient A testified that she laughingly told Dr. Ateyah that her periods were every 20 days as it is such an annoyance for a woman to have her period so frequently. When she went on to say she was menopausal, Patient A testified that Dr. Ateyah then made the comment about her being too young and commenting on her appearance. This lighthearted exchange established a connection between the two and it is entirely plausible that in that moment, the shoulder rubbing and the comment was made as alleged by Patient A. In the

context of this patient encounter, these actions constitute boundary violations that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

To be clear, I do not consider all touching by a physician aimed at reassuring a patient to be a boundary violation. Nor do I consider any remark on a patient's appearance that could be construed as flattery to be a boundary violation. Context is important. In this case, the comments and touching were by a male physician towards a female walk-in patient with whom he did not have an established relationship; there were only a few prior episodic visits to the clinic. I find that the comment and touching were a prelude to a physical examination that involved sexual abuse. Dr. Ateyah was effectively flirting with the patient in an effort to test her boundaries. These actions, coupled with his subsequent comments about the serious nature of her condition, were deliberate measures taken to ensure the patient would be compliant and allow him to touch her in the manner described by Patient A during the purported examinations. As such, the rubbing of Patient A's arm and the comments on her appearance constitute disgraceful, dishonourable or unprofessional conduct.

(iii) Pulling down Patient A's pants

Patient A testified that Dr. Ateyah pulled down her pants during the range of motion test. I believe her evidence on this point. Dr. Faulds testified that she would never conduct a back examination or a range of motion examination while a patient had her pants around her knees or ankles. She testified that this would be "absolutely inappropriate".

I find that Dr. Ateyah engaged in disgraceful, dishonorable and unprofessional conduct on the basis that he pulled down Patient A's pants and conducted the examination while her pants were around her knees.

(c) Failure to Maintain the Standard of Practice of the Profession

I gave more weight to Dr. Faulds evidence with respect to the standard of practice of the profession than Dr. Stanton's. Dr. Faulds has been involved with teaching medical students and residents for about 30 years, while Dr. Stanton's experience in this area was much more limited. As an involved teacher for many years, Dr. Faulds would be required to maintain her knowledge of clinical skills, examination and the maintenance of boundaries in the clinical setting current. Although both physicians had leadership roles within their clinics and local health networks, Dr. Faulds had more involvement provincially, nationally and internationally. She had clear indication on her CV of publications, presentations, and numerous awards. Dr. Faulds had more experience as an independent assessor for the Inquiries Complaints and Reports Committee of the College.

Although Dr. Stanton had many years of experience in his family medicine clinic and at the local emergency department in his hospital, I did not give Dr. Stanton's evidence as much weight as that of Dr. Faulds. His experience was not as extensive in various teaching and other clinical environments. Dr. Stanton was less concerned with the need for the patient to be appropriately draped. He considered that having a patient lie on the table and pull down their pants for an abdominal/inguinal examination without proper drapes or gowns to be acceptable. This testimony detracted from the acceptance of his testimony overall as sensitivity to the patient's privacy, especially between a male physician and a female patient, is paramount in any patient encounter.

I found that Dr. Ateyah failed to maintain the standard of practice of the profession in the following areas.

(i) Failure to establish a chief complaint

Both Dr. Faulds and Dr. Stanton agreed that establishing a chief complaint is important in order to respond appropriately to the patient's concerns and to ensure that subsequent examinations, diagnoses and differential diagnoses are reflective of the chief complaint.

Dr. Ateyah's counsel argued that Patient A was inconsistent on her reason for the appointment with Dr. Ateyah. I disagree. She was clear that back pain was the problem and she only mentioned itchiness when she was asked if it burned when she peed. Dr. Ateyah's chart corroborates that evidence. Patient A testified that she told Dr. Ateyah repeatedly that it was her back that was bothering her but back pain was number seven on his list of subjective complaints, below his note regarding bowel movements.

I find that the standard of practice of the profession requires a physician to identify the patient's chief complaint and that Dr. Ateyah failed to identify Patient A's chief complaint. I find that Patient A's chief complaint was back pain. Dr. Ateyah ignored her chief complaint and focused his purported examinations on the vaginal area.

(ii) Failure to take a history that related to the differential diagnoses

Dr. Ateyah came to differential diagnoses of ovarian pathology, PID, and renal stones. Dr. Ateyah did not record a history that would substantiate or show how he arrived at the differential diagnoses. No relevant history was taken of the ovarian pathology he was considering. Other than asking if there was pain with intercourse, there were no questions related to sexual history that would be expected with PID as a differential diagnosis. He did not ask any questions about renal stones. Although the summary of the questions asked as part of the history do not need to be exhaustively listed in the subjective portion of the charting, it needs to contain enough positive and negative points to elucidate his thinking. That was not done, nor was there any history recorded about Patient A's back pain complaint.

I find that the standard of practice of the profession requires a physician to conduct a history that relates to the differential diagnoses. I find that Dr. Ateyah did not take a proper history in keeping with his differential diagnoses.

(iii) Failure to adequately prepare Patient A for examination

a) Failure to adequately explain why and what he was doing

Patient A's testimony, which I accept, was that she did not know what was happening in the examination. I find that the standard of practice of the profession requires a physician to explain their intended examination to the patient before and throughout to ensure the patient's consent to the examination. I find that Dr. Ateyah did not explain to Patient A the rationale for or the manner of his intended examination prior to or during the course of the examination. He thereby failed to adequately explain and prepare her for the examination and obtain her consent to it.

a) Failure to properly prepare the patient by providing gowns, or drapes, or gloves or a chaperone

Dr. Ateyah did not offer Patient A a gown, drape or have a chaperone available in the room. Dr. Faulds testified that the standard of practice is that the physician should leave the room after giving instructions to the patient to change from the waist down and giving her a drape and gown if he was going to do an abdominal and pelvic examination and that an inguinal examination required proper draping of the patient, Dr. Stanton's view was that it was appropriate for a patient to have an examination of the abdomen and inguinal area without a gown and drape. I prefer the evidence of Dr. Faulds on the standard of practice with respect to when to provide a gown or drape, because of her more current experience with

teaching clinical skills to medical students and her lengthy history as an educator to medical students. I find that Dr. Ateyah failed to adequately prepare the patient by not providing a gown and a drape and therefore failed to maintain the standard of practice of the profession.

Failure to provide a chaperone for a sensitive examination of the inguinal area also falls below the standard of practice. Dr. Faulds noted, and I agree, that the inguinal area is a private and sensitive area for a patient given its proximity to the genitals. When a male physician is examining a woman in this area, a chaperone should be provided or offered. I find that Dr. Ateyah failed to maintain the standard of practice of the profession by failing to provide or offer a chaperone for an examination of the inguinal area.

Dr. Faulds and Dr. Stanton did not agree on whether gloves should be worn for a sensitive inguinal examination. I was not persuaded that the standard of practice requires that a physician wear gloves when examining the abdomen or inguinal area.

I find that the standard of practice of the profession requires a physician to offer a patient a gown and/ or drape when conducting a physical examination of a sensitive or private body part, such as the inguinal area. Further, I find the standard of practice of the profession requires the physician to provide or offer to have a chaperone present for such an examination. To be clear, I do not find that the standard of practice requires a drape, gown, gloves or chaperone to examine the abdomen. I find that Dr. Ateyah failed to maintain the standard of practice of the profession by failing to provide or offer Patient A a gown and drape and chaperone for an examination that included an examination of the inguinal area. To be clear, however, I have found that these purported examinations of the pubic/inguinal area were for no clinical purpose, rather, it

was touching of a sexual nature of the patient's vaginal area and constitutes sexual abuse.

(iv) Failure to conduct an examination related to a differential diagnosis

.

If Dr. Ateyah thought that the history and examination were pointing to diagnoses such as ovarian pathology and PID, which were based in the pelvis, a pelvic examination was required. Both Dr. Faulds and Dr. Stanton held the opinion that a pelvic examination should have been done based on Dr. Ateyah's clinical note. Whether or not Patient A was a walk-in patient should not have made a difference.

Dr. Stanton listed several reasons why a pelvic examination might be deferred, including a non-acute abdomen on examination and it is not an emergency. Dr. Faulds testified that on cross-examination that PID is an emergency situation and that if a pelvic examination is warranted, it should be conducted regardless whether it is a walk-in clinic. Dr. Stanton opined that if a pelvic examination was not done, it might be deferred with a plan, i.e., the patient had to be referred to her family doctor to have one done. Dr. Ateyah did not know if Patient A had a family doctor. Although he testified that he "hoped" she would see her family doctor, he did not even mention in his notes that she should have a pelvic examination with her family doctor. He did testify that he "might" have told Patient A to see her family doctor but forgot to chart it.

I find that Dr. Ateyah failed to maintain the standard of practice of the profession with regard to not doing a pelvic examination or sending Patient A to her family doctor to have it done in light of his differential diagnoses.

(5) Summary of Dr. Clapperton's Findings

I find that Dr. Ateyah committed an act of professional misconduct in that:

- he engaged in sexual abuse of patient by touching of a sexual nature of Patient A's vaginal area three times during a medical appointment;
- he engaged in disgraceful, dishonourable or unprofessional conduct by touching of a sexual nature of Patient A; by inappropriate rubbing of her arm and inappropriate remarks about her appearance during a medical appointment; and by pulling down her pants during the range of motion test and conducting the examination with her pants at her knees
- he failed to maintain the standard of practice of the profession.

DECISION AND REASONS FOR DECISION

ANALYSIS AND FINDINGSOF THE DISCIPLINE COMMITTEE

(1) Overview

The Discipline Committee had the opportunity to review Dr. Clapperton's decision above. The Committee agrees with and adopts that part of her decision set out in Part A (Background, Issues, Evidence and Law). For the reasons below, however, the Committee came to different conclusions with respect to its assessment of the credibility and reliability of the two fact witnesses, Patient A and Dr. Ateyah, and with respect to our assessment of the expert evidence. In the result, the Committee finds that the allegation of sexual abuse of Patient A by Dr. Ateyah is not proven. The Committee finds that the allegation of failing to maintain the standard of practice of the profession is proven, but for significantly different reasons than those of Dr. Clapperton. Finally, the Committee finds that the allegation of disgraceful, dishonourable or unprofessional conduct is not proven.

(2) Credibility and Reliability of the Fact Witnesses

Patient A's testimony and Dr. Ateyah's testimony were contradictory on many points. The Committee's evaluation of the credibility and reliability of these witnesses was a significant factor in its consideration of the allegations.

(a) Credibility and Reliability of Patient A

The Committee finds that Patient A sincerely believes that she was inappropriately touched by Dr. Ateyah. The Committee, however, finds that there were a number of inconsistencies between Patient A's evidence and that of Dr. Ateyah and her evidence and the clinical records. Further, Patient A's evidence

was inconsistent and confused at times. For these reasons, the Committee did not find her account of what happened during the examination in question to be reliable.

(i) Recollection regarding Earlier Appointments

Patient A erred in her recollections of the earlier examinations by Dr. Ateyah. Her evidence concerning the dates, the number of visits and the issues or complaints that resulted in the visits was inconsistent with Dr. Ateyah's clinical records. Patient A said in examination in chief that she saw Dr. Ateyah three times before the incident in question. She testified, "I believe I saw him twice for chest infections and then I had some stitches removed out of my hand about three years ago".

The clinical records show that she saw Dr. Ateyah four times before the incident in question. According to her clinical records, the first time she visited Dr. Ateyah was to have stitches removed (on a date in August, 2013). Her second visit was for leg pain (on a date in September, 2013). She did not recall the appointment for leg pain until shown the reference in the clinical notes. Her third visit was because she had fever and coughing (on a date in October, 2014). She then saw Dr. Ateyah for a fourth time (on a date in February, 2015) for a sore throat and coughing.

Patient A also testified that she thought that the first time she attended the clinic at which Dr. Ateyah works, it was for a "bronchial thing" and that she saw a female doctor. This was not correct as the clinical records showed only appointments at the clinic with Dr. Ateayh and the first visit was to have stiches removed, as indicated above.

Patient A testified that she had not reviewed her clinical record before testifying. Taken alone, the Committee would not have found the fact that she forgot how many times she attended to see Dr. Ateyah, why she attended, and whether or not she also saw a female doctor at the same clinic to be of great significance, but when taken together with other problems with her evidence, which are described below, these difficulties with her recollection were factors that the Committee took into consideration in assessing the overall reliability of her evidence.

(ii) Location of Examination Room

Patient A testified the she was examined in Room 3, which she described as "the last one down the hall" and that to get to Room 3 she had to walk 20 or 30 steps down a hallway. There is no dispute that the examination in question did take place in Room 3. The photographs of Dr. Ateyah's office, however, show that Room 3 is the first exam room off the reception area and not down a hallway, contrary to the description provided by Patient A.

(iii) The Reason for the Appointment

Patient A's evidence with respect to the reason she sought medical attention was not consistent. She testified in her examination-in-chief that the reason she wanted to see a doctor on that day in October was "I had a pain in my right back area and it was hurting so I wanted to get it looked at." When asked in examination in chief if there was anything else bothering her that day when she decided to seek medical attention, she replied, "No, I had some itchiness in my vagina area which was probably a yeast infection but it had nothing to do with why I was there." In cross-examination, she agreed that when she had called her own family doctor earlier that day to try and get an appointment, "I told [the receptionist] my sore pain and the itchiness". She eventually agreed on cross-

examination that one of the reasons she sought medical attention that day was because of the itchiness, even though she had denied this in her evidence in chief.

Patient A's evidence was also inconsistent with Dr. Ateyah's clinical notes as to the nature of her complaint on the date in October, 2016. Dr. Ateyah's clinical note, which formed part of his EMR clinical record, indicates that Patient A's presenting complaint was "vaginal discomfort and burning for many days when urinating". The notation "lower abdo discomfort and back pain" only occurs in his notes after a number of other facts collected from the patient as part of the subjective section of Dr. Ateyah's notes. Dr. Ateyah provided the following evidence with respect to the subjective section of his clinical note:

Notation	**Dr. Ateyah's explanation in testimony**
Vaginal discomfort and burning for many days when urinating	Pt here for discomfort in the vaginal area and burning for many days when she urinates.
No fever	Helps to assess if the matter is urgent.
Changing cycles and periods getting closer	Helps to assess if this is a gynecological issue. Also helps to determine if menopause is a problem.
No pain during sex	Eliminates the likelihood of a cyst or other gynecological issue.
No increase in urine freq	To aid in assessing if this was a bladder infection.
Normal BMs	BM = Bowel movements To aid in assessing if the issue is anxiety related or irritable bowel syndrome. Diarrhea might have led to infection in the vaginal area and hence the itchiness.
Lower abdo discomfort and back pain	Important to know the area of the pain to help in diagnosing if this was kidney related.

Not on meds	Aids in assessing if any meds might be causing some of the discomfort.
Codeine and penicillin allergies	Need to know when prescribing medications.

The Committee found no reason to doubt the accuracy of Dr. Ateyah's clinical note. The fact that Patient A was focused on back pain in her testimony at the hearing and insisted that this was the primary reason for her attendance on that date in October was inconsistent with Dr. Ateyah's clinical note and caused the Committee to question the reliability of Patient A's account.

(iv) Remarks Made at the Appointment

Patient A testified that Dr. Ateyah asked her questions about her menstrual periods, including when her last cycle was. In response, Patient A testified that she laughed and said that her periods were every 20 days as she was going through menopause. Patient A testified that Dr. Ateyah laughed in response, and said it was not possible as she could not be old enough. Patient A testified that Dr. Ateyah asked her how old she was and she stated she her age (in her early 50's). Patient A testified that Dr. Ateyah then went over to his computer and came back and said "you look so young" and "you couldn't possibly be" and that Dr. Ateyah then rubbed her arm up and down and said, "Whatever you're doing, keep it up. You look fabulous."

Patient A agreed that she did not use the word "fabulous" in the letter she wrote to the College three days after the appointment describing her complaint, nor did she use the word "fabulous" when she was interviewed by the College investigator. She agreed that in her letter to the College she said that Dr. Ateyah said she looked young, and she looked great and "good for you". In the interview

with the College investigator she reported that Dr. Ateyah said “Oh, my God, you look so young, Whatever you are doing keep it up. You look fantastic”.

The Committee finds that Patient A has been inconsistent in her description of what Dr. Ateyah said to her during the appointment, specifically with respect to the words that were used in or around the time he touched her shoulder. The Committee does not find that there is any significant difference in the substance of the various comments - “Your look fabulous”. “Your look fantastic”, “You look great” or “You look so young” - but the fact that Patient A has provided different versions of what was said on each time she is asked indicates that she does not actually recall what was said to her by Dr. Ateyah on the occasion in question.

(v) “Jumping” off the Examination Table

In examination in chief, Patient A described getting off the examination table for the range of motion test as “jumping” off the table. In cross-examination, she clarified that by using the term “jumping” she meant that she “got off quickly”. She says “both feet would have hit the floor at the same time, which is why I say “jump”. The photograph and testimony of Dr. Ateyah indicates that the examination table in Room 3 is a massage table which is quite low to the ground. Patient A’s use of the term “jump” seemed to the Committee to be an embellishment of her actual movements, tending to suggest that she was trying to get away from Dr. Ateyah. She would simply have had to stand-up to get off the examination table.

(vi) Abdominal Examination

Patient A was adamant that Dr. Ateyah did not examine her abdomen. The clinical notes were clear that an abdominal examination was conducted. Dr. Ateyah testified, based on his interpretation of the clinical note, that he

conducted an abdomen examination on Patient A. He described how he would conduct such an examination. Based on the clinical notes, Dr. Ateyah testified that his differential diagnosis led him to the conclusion that an examination of the abdominal area was necessary. The Committee struggled with the fact that Patient A denied that an abdominal examination was conducted, while the clinical notes clearly indicated that such an examination was performed. The Committee finds this to be further evidence of Patient A's poor recollection or confusion regarding what took place during the examination.

Dr. Ateyah's EMR records were very detailed and consistent in approach. The possibility of a clerical error or an incorrect entry in his records is not a reasonable explanation for the inconsistency between the clinical notes and Patient A's evidence. With respect to any suggestion that Dr. Ateyah's notes are not reliable and he may have deliberately entered misleading information in his clinical notes, there is no evidence to support such speculation. Further, this accusation was never put directly to Dr. Ateyah in cross-examination. Further, there was also no evidence that Dr. Ateyah's EMR notes were altered at some point after the appointment with Patient A, or that alteration would even have been possible without detection.

(vii) Position during Range of Motion Test

When Patient A described Dr. Ateyah's actions on the range of motion test, she provided different versions of where his hand was during the examination. Her evidence in chief was that he came from behind her, "he was behind me, so I just felt my pants go down". She then adds in chief that "he was standing sort of to the right of me and his hand went down between my legs from behind"; her evidence on cross was that he was behind her to the right as his hand came from the right side of her. Further, her testimony was inconsistent as to whether her pants were around her ankles or at her knees during this part of the examination.

(viii) Confusion regarding subsequent Sighting of Dr. Ateyah

Patient A testified that she saw an Indian man in the grocery store in the same mall as Dr. Ateyah's office a short time after the October, 2016 appointment and that as a result she left the store hurriedly and in a shaken state. Dr. Ateyah is from Iraq and not India.

Patient A also testified that although she had been examined by Dr. Ateyah on four previous visits she would not be able to identify him outside of his office setting. The fact that Patient A mistook someone else for Dr. Ateyah, despite having attended on him on four previous occasions, including the recent appointment, caused the Committee to question the reliability of her observations.

(b) Credibility and Reliability of Dr. Ateyah

Dr. Ateyah testified that he has no recollection of the encounter with Patient A on the date in October, 2016, or on any prior occasion that he saw her. His defence was entirely based on his clinical notes and his normal practice as a family physician. Although Dr. Ateyah had no recollection of Patient A, he strenuously denied that he touched her in the manner she alleged.

Dr. Ateyah was notified by the College in October, 2016 [eleven days later] that a complaint had been filed relating to a patient examination on a date in October, 2016. Dr. Ateyah reports that the next day he pulled the clinical records from his EMR, but was still not able to recall the encounter. The Committee finds that it is entirely plausible that Dr. Ateyah would not remember Patient A. Although she had attended on five occasions over a three year period, (including as recently as 11 days prior to being notified of the compliant), there was nothing remarkable or

noteworthy about any of her prior health concerns, which were all rather routine. She was not a rostered patient of Dr. Ateyah's and only attended on a walk-in basis. Dr. Ateyah testified that he did not typically take a full patient history on walk in patients. This might have been a factor in why he did not recall her. Further, Dr. Ateyah had a busy family practice that included both scheduled patients and walk-in patients. Dr. Ateyah testified that in October of 2016, he had 2,300 rostered patients, which included approximately 35% of the population Schomberg. As part of his walk-in practice, he would also see patients who were both rostered and non-rostered patients. He testified that although there is one other medical clinic in Schomberg, it does not accept walk-in patients. He testified Schomberg has a population of approximately 3,000 to 3,200. Dr. Ateyah testified that he is also part of the Dixon Family Health Group in Newmarket and saw patients at the Superstore in New Market once every two to three months. Taking into account these facts, the Committee finds it entirely plausible that he would not remember Patient A.

Dr. Ateyah's testimony as to his treatment of Patient A was based on his normal practices and the notations in his clinical record. The College urged the Committee to conclude that the absence of reference to an abdominal and respiratory stethoscope examination in Dr. Ateyah's November 24, 2016 response to the complaint meant that these examinations never took place. These examinations, however, are recorded in the EMR record. No evidence was introduced that the EMR record had been altered or prepared at a later date. It stretches credulity to deduce that Dr. Ateyah would purposefully mislead the CPSO by deliberately omitting to refer to these examinations in his response to the complaint when the EMR notes are clear on these points and refer to these examinations.

The Committee finds that Dr. Ateyah was forthright in his testimony, and he did not waiver under cross examination. He did his best to answer the questions

asked of him by both his own lawyer and the College lawyer. He was not argumentative. He was confident in describing his diagnosis and treatments given the notations in his clinical records. The Committee finds his testimony to be thoughtful, precise and responsive to the questions asked. The Committee concludes that Dr. Ateyah is credible and his evidence is reliable.

(3) The Expert Evidence

The Committee found both Dr. Stanton and Dr. Faulds to be qualified to provide opinion evidence on the standard of practice of a family physician. The Committee finds that each witness was independent and free of bias. The weight that the Committee assigned to each expert's opinion is dealt with below.

With respect to the evidence of Dr. Krakowsky's, the Committee agrees with the analysis provided by Dr. Clapperton.

(4) Findings of the Discipline Committee

(a) Sexual Abuse

The College has the onus of proof. It must prove the allegations on a balance of probabilities. The evidence upon which it relies must be clear, cogent and convincing.
The Committee finds that the College did not prove the allegation that Dr. Ateyah engaged in sexual abuse of Patient A.

Patient A's testimony was compelling, but there were inconsistencies and embellishments in her evidence, as noted above that caused the Committee concern. The Committee was of the opinion that Patient. A believes that she was inappropriately examined by Dr. Ateyah. Her subjective interpretation of what

occurred, however, is only one factor that the Committee must take into account. The test from *R. v. Chase* is whether a reasonable observer would conclude that the examination was of a sexual nature.

There are three instances where it is alleged that inappropriate touching occurred during the physical examination - twice during the examination while Patient A was lying on the examination table and then again when she was standing for the range of motion test.

Looking at Patient A's evidence, it would appear that the appointment first became uncomfortable for her when Dr. Ateyah rubbed her shoulder. She testified that, "it felt to me like I was - my space was being invaded". She then testified that when he asked her to open her legs outward, as she was lying on the examination table, she did not, stating "I was resisting. I was very tense." According to Patient A, Dr. Ateyah then "cupped" her whole vaginal area as he asked her to move her legs back and forth, first over her underwear and then under her underwear - each time for 5 to 6 seconds. She said she knew the second time that his hand was under her underwear because "My pubic hair was being pulled as his hand slid down."

With respect to the examination on the examination table, the Committee finds that Dr. Ateyah conducted the examination of the pubic/abdominal area as he described. This would have involved an examination of the inguinal area. Dr. Ateyah testified that if the patient's underwear was covering the inguinal area, he would ask the patient to lower the underwear just to expose the examining area. Dr. Ateyah testified that it was not possible that he would come in contact with the patient's labia, but it was possible he could come into contact with the patient's pubic hair. He explained that when he moves his hand from the iliac crest down to the pubic bone it is possible to be touching pubic hair. Dr. Stanton's evidence with respect to how he would expect a physician to examine the lower part of the abdomen, the supra pubic area and the inguinal canal was

consistent with the description of the area Dr. Ateyah's says he would have examined Patient A.

There was insufficient evidence to conclude that the examination was of a sexual nature. In particular, the Committee does not believe that Dr. Ateyah placed his hand over Patient A's labia either over or under her underwear as described by Patient A. The Committee finds that Patient A was tense and resisting, as she describes, before any alleged wrongdoing. Her level of discomfort was probably exacerbated by the fact that she did not understand how Dr. Ateyah intended to examine her or why. Dr. Ateyah did not take the time to properly explain to Patient A how he was going to conduct his examination or how his examination related to her complaint. This undoubtedly left Patient A confused and tense as he began to examine what many would reasonably regard as a sensitive or intimate area - the inguinal area - given its proximity to the patient's vaginal area. Further, as she stated, "I wasn't looking. My eyes were up." It is possible he pulled at some of her pubic hair as he conducted his examination. This may have caused her to believe that something inappropriate was occurring. Her evidence that Dr. Ateyah "cupped" the whole vaginal area was not the way she had described the incident on the examination table in her initial letter of complaint or interview with the College investigator.

Both Dr. Faulds and Dr. Stanton testified that a vaginal examination would have been appropriate, but Dr. Ateyah testified that he felt this would be unnecessarily intrusive and so Dr. Ateyah recommended an ultrasound as an alternative. Patient A testified that Dr. Ateyah advised her he would not be conducting a pelvic examination and he made a note in his EMR record to this effect. The fact that Dr. Ateyah decided not to do a vaginal examination and informed Patient A of this fact demonstrates that he had regard for the patient's privacy and comfort level. Unfortunately by failing to explain the nature of the examination he did intend to conduct, he left the patient feeling uncomfortable and confused.

The evidence from Patient A was simply not strong enough to persuade the Committee that Dr. Ateyah touched Patient A during the conduct of his examination in any way which was not medically indicated. The Committee finds that Patient A, in part due to Dr. Ateyah's failure to properly communicate his actions, which will be discussed below, misconstrued what happened during the examination on the table.

Patient A's account of what occurred during the range of motion test is more difficult to reconcile with Dr. Ateyah's account of how he would have conducted this examination. Patient A testifies that after she "jumped" down from the examination table, Dr. Ateyah told her that he needed to do one more thing and asked her to lower her pants to her knees. When she did not, Patient A says. "I was trying to pull them up, and he came from behind and pulled my pants down." She testified her pants ended up around her knees. Patient A then testified that, "This part was very fast. Dr. Ateyah was standing sort of to the right of me, and his hand went down between my legs from behind. So, he was behind, like moved over behind me, put his hand between my legs and started rocking me back and forth." Patient A testified the rocking motion lasted 6 to 7 seconds. She then said, "But the pain is in my back". She then repeated this statement as she pushed back behind her with her right arm in an elbowing motion and he let her go.

Dr. Ateyah explained that if you touch the iliac crest and it is tender, then you proceed to the range of motion test to see if the muscles attached to the iliac crest are all tender. Dr. Stanton agreed that a range of motion test was appropriate in this case. Dr. Ateyah testified that during the range of motion test, he would ask a patient to bend forward and back to determine flexion and extension. His hands would be in front of the patient and at their back, but not touching the skin. This would be done to assist the patient if he or she lost their balance. Dr. Ateyah denied cupping Patient A's genital area during the range of

motion test. He denied asking Patient A to rock back and forth. He said it was possible that he could have touched her back in a reassuring manner.

The Committee finds Dr. Ateyah's evidence to be credible with respect to his conduct of the range of motion test. Conducting such a test followed from his determination that the iliac crest was tender. This finding and the fact that he carried out a range of motion test are reflected in his EMR notes. With respect to how the test was performed, the Committee did not find Patient A's account to be sufficiently reliable or credible. The Committee acknowledges that Patient A's evidence of what occurred is so divergent from Dr. Ateyah's evidence regarding how he would have conducted the range of motion test that it cannot be explained by concluding that Patient A misconstrued this part of the examination. The Committee cannot explain Patient A's account, but is not prepared to believe her over Dr. Ateyah given our concerns about the overall reliability of her evidence and our finding that Dr. Ateyah's evidence is credible.

The Committee finds that the College has not proved that Dr. Ateyah sexually abused Patient A.

(b) Failing to Maintain the Standard of Practice

On the matter of Dr. Ateyah failing to maintain the standard of practice of the profession, the Committee finds as follows.

(i) Identification of Chief Complaint

Dr. Faulds testified that the physician is required to establish the patient's chief complaint through reflective listening. Dr. Faulds testified that at the end of the history taking the physician and the patient should reach a consensus as to the chief complaint and this forms the basis of consent by the patient for the

examination. Dr. Faulds testified that there was no consensus between Dr. Ateyah and Patient A with respect to the chief complaint. She based her opinion on discrepancies between Patient A's account and Dr. Ateyah's clinical records. Dr. Faulds stated that her understanding was that Patient A's complaint was upper back or flank pain, with some mention of vaginal itching. In this case, Dr. Faulds testified that the patient expected one examination (based on her chief complaint) and the physician provided another examination.

In Dr. Ateyah's record the first thing he notes is "vaginal discomfort, burning when urinating". Later in the subjective section of his note, he notes "lower abdominal discomfort and back pain". Dr. Stanton testified with reference to the notation "Vaginal discomfort, burning when urinating" that this was the "primary comment" and "usually when we're documenting like this, it's the first thing that the patient discusses or talks about when they come in." When asked to elaborate on what he meant by "primary comment", Dr. Stanton testified, "Well, generally speaking, when the patient comes in and you ask them what they're there for, they usually state their primary concern about what caused them to come to the physician for the day."

The Committee accepts that the standard of practice of the profession is for the physician to establish the chief complaint or primary concern of the patient. For the reasons stated above, however, the Committee questions the reliability of Patient A's evidence that she clearly articulated to Dr. Ateyah that her chief complaint was back pain. She eventually agreed on cross-examination that one of the reasons she sought medical attention on the date in October was to deal with vaginal itchiness - a symptom she articulated to Dr. Ateyah and which was the first thing he made note of in the subjective section of his clinical notes.

The Committee finds that it was Dr. Ateyah's responsibility to establish the chief complaint and to communicate his understanding of the chief complaint to the

patient. A physician's failure to communicate to the patient his or her understanding of the chief complaint could result in confusion and result in a physician not having obtained the consent he needs to carry out an appropriate physical examination. In this case, however, the Committee did not find that the evidence was sufficient to satisfy it that Dr. Ateyah and Patient A had not reached a consensus as to why she had attended for medical attention. Dr. Ateyah's notes make reference both to vaginal itchiness and back pain, both of which were symptoms that Patient A was experiencing and which she agrees she communicated to Dr. Ateyah.

(ii) History Taking and Differential Diagnosis

It was alleged that Dr. Ateyah did not take a complete patient history that would justify his physical examination or differential diagnosis. Patient history is critical in evaluating symptoms and forming a diagnosis. The fact that Patient A was a walk-in patient does not excuse or justify a failure to take a complete patient history.

Dr. Faulds testified that Dr. Ateyah did not take a proper sexual history, including any prior sexually transmitted diseases or pregnancies. Dr. Faulds was of the opinion that the history taken by Dr. Ateyah did not justify the physical examination he conducted and did not support the differential diagnosis of ovarian pathology, pelvic inflammatory disease and renal stones.

Dr. Stanton, however, testified that the examinations and diagnoses that are recorded in Dr. Ateyah's clinical note, in the context of the entire note and the presentation of the patient, were reasonable. He also testified that the plan recorded by Dr. Ateyah was reasonable. Dr. Ateyah explained that he had asked Patient A about discharge, because it was related to the possibility that the patient had a sexually transmitted disease. He also asked Patient A if she

experienced pain during sex. Dr. Stanton testified that if pain or discomfort was not replicated during intercourse, it would imply that it was less likely to be related to the external genitalia or to the vagina or cervix, because often if the disease process would localize there, it would increase pain during intercourse. Dr. Stanton indicated that the fact the patient reported no pain during sex would lead him away from a diagnosis relating to vaginitis or to a disease of the external genitalia and more towards other diagnoses of other origins of the pain from the genitourinary tract.

With respect to whether or not the examination of the inguinal area arose on the history provided, Dr. Stanton testified that any abdominal pain or any abdominal, pelvic or lower abdominal discomfort could be related to pathology in the inguinal canal. He testified there could be hernias palpable in that area. In addition he opined, there could be swollen lymph nodes in that area that could be palpable, that would reflect inflammation or infection in the groin or pelvis. He testified that an examination of inguinal area should be part of the examination of the abdomen. The Committee accepts this evidence and prefers it over the evidence of Dr. Faulds who testified that an examination of the inguinal area, based on the history recorded by Dr. Ateyah, was not “necessary”.
The Committee finds that the evidence does not support a finding that Dr. Ateyah failed to maintain the standard of practice of the profession with respect to his history taking and therefore finds that this allegation is not proven.

(iii)Failure to Communicate Nature of Examination

Dr. Faulds testified that a more fulsome explanation to the patient of the abdomen examination would have been appropriate. The Committee agrees. A physician needs to communicate the processes of the examination clearly to a patient, especially when it involves the examination of a sensitive or private area. One of the main themes of the Policy on Maintaining Appropriate Boundary and

Preventing Sexual Abuse is the importance of communication and explanation of the applied procedures.

The Committee finds that Dr. Ateyah did not clearly communicate to Patient A in advance the type of examinations he intended to perform or the reasons for them. In the result, Patient A was confused and did not understand what Dr. Ateyah was doing or why he was doing it during the initial examination on the examination table. His failure to explain the nature of his examination may have resulted in causing stress to Patient A who clearly did not understand why he was examining her and assumed that what he was doing was improper. The Committee finds that the allegation of failing to maintain the standard of practice of the profession is proven in that Dr. Ateyah failed to clearly explain the nature of the examinations he intended to conduct before embarking on that examination.

(iv) No Vaginal Examination

Dr. Ateyah did not conduct a vaginal examination. Both experts agreed that a pelvic examination was medically indicated. Dr. Stanton, however, was of the view that the vaginal examination could be deferred, with a plan, if it was a non-emergent situation, or if the patient or doctor was uncomfortable having the vaginal examination done or if a chaperone was not available. Dr. Stanton was of the view that Dr. Ateyah's explanation as to why he did not perform the vaginal examination was reasonable, given that the patient was not exhibiting or showing themselves to be a toxic or an acute abdomen. In his view it was reasonable to defer that vaginal examination to the patient's own family doctor. The Committee agrees. The Committee finds that the standard of practice did not require Dr. Ateyah to conduct a vaginal examination at this time under these circumstances and therefore, the allegation of failing to maintain the standard of practice in this respect is not proven.

(v) Conduct of Examination - Chaperone, Gowning and Gloves

The experts did not agree on the standard of practice with respect to when a physician should wear gloves, or have a chaperone present.

In Dr. Stanton's opinion, given the scope of the abdominal examination as described in the clinical notes, gloving was not required. He testified that it would be normal practice for gloving if the examination scope included a vaginal examination. Dr. Stanton also testified that if the examination did not include an examination of the external genitalia or a vaginal examination a chaperone was not required. He stated, "I think it's appropriate to do a full abdominal examination without a chaperone." Dr. Stanton also testified that examination of the area of the inguinal canal and the lymph nodes is a very challenging part of the body to examine from a draping perspective. He testified that if you have a patient completely undressed and wearing a gown, you're going to have to raise the drape up or put your hand under the drape to feel this area, and you would be potentially exposing the patient's genitals at that point. In Dr. Stanton's opinion it is reasonable to do this examination with the patient draped or it is also reasonable to do it with a patient who is clothed by undoing their pants and pulling them down far enough so that you can expose and see this area, and keep their genitals covered.

Dr. Faulds testified that in her opinion the palpation of the groin area should have included gowning and gloving of the hands. She also testified that for an examination of the "abdomen, pelvis or genital area," a physician should leave a drape, ask the patient to change from the waist down, and let her know that he would bring back in a chaperone for the examination. Dr. Faulds clarified on cross examination that she is not of the view that a chaperone is required for every abdominal examination, but "I think a chaperone is required whenever a

patient is being examined -- whenever an area of a patient is being examined that is a sensitive and private area." She further stated that a reasonable physician would be required to have a chaperone present for the examination of the lower abdominal region, including the inguinal canal and the pubic bone.

Dr. Faulds also testified that in order to conduct a back examination, she would ask the patient to change, leaving on underwear, and give the patient a gown and drape. Based on the assumption that the complaint was in the flank or upper back area, she would go through a back examination from the thoracic spine to the lumbar spine. She would ask the patient to stand and open the gown at the back and have the drape around their bottom end to inspect the back. She testified that a physician would want to palpate along both the bony part of the back and palpate along the lateral aspect and into the chest wall. For the range of motion test, one have the gown closed and the patient properly draped. Dr. Stanton did not address draping or gowning for a back examination or range of motion test.

The College's policy on "Maintaining Appropriate Boundaries and Preventing Sexual Abuse" was filed as an exhibit. There was disagreement on whether the examination of the inguinal area fell within the bounds of requiring chaperoning and/or gloving pursuant to the policy. This was a requirement for an examination of the genital area but the policy was silent on the abdominal area.

Dr. Ateyah testified that he felt gloving was not required and that the palpation was superior when his fingers were touching the skin. He also stated that he did not have a chaperone present because he was not going to conduct a pelvic examination.

The Committee concludes that there was not a precise standard of practice as to when gloving was required and that the individual circumstances of the examination dictated the appropriate approach based on the physician's

judgement. Further, the Committee was not persuaded that the standard of practice required one to have a chaperone present for an abdominal examination of this nature. With respect to gowning and draping, the Committee accepted Dr. Stanton's evidence that it was not necessary to have a patient undress and provide draping for an examination of the inguinal area, and that there would be less risk of exposure of the patient's genitalia being exposed by simply asking the patient to undo her pants and pull them down far enough to expose the inguinal area. The Committee was not persuaded that standard of practice requires a patient to be unclothed and draped for a range of motion test.

The Committee finds that the allegation of failing to maintain the standard of practice of the profession is not proven in relation to Dr. Ateyah failure to use gloves, gowning or chaperone. In the Committee's view, wearing gloves, providing the patient with a gown, and having a chaperone present would have been preferable. Notwithstanding, a failure to do so in this case did not constitute a failure to maintain the standard of practice of the profession.

(vi) Comments and Arm Rubbing

As indicated above, it is unclear what Dr. Ateyah said to Patient A regarding her age and appearance prior to commencing the physical examination. He does acknowledge that he could have said something positive to Patient A in this regard and that he could have touched her shoulder. Physicians must be very careful not to make a patient uncomfortable by providing unsolicited remarks about their appearance or to make a patient uncomfortable by touching them, even is the intention of the touch is simply to reassure or comfort a patient, or, as may be described in this case, acknowledge or congratulate them. Such remarks or physical contact can be easily misinterpreted. The Committee, however, finds that the evidence surrounding the circumstances in which Dr Ateyah allegedly touched Patient A and made the comments to be unclear and is not prepared to

make a finding that he failed to maintain the standard of practice of the profession on this basis.

(c) Disgraceful, Dishonourable or Unprofessional Conduct

The College takes the position that Dr. Ateyah sexually abused Patient A and that this conduct also supports a finding of disgraceful, dishonourable or unprofessional conduct. The Committee finds that the College did not prove the allegation of sexual abuse. Consequently, the Committee finds that the allegation that Dr. Ateyah engaged in disgraceful, dishonourable or unprofessional misconduct on this basis is also not proven.

The College also alleged that even in the absence of a finding of sexual abuse, the Committee should make a finding of disgraceful, dishonourable or unprofessional misconduct on the basis that Dr. Ateyah inappropriately rubbed Patient A's shoulders, made inappropriate remarks and pulled down her pants during the examination. The Committee has already stated that the evidence with respect to what was said is unclear. Patient A's evidence with respect to what was said was sufficiently unreliable that the Committee was not persuaded that the remarks or actions (rubbing of arm or shoulder) were as she described them to be. The Committee is not prepared to make a finding of disgraceful, dishonourable or unprofessional conduct based on the allegation of inappropriate remarks or rubbing of the arm or shoulder.

Finally, the Committee finds that Dr. Ateyah did not in fact pull down Patient A's pants as she described during the range of motion test, nor did he examine her with her pants around her knees. The evidence from Patient A and Dr. Ateyah is irreconcilable on this point, but the Committee prefers the evidence of Dr. Ateyah because on the whole we find him to be more credible and reliable. Consequently

this is not a basis upon which the Committee makes a finding of professional misconduct.

(5) Summary of Findings

The Committee finds that:

- Dr. Ateyah committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession in not clearly explaining to Patient A the type of examination he intended to conduct and the reasons for conducting that examination.
- the allegation of sexual abuse is not proven; and
- the allegation of disgraceful, dishonourable or unprofessional conduct is not proven.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Ateyah,

2019 ONCPSD 56

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 Surgeon 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. WAMEED ATEYAH

PANEL MEMBERS:

DR. P. TADROS (CHAIR)
MR. P. PIELSTICKER
DR. C. CLAPPERTON
MR. P. GIROUX
DR. P. BERGER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS E. WIDNER

COUNSEL FOR DR. ATEYAH:

MR. J. KOZIEBROCKI
MS L. YERMAKOVA

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. MCALEER
MR. B. SELLS

Hearing date: **October 7, 2019**
Decision date and Release of Reasons date: **December 23, 2019**

PUBLICATION BAN

PENALTY DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") delivered its written Decision and Reasons for Decision on finding in this matter on July 19, 2019.The Committee found that Dr. Ateyah committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession in not clearly explaining to Patient A the type of examination he intended to conduct and the reasons for conducting that examination.

The Committee heard evidence and submissions on penalty on October 7, 2019, and reserved its penalty decision.

AGREED STATEMENT OF FACTS ON PENALTY

The following Agreed Statement of Facts on Penalty was filed and presented to the Committee:

1. Since May 30, 2017, pursuant to an undertaking signed by Dr. Ateyah in lieu of an order under former section 37 of the *Health Professions Procedural Code*, Dr. Ateyah must have a practice monitor present for all professional encounters with female patients until final disposition of this matter by the panel.

2. Following the release of the Discipline Committee's decision, Dr. Ateyah attended for ethics instruction on two occasions with Dr. Erika Abner. Attached at Tab A of the Agreed Statement of Facts on Penalty is a final report from Dr. Abner dated September 27, 2019. Dr. Abner is a College-approved ethics instructor.

3. Dr. Ateyah has enrolled with course provider Saegis for the class, “Successful Patient Interactions” scheduled for October 24, 2019. Saegis is a College-approved course provider.

4. Following consideration of a public complaint about a medical examination on January 24, 2009, the Inquiries, Complaints and Reports Committee (“ICRC”) provided Dr. Ateyah with a counsel regarding patient communication and patient privacy. The ICRC decision dated July 2009 is attached at Tab B of the Agreed Statement of Facts on Penalty.

5. Following consideration of a public complaint about a medical examination on May 2, 2016, the ICRC required Dr. Ateyah to complete a Specified Continuing Education or Remediation Program (“SCERP”) that included a review of the College’s policy on “Maintaining Appropriate Boundaries and Preventing Sexual Abuse”. The ICRC decision dated February 21, 2018 is attached at Tab C of the Agreed Statement of Facts on Penalty. Dr. Ateyah has completed the requirements of the SCERP.

SUBMISSIONS ON PENALTY

Counsel for the College submitted that the appropriate penalty and costs order would consist of: a two-month suspension, the imposition of terms, conditions and limitations on Dr. Ateyah’s certificate of registration and a reprimand, and also submitted that he should pay costs in the amount of $20,550.00. College counsel indicated that the amount of costs proposed represents one day of hearing of the allegations, considering the Committee made a finding of failure to maintain the standard of practice of the profession, and based on the tariff rate at the time, and one day of penalty hearing at the current tariff rate.

Counsel for Dr. Ateyah submitted that a suspension was not warranted. He proposed that a term, condition or limitation be placed on Dr. Ateyah's certificate of registration providing that Dr. Ateyah participate in the Saegis Successful Patient Interactions Course ("Saegis course") by receiving a passing evaluation or grade, without any condition or qualification, and that Dr. Ateyah complete the Saegis course within 6 months of the Committee's order on penalty, and provide the College with proof of completion, including registration, attendance and participant assessment reports, within one month of completing the program. Counsel for Dr. Ateyah agreed to the ordering of a reprimand. He submitted that costs should be ordered for only one day of hearing at the rate of $10,275.00, payable within 30 days.

PENALTY AND REASONS FOR PENALTY

Several principles guide the Committee in determining an appropriate penalty. Public protection is paramount. Other penalty principles include maintaining public confidence in the integrity of the profession and in the College's ability to regulate the profession in the public interest. The misconduct needs to be denounced by the Discipline Committee. The penalty should address general deterrence, that is, a penalty that when looked at by the members at large will be viewed as sufficient to deter other physicians from engaging in similar behavior. Specific deterrence of the member is another consideration such that the penalty serves to dissuade the physician from engaging in similar misconduct in the future. The penalty should also provide for rehabilitation of the member, if appropriate, and be proportionate to the misconduct.

When determining an appropriate penalty, the Committee considers the overarching principles of penalty and the circumstances of the specific case, including any aggravating or mitigating circumstances. The Committee also

considers prior cases to ensure the penalty is proportionate and falls within a reasonable range of penalties in similar cases.

Aggravating Factors

Two decisions of the Inquiries, Complaints and Reports Committee (ICRC), from 2009 and 2018, respectively, were attached to the Agreed Statement of Facts on Penalty.

In 2009, Dr. Ateyah was the subject of a prior complaint to ICRC, for behaviour which was alleged to be similar to the misconduct found by the Committee in the current case. The complainant in the 2009 case saw Dr. Ateyah for several bites around her ankles. She reported that she was concerned as Dr. Ateyah said he had to check her breathing, then he felt her breasts and examined her inner thighs and genital area. She complained that Dr. Ateyah checked her inner thigh multiple times. She had experienced an anxiety attack a couple of days previously and her mother accompanied her to the doctor's office. The complainant recalled that, after asking her to undo her pants, Dr. Ateyah pressed the tops of her thighs, both the outside of her hip joint and the inner thigh area. When a College investigator showed the complainant a diagram of the lymph nodes on the body, she confirmed that Dr. Ateyah pressed the lymph nodes on various parts of her body, including her inguinal nodes. The complainant said she felt sexually violated by the examination. During the investigation, Dr. Ateyah explained what he would have done, and his rationale. He explained his clinical note. The ICRC concluded that it was clinically indicated for Dr. Ateyah to examine the complainant's lymph nodes for evidence of a possible infection. The ICRC was of the view that the fact that the patient's mother was with her would likely act to deter any untoward behaviour on the part of Dr. Ateyah. The ICRC was satisfied that the complainant's impressions relating to her examination in all likelihood arose out of unfortunate misunderstandings on her part regarding procedures that Dr. Ateyah was quite properly engaged in. However, the ICRC

stated that Dr. Ateyah's communication about the purpose and nature of the examinations could have been more clear. In addition, the ICRC noted that Dr. Ateyah stayed in the room while the patient disrobed.

The Committee recognizes that it is not the ICRC's role to make findings of fact and it did not do so in 2009. The Committee does not rely on the 2009 ICRC decision as proof of the truth of the facts alleged by the complainant. However, the direction that the ICRC gave to Dr. Ateyah at that time is relevant. After an analysis of that complaint, the ICRC specifically counselled Dr. Ateyah to communicate clearly with patients about the need for a physical examination, and to ensure he arranged for patient privacy by not being present while they are changing, and by providing appropriate gowns and drapes, in accordance with the College policy. At that time, Dr. Ateyah was provided with a copy of the College Policy #4-08, *Maintaining Appropriate Boundaries and Preventing Sexual Abuse*.

The ICRC counselled Dr. Ateyah in 2009 to communicate clearly to patients about the need for a physical examination. In the Committee's view, the aggravating effect of the 2009 case is that despite being counseled about appropriate communication and ensuring respect for patient dignity and privacy, the Committee in the present case found that Dr. Ateyah did not clearly communicate to Patient A in advance the type of examinations he intended to perform and the reasons for them.

Dr. Ateyah's failing to communicate to the patient and clearly explain what type of examination he was conducting, and the reasons for it, led to the Committee's finding of professional misconduct. The fact that Dr. Ateyah had been counselled by the College in the past yet failed to be guided by this instruction in his examination of Patient A is an aggravating factor.

The College also directed the Committee to a 2018 decision of the ICRC, which the ICRC considered after the allegations in this matter were referred to the Discipline Committee on April 19, 2017. In that matter, which also involved the examination of a woman's lymph nodes, the ICRC was concerned about Dr. Ateyah's manner of conducting the examination, in particular, that it was alleged did not provide a drape or gown, and he put his hand down the patient's pants without obtaining consent to the examination. The ICRC's view was that the examination was clinically indicated, but Dr. Ateyah's technique was not appropriate. Given that Dr. Ateyah had previous history with the College regarding examinations of the groin area, including open allegations before the Discipline Committee at the time the complaint was considered, the ICRC elected to order a SCERP requiring Dr. Ateyah to undergo education on communication, appropriate clinical examination of the abdomen and inguinal area lymph nodes, including draping, documentation and obtaining consent. Given that this order was made by the ICRC after the referral in this matter (and the facts that gave rise to the referral), the Committee does not consider it to be an aggravating factor.

The College also submitted that the impact on Patient A should be considered an aggravating factor. Patient A did not submit a witness impact statement, but the Committee certainly did hear her testify and hear her express the impact that Dr. Ateyah's actions had on her. It was clear to the Committee that Dr. Ateyah's failure to communicate left Patient A feeling that she had been subjected to an improper examination. The fact that Dr. Ateyah's conduct resulted in such confusion and discomfort for his patient was an aggravating factor.

Mitigating Factors

It is a mitigating factor that Dr. Ateyah has had no previous history before the Discipline Committee.

In addition, Dr. Ateyah has shown willingness to be rehabilitated and has complied and been pro-active in dealing with the issues that brought him before the Committee. Appended to the Agreed Statement of Facts on Penalty was the September 2019 report from the ethics instructor whom Dr. Ateyah attended following release of the Committee's decision on finding. The report indicated that Dr. Ateyah received instruction on physician-patient communication and the use of chaperones and guidance for intimate examinations. He was also provided with articles on implied and express consent during intimate examinations. The instructor reported that Dr. Ateyah was prepared for and engaged in both meetings. That Dr. Ateyah has taken successful steps to rehabilitate himself is a mitigating factor.

Counsel for Dr. Ateyah also submitted that Dr. Ateyah had agreed to an undertaking imposing interim restrictions on his practice pending the disposition of the allegation, and as a result has had a monitor for patient encounters for an extended period of time. Counsel submitted that this was at a significant cost to Dr. Ateyah and should be taken into account as a mitigating factor.

It is the Committee's view that the duration of practice monitoring pending disposition of the allegations is not a mitigating factor on penalty. Certainly, however, positive reports from a practice monitor could be taken into account as a mitigating factor.

Prior Cases

The Committee considered cases submitted by both counsel in coming to a decision with regard to penalty. Although each case is different, the Committee recognizes that like cases should be treated alike.

In *CPSO v. Raja (2018),* the Committee found the physician's conduct to be disgraceful, dishonourable, or unprofessional when he failed to respect his patient's dignity and privacy by insensitively exposing her breast while listening to her heart, leaving her feeling scared, threatened, and embarrassed. He also failed to adequately communicate to her what he was doing and why. The Committee accepted the parties' joint submission on penalty and ordered a suspension of Dr. Raja's certificate of registration for two months, a public reprimand and a costs order. The *Raja* case is quite similar to the case at hand. However, it differs in that Dr. Raja had no prior history with the College and there was a finding of disgraceful, dishonourable, or unprofessional conduct.

In *CPSO v. Choptiany, (2011),* the Committee found that the physician (who had entered a plea of no contest) had committed an act of professional misconduct in that he had engaged in disgraceful, dishonourable, or unprofessional conduct. The misconduct related to failing to maintain respectful boundaries in performing examinations of an intimate nature, and failing to explain and ensure that patients were comfortable about what the doctor was about to do. Three patients were involved. Dr. Choptiany also made inappropriate comments to one patient about her sexual relationship with her husband. When Dr. Choptiany examined another patient, she felt his pelvic area against her arm. Similarly to Dr. Ateyah, Dr. Choptiany undertook voluntary remediation. He also had no prior discipline history with the College. Following a joint submission on penalty, Dr. Choptiany was ordered to undergo a two month suspension and terms, conditions and limitations were placed on his certificate of registration, including that he have a practice monitor for female patients. The Committee also ordered a reprimand and costs.

The *Choptiany* case is similar to Dr. Ateyah's because the physician failed to explain the examination and ensure that patients were comfortable about what the doctor was about to do. An additional aggravating feature in *Choptiany* was

the inappropriate sexual comments. However, the physician had no prior history with the College and had taken steps to deal with the deficiencies in a comprehensive way.

In *CPSO v. Irwin (2018),* the physician had significant clinical deficits and poor record keeping. The Committee found that Dr. Irwin had committed an act of professional misconduct, in that he had failed to maintain the standard of practice of the profession and also made a finding that he was incompetent. The physician received a five-month suspension along with numerous terms, conditions and limitations placed on his certificate of registration, commensurate with the clinical and record-keeping deficiencies he displayed. Dr. Irwin's case is quite different from that of Dr. Ateyah and the Committee did not consider.it of any assistance when determining an appropriate penalty in this case.

In *CPSO v. Takhar (2019),* the Committee found that Dr. Takhar failed to maintain the standard of practice with regard to record keeping, practice management and clinical management of patients. At the time of the hearing, a joint submission on penalty was proposed and ultimately accepted. The physician had a lengthy prior history of complaints and investigations by the ICRC. The Committee expressed its concern that Dr. Takhar continued to have problems for a period of time with practice management despite cautions from ICRC. It concluded, however, that in light of the test in *R. v. Anthony Cook*, the penalty was not outside the range of appropriate penalties in the circumstances of the case. Dr. Takhar had also taken steps to remediate her practice and submitted excellent reports about the changes she had made. Dr. Takhar was reluctant initially to comply with ICRC cautions about her practice, but eventually she made the changes that she needed to in order to maintain the standard of practice of the profession. This case was not particularly helpful to the Committee as the facts were quite

different from those in Dr. Ateyah's case. Dr. Ateyah has not demonstrated any improvement in his standard of practice since the ICRC's direction in 2009.

In *CPSO* v. *Shamess (2019),* the physician was found to have engaged in disgraceful, dishonourable or unprofessional misconduct. The Committee found him to be insensitive to the patient's privacy interests. Dr. Shamess had been cautioned in 1996 for somewhat similar behaviour. The Committee accepted the joint submission on penalty and ordered only a reprimand and costs. Dr. Shamess recognized that he had made the patient uncomfortable by his actions. He discussed this with her at a subsequent appointment, apologized and took responsibility for his actions. He also initiated a chaperone policy in 2014 in an attempt to remedy the problem. The Committee in that case considered Dr. Shamess' insight to be a mitigating factor. Dr. Ateyah did not admit the allegation of professional misconduct in this case. That is not an aggravating factor, but the absence of the same degree of accountability and insight as in the Dr. Shamess decision is a distinguishing factor.

Counsel for Dr. Ateyah put forward the case of *CPSO v. Eisen (2003)* as being most analogous to this case. Dr. Eisen failed to communicate with the patient or obtain her consent for his examination, during a house call. He was insensitive and found to have engaged in disgraceful, dishonourable, or unprofessional conduct. The Committee accepted the joint submission on penalty and ordered a reprimand and imposed terms, conditions and limitations on Dr. Eisen's certificate of registration, but did not order a suspension. It also ordered costs. This case is considerably older than the cases submitted by the College. The reasons for decision are quite brief and do not discuss any mitigating or aggravating factors. The Committee did not find this decision as helpful due to the fact it is from over 15 years ago and the analysis is brief.

Dr. Ateyah's counsel submitted that since the Discipline Committee did not make a finding of sexual abuse or disgraceful, dishonourable or unprofessional conduct, there was no indication of "moral failure" or of conduct that called into question Dr. Ateyah's professionalism in that regard. Counsel submitted that as a result, a lower penalty is warranted. Counsel for Dr. Ateyah further submitted that the absence of a finding of disgraceful, dishonourable or unprofessional behaviour sets Dr. Ateyah's case apart from the other cases relied on by the College.

In the Committee's view, the absence of a finding of disgraceful, dishonourable, or unprofessional conduct does not necessarily entitle Dr. Ateyah to a lesser penalty. The failure to maintain the standard of practice of the profession in this case with respect to his communication with Patient A resulted in a significant failing and led Patient A to believe she had been touched inappropriately. No patient should ever leaver her doctor's office believing (or even questioning) whether she has been touched inappropriately as a result of a physician's failure to explain what he is doing and why. Such failure significantly erodes patient trust in the integrity of the profession. We do not accept the submission that a finding of failing to maintain the standard of practice is necessarily less serious that a finding of disgraceful, dishonourable or unprofessional conduct. Much depends on the particular circumstances of the case.

ANALYSIS

The Committee considers that a reprimand, as agreed to by both parties, is appropriate. It sends a message to Dr. Ateyah and the membership that proper communication with patients is fundamental, especially when reacted to the examination of a sensitive or private part.

The Committee finds that a two-month suspension of Dr. Ateyah's certificate of registration is appropriate in this case. Dr. Ateyah had been counselled years before to be more sensitive to his patients' needs for physical privacy and to communicate effectively about his physical examinations. The failure to explain the nature of his examination clearly in this case suggests that he never took the ICRC counsel seriously years ago. Dr. Ateyah's failure to communicate in this case caused a significant amount of distress and upset for Patient A. Patient A believed that something improper had happened. If Dr. Ateyah had properly communicated what he was doing and why, it is unlikely his actions would have been misinterpreted. Dr. Ateyah has shown a disregard for the College's guidance in the past and the Committee therefore needs to take a stronger measure to highlight to him that patients must be treated with respect and given adequate explanation before they are touched in private and sensitive areas for the purpose of examination.

A two-month suspension should bring that message home to Dr. Ateyah and serve as a specific deterrent to him so that he does not repeat this insensitive behaviour in the future. The membership will also be reminded that proper communication is fundamental. Patients have a right to understand why they are being examined and in what manner. A failure to do so can result in significant distress for a patient.

Dr. Ateyah has already completed an ethics course related to communication and the upcoming Saegis course that he is registered for should further enhance his rehabilitation. The Committee agrees that, given the two month suspension and the agreement with respect to the Saegis course, the terms, conditions or limitations proposed by the College are appropriate.

The public will be protected by this Order, because it should result in rehabilitation for Dr. Ateyah and provide both specific deterrence to Dr. Ateyah

and general deterrence to the profession. The order should also maintain the integrity of the profession and public confidence in the College's ability to regulate in the public interest in demonstrating that the College expects that physicians communicate clearly with their patients about the examinations that are being conducted.

COSTS

With regard to costs, College counsel submitted that an order for two days of costs was appropriate. Counsel for Dr. Ateyah submitted that since two of the allegations were not proven, the award of costs should be only for one day, the day of the penalty hearing.

The Committee notes that experts from both sides gave testimony about communication and the standard of practice of the profession with respect thereto. Dr. Ateyah also testified with respect to his communication with Patient A. One of the allegations of professional misconduct was proven (and had been contested) and there was considerable time devoted to evidence on that matter. Consequently it is appropriate to order one day of costs for the hearing of the allegations and one day for the penalty submissions, at the relevant tariff rate. The Committee notes that Dr. Ateyah

asked for 30 days to pay one day of hearing costs. Given our order that he pay two days
of costs, the Committee is providing him with 60 days to pay that cost order.

ORDER

The Committee orders and directs on the matter of penalty and costs that:

1. The Registrar suspend Dr. Ateyah's certificate of registration for a period of two months, commencing on January 6, 2020 at 12:01 a.m;
2. The Registrar place the following terms, conditions or limitations on Dr. Ateyah's certificate of registration:

    (i) Dr. Ateyah shall comply with the College Policy "Closing a Medical Practice", a copy of which is attached to this Order;

    (ii) Dr. Ateyah will participate in the Saegis Successful Patient Interactions Course by receiving a passing evaluation or grade, without any conditions or qualification. Dr. Ateyah will complete the Saegis course within 6 months of the date of this Order and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

3. Dr. Ateyah shall appear before the Committee to be reprimanded; and

4. Dr. Ateyah shall pay to the College costs in the amount of $20,550.00 within 60 days of the date of this Order.