

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Gerald Dixon Smith, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of any complainant witness and similar act witness, or any information that could disclose the identity of those witnesses 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 of the Code, which is concerned with failure to comply with these orders, reads:

93(1) Every person who contravenes an order made under section 47 is guilty of an offence and on conviction is liable to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

Indexed as: Smith (Re)

**THE DISCIPLINE COMMITTEE OF THE COLLEGE
OF PHYSICIANS AND SURGEONS OF ONTARIO**

IN THE MATTER OF a Hearing directed
by the Complaints Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) of the *Health Professional 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. GERALD DIXON SMITH

PANEL MEMBERS:

**DR. R. MACKENZIE (CHAIR)
DR. M. GABEL**

J. MARTEL

**R. SANDERS
DR. M. WOLFISH**

PUBLICATION BAN

Hearing Dates:

December 16-19, 2002
March 24-26, 2003
September 22-26, 2003
October 31, 2003

Decision/ Released Date:
Altered Decision:

September 26, 2003
October 31, 2003

DECISION AND REASONS FOR**DECISION**

The Discipline Committee of the College of Physicians and Surgeons of Ontario (“the Committee”) heard this matter at Toronto on December 16 to 19, 2002, March 24 to 26 and September 22 to 26, 2003. The Committee rendered an oral decision on September 26, 2003. At a further appearance on October 31, 2003, the Committee raised an evidentiary issue with counsel, and heard further submissions, which led the Committee to amend slightly its earlier oral decision. The Committee’s ultimate decision on the allegations is set out below, together with the Reasons therefor. The Committee finds that allegations 2, 3 and 5 are established on the evidence, and that allegations 1 and 4, and the allegation of incompetence, are not made out.

PUBLICATION BAN

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The Committee also made orders under subsection 45(3) of the Code, for reasons, which it stated on the record:

- Prohibiting the publication of any patient records;
- Prohibiting the publication of proposed similar act evidence heard on a *voir dire*, except to the extent that it was admitted into evidence as part of the hearing itself. A portion of the proposed similar act evidence (concerning an alleged incident following the administration of an injection) was not admitted and, therefore, is subject to a publication ban.
- Prohibiting the publication of the identity, or any information that could disclose the identity, of the current patient X.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Smith committed acts of professional misconduct:

1. under clause 51(1)(b.1) of the Code, in that he has sexually abused patients;
2. under paragraph 26.28 of Ontario Regulation 577/75 as amended, R.O. 1975 (“O. Reg. 577/75) and under paragraph 27.29 of Ontario Regulation 448, R.R.O. 1980 (“O. Reg. 448”), in that he engaged in sexual impropriety with a patient;
3. under paragraph 26.20 of O. Reg. 577/75 and paragraph 27.21 of O. Reg. 448, in that he failed to maintain the standard of practice of the profession;
4. under subsection 34(3) of the *Medical Act*, R.S.O. 1970, as amended, in that he has been guilty, in the opinion of the Discipline Committee, of misconduct in a professional respect or of conduct unbecoming a medical practitioner; and
5. under subsection 1(1)33 of O. Reg. 856/93, under paragraph 26.31 of O. Reg. 577/75 and under paragraph 27.32 of O. Reg. 448, in that he engaged in conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Smith is incompetent, as defined in subsection 52(1) of the Code and subsection 61(4) of the *Health Disciplines Act*, in that he displayed in his professional care of the patients named in the Appendices to the Notice of Hearing, a lack of knowledge, skill or judgment or disregard for the welfare of the patients, of a nature or to an extent that demonstrates that he is unfit to continue in practice.

RESPONSE TO ALLEGATIONS

Dr. Smith denied all allegations in the Notice of Hearing.

EVIDENCE

Evidence for the College

Complainant #1

Complainant #1 was a female patient of Dr. Smith's intermittently from 1976 to 1988 for psychotherapy treatment. She testified, that during an office visit in 1978, Dr. Smith made a comment about how good she looked and suggested that she should take her dress off in order that he could see what her "new figure" looked like. He then left the room and came back to see her standing in her slip. She testified that Dr. Smith then approached her and kissed her on the lips. She recalls that she then put her dress back on and they continued with the psychotherapy session.

Afterwards, she described feeling very disturbed about this encounter. She realized that her self-esteem was very low and that Dr. Smith's attention and interest in her made her feel good. She respected him and assumed that he knew what was best for her.

Complainant #1 testified that she and Dr. Smith began a sexual relationship in 1980, which escalated over the next two years. She continued to receive intermittent psychotherapy from Dr. Smith during this period. The sexual component of the relationship diminished after about 1982 and, ultimately, ended by 1985. Dr. Smith performed oral sex on her on numerous occasions in his office during psychotherapy sessions. She also recalls performing oral sex on him on one or two occasions.

Complainant #1 testified that she called him once in desperation when she ran out of medication. He advised her to come to the office immediately whereupon they had sexual intercourse. She stated that he pulled out to ejaculate and insisted that, by so doing, they were not engaging in "real sex". She recalls him asking her on a couple of occasions not to wear powder or perfume for fear Dr. Smith's wife would find it on his shirt.

When asked in cross-examination why she continued to see Dr. Smith through the period of the sexual relationship and afterwards, she replied that she "was in love with him".

Throughout the duration of her treatment with Dr. Smith, complainant #1 testified that they spent a great deal of time discussing issues in Dr. Smith's personal life.

Complainant #1 testified that she became addicted to tranquilizers during the last couple of years of her treatment with Dr. Smith and that she then began abusing alcohol. She requested that Dr. Smith refer her for substance abuse treatment. During a subsequent treatment program, she recalled discussing her concerns about Dr. Smith with one of the counselors, who advised her to file a formal complaint. She did not follow up on this advice because she felt too guilty. She felt that she was partly to blame for what happened. In addition, she was totally dependent on her husband at the time and was convinced he would leave her if he found out. After completing only part of that treatment program, she entered a local treatment program, at which point she terminated the professional relationship with Dr. Smith.

After reading an article in the newspaper in 1997, which reported on other allegations against Dr. Smith at the College, complainant #1 recalls feeling very upset and angry that he had been acquitted of the charges. She subsequently made her own complaint to the College.

Complainant #2

Complainant #2 testified that she became a patient of Dr. Smith's in January 1984, seeking counseling for family dysfunction and anxiety-related symptoms. She continued to see him for six months, at which point he suggested it was appropriate for her to discontinue treatment. She resumed seeing Dr. Smith in 1987, when her marriage was beginning to fall apart, and continued to see him on a regular basis until 1997. She described the nature of the therapy sessions as very congenial and informal. Dr. Smith and complainant #2 spent a great deal of time discussing mutual personal interests such as music, shopping and comedy videos. He would frequently talk about his family and discuss other personal issues. He regularly told her sexual-themed "dirty jokes" which made her feel quite uncomfortable. One joke in particular about oral sex she found particularly offensive. Dr. Smith would frequently play excerpts from old comedy films on the television in his office. On one occasion, complainant #2 recalls him cueing up a

particular segment where two naked women were engaged in sexual acts. She recalls being particularly shocked at this and that Dr. Smith responded by fast forwarding through the clip and making no mention of the incident whatsoever. Complainant #2 did not give evidence indicating the year or years when the joke incidents, and the sexual video clip incident, occurred.

Complainant #2 testified that she did not think that the personal discussions and personal disclosures had any therapeutic purpose, but admitted that she was naïve to the techniques of psychotherapy and assumed that he may have simply been “testing her responses”.

Complainant #2 also testified that Dr. Smith initiated physical contact with her during their sessions. It began innocuously with putting his hand on her shoulder. As time went on, he would give her an occasional hug at the end of the visit. On a couple of occasions, she could feel his firm genitals pressing against her. She recalls these becoming progressively more intense and impassioned, which made her sufficiently uncomfortable that she would have to tap him on the back to signal that it was time to terminate the contact. She admits to being confused about the appropriateness of the boundaries in their relationship, but uncertain what she should do about it.

On one occasion, in May 1997, she recalls being very upset and crying in his office. Dr. Smith came over to her chair, crouched down beside her and began to hug her and stroke her arm. She sensed that he was becoming sexually aroused when he began breathing heavily and stroking her more forcefully. She recalls telling him “I think you should go back to your chair”. He replied that he would never do anything to hurt her, but it was his office and he would go wherever he pleased. She remembers being very angry about this, but that Dr. Smith finally did get up and go back to his desk.

About two weeks later, she read a newspaper article reporting on a College of Physicians and Surgeons of Ontario discipline hearing in which allegations had been made against Dr. Smith for sexual impropriety (he was acquitted of the allegations). She recalls feeling very angry and betrayed that he would have behaved as he did with her in light of these

charges. She believed she could no longer trust him. At a subsequent appointment, she confronted him about the article and her feelings of betrayal. At that point, she decided to terminate the relationship.

In cross-examination, complainant #2 admitted that she liked and enjoyed the “human side” of the relationship with Dr. Smith. He was soft-spoken, kind and had a gentle demeanour that made her feel comfortable in dealing with him.

Complainant #3

Complainant #3 began seeing Dr. Smith for psychotherapy following a hospital admission for a drug overdose in June, 1995. She continued to see him on a weekly basis thereafter for two years. She admits to feeling chronically depressed and lacking direction in her life. She recalls that Dr. Smith was extremely kind to her and put her at ease. During sessions, they chatted about mutual interests such as music and classic comedy videos. They frequently exchanged videos back and forth. At the time, she had a very poor self-image. She felt unattractive and overweight. She had no active sex life. Dr. Smith directed much of their discussions around sexual topics. Although she saw no obvious therapeutic purpose to these discussions, she felt that it might have been a technique to help her open up to him.

Complainant #3 testified that Dr. Smith was a very “touchy” person, seeming to take every opportunity to touch her hands, her arms or her shoulders. He regularly sat beside her during sessions holding her hands and stroking her. She frequently would ask him to move away as the intimacy made her feel very uncomfortable. He regularly hugged her and would pull her towards him until she stumbled. Although never comfortable with this, she thought it was what she needed to become a complete person again. She admits she wanted him to like her more. At times, she would make herself up in order to look nice for him. On at least two occasions she recalled Dr. Smith asking her if she was wearing makeup or perfume, intimating that he did not want anyone to know what was going on between them.

During several of their sessions, Dr. Smith would engage in discussions about his own health and personal problems. She felt like she had to comfort and console him and would pat his hand or give him a hug. Towards the end of the therapeutic relationship, she began leaving the sessions feeling worse than when she came in. In June 1997, she went to see Dr. Smith with the intention of making it her final visit. She wanted to get prescriptions for her medication and then leave. She testified that Dr. Smith hugged her quite forcefully at one point and, when she broke the contact, he apologized for getting his dry skin on the front of her dress and proceeded to rub the palm of his hand down her breast with significant pressure. She admitted that this bothered her a great deal but she said nothing and proceeded to leave his office for the last time.

During cross-examination, complainant #3 admitted that she had begun shoplifting during the period she was attending Dr. Smith. She adamantly denied that the physical touching was “ever right with her”. She believed he was doing this for her own good, which is why she may have protested, but not as vehemently as she should have.

Dr. A.

Dr. A. was called by the College as an expert witness. She is a family physician who has developed a special interest in psychotherapy and, from 1992 to 1999, restricted her practice to psychotherapy. Her patients were all female, mostly with diagnoses of personality disorders or victims of sexual abuse. Although she had no formal training in psychiatry, she has attended many conferences and done an extensive review of the psychiatric literature. Since 1999, she has limited her professional activities to developing and conducting teaching workshops for mental health professionals. She has developed training modules in boundaries, particularly as applied to patients with personality disorders. She has published numerous articles on the subject of self-abuse.

The College sought to have Dr. A. qualified as an expert qualified to give opinion evidence in respect of the standard of care applicable to a family physician practicing psychotherapy. She was asked to provide her opinion based on a review of Dr. Smith’s respective clinical records. Counsel for Dr. Smith objected to Dr. A.’s qualifications as an expert inasmuch as she had no formal training in psychiatry. He submitted that, even

though Dr. Smith had not passed his certification exams in psychiatry, he had gone through a full psychiatric training program at the Menninger Institute and was functioning as a psychiatric consultant in his medical community. The panel concluded that Dr. A. was qualified to give expert opinion evidence in respect of the standard applicable to a family practitioner with a special interest in psychotherapy.

Dr. A. testified that she reviewed the complainants' correspondence with the College, the College investigators' reports and the entirety of Dr. Smith's clinical records for the three complainants. She testified that clear boundaries are necessary for patients to develop a trusting relationship wherein they are safe to disclose intense personal feelings. These boundaries include both the actions and the words spoken during therapy. The psychotherapeutic relationship is all about the patient, not the doctor, which serves to severely limit the amount of self-disclosure permissible on the physician's part. Dr. A. gave evidence that it is the therapist who has the responsibility for maintenance of these boundaries and, in her opinion, the maintenance of such boundaries is part of the standard of practice. Dr. A. opined that competent physicians should be aware of warning signs that would warrant even more vigilant adherence to boundaries. These include patients who act out, inflict self-harm, and have been physically or sexually abused, or those who switch therapists frequently.

With respect to complainant #2, Dr. A. observed that she had been sexually molested as a child, which should have in her opinion raised an immediate red flag for Dr. Smith. The progression of physical contact to progressively more impassioned hugs would be completely inappropriate and represent a major boundary transgression in respect of such a patient. Because the contact made complainant #2 uncomfortable, it therefore would take on a definite sexual flavour from the outset, which is unacceptable in any therapeutic relationship, and particularly so in psychotherapy. The telling of sexual jokes sexualizes the relationship and diminishes the seriousness of the patient's own problems. In Dr. A.'s opinion, this would represent a serious boundary violation.

Dr. A. agreed that some degree of self-disclosure by physicians in prolonged psychotherapeutic relationships becomes somewhat inevitable, and is permissible in that

context, so long as it has some sort of therapeutic intent (e.g. promoting insight or giving empathy). With respect to the use of videos, she noted that there are no entries in Dr. Smith's clinical record that would suggest that this was used as a therapeutic tool. She concluded that it had no therapeutic purpose and was inappropriate. In the absence of therapeutic intent, any self-disclosure should be viewed as a boundary violation.

With respect to the pornographic video segment, Dr. A. testified that this would be a major boundary violation regardless of whether it was shown deliberately or by accident. It could have no possible therapeutic purpose, particularly since Dr. Smith made no comment about it after the fact.

With respect to the patient complainant #3, Dr. A. noted that Dr. Smith records in his notes that "she is starting to become obsessed with me". This represents transference feelings by the patient and the doctor should be particularly guarded not to respond with any behaviour that can be misconstrued as sexual. In Dr. A.'s opinion, Dr. Smith should never have engaged in any physical contact with this patient, let alone the extent of contact that allegedly occurred over the course of the therapeutic relationship. The specific incident in which Dr. Smith is alleged to have brushed complainant #3's breast was of particular concern to Dr. A. because of the obvious sexual connotations. In her opinion, this incident in itself would represent a serious boundary violation and a breach of the standard of care.

In Dr. Smith's notes for the patient complainant #1, he noted that she "has erotic transference feelings and feels rejected when they are not responded to". In Dr. A's opinion, any therapist who recognizes this interaction developing should be extremely careful in his comments and physical demeanour, because the patient is much more likely to interpret things in a sexual context. In the event that the physical and sexual contact described by complainant #1 did occur, Dr. A was of the opinion that this would represent the most serious form of boundary violation and would clearly breach the standard of practice in any therapeutic relationship.

On cross-examination, Dr. A. testified that patients with Borderline Personality Disorders require even clearer boundary distinctions than other psychiatric patients. She disagreed with the suggestion that therapists who deal with these difficult patients need to be significantly more creative and be prepared to “think outside of the box”.

Dr. A. agreed that individual self-disclosures are not a breach of the standard, but went on to testify that the pattern and accumulation of disclosures alleged by the complainants would clearly breach the standard of practice.

Similar Act Witnesses

Following the testimony of the three complainants in this case, the College proposed that two additional witnesses be permitted to testify about “similar acts” concerning Dr. Smith. The evidence of these witnesses was initially heard by the Committee in the context of a *voir dire*. After hearing this proposed similar act evidence, and the submissions of counsel on the issue, the Committee ruled that, subject to one exception, the testimony of these witnesses could be admitted as “similar act” evidence. The Committee released separate reasons for its decision in this respect. The parties agreed that the evidence given on the *voir dire* could be treated as having been given in the hearing itself, although further cross-examination was permitted.

Ms. B.

Ms. B. began seeing Dr. Smith for psychotherapy in 1976, and continued to see him for a few months. She recalls that she was feeling depressed and suicidal at the time. She was also struggling with issues of self-esteem and resorted to promiscuity to gain the attention of men. She remembers feeling attracted to Dr. Smith because he held a prominent position as a psychiatrist and she felt flattered that he paid attention to her. As a result, she did her best to charm him, both by her behaviour and manner of dress. On one occasion she wore a pair of exotic panties to the office and told Dr. Smith about them. She testified that Dr. Smith then asked her to pull up her skirt to show him, which she did. Afterwards, she recalls feeling gratified because she had successfully attracted his attention.

Ms. B. testified that Dr. Smith gave her a phone number to call if ever she were to feel suicidal. One day, she did call him when she was particularly depressed and he came and picked her up in his car. He then drove to an apartment building and took her up to an apartment inside. She recalls that the apartment was in one of several high-rise buildings that formed a complex. In the apartment, they had sexual intercourse. He insisted that they do so in the living room because she “wore too much makeup”. She recalls that the skin on his penis was bleeding and that he reassured her that it was simply eczema. She cannot remember whether or not he used a condom.

During cross examination, Ms. B. recalls that there were children’s toys in the middle of the apartment living room that were appropriate for children in the range of 4-6 years old.

Afterwards, she continued to see Dr. Smith as a patient, but in her mind he was also her lover. On the next office visit, she recalls that it was about 4 p.m. and Dr. Smith suggested they leave to go somewhere else. He then took her to a park where he unzipped his pants and asked her to perform fellatio. She refused because there were people in the park who could have seen them. She testified that he took her back to his office where they had sex. She was unable to recall if it was intercourse or oral sex on that occasion. She was unable to recall whether or not Dr. Smith wore a condom.

Afterwards, she remembers feeling very degraded. She felt he could not think very much of her if he would ask her to have sex with him in broad daylight. She decided, at that point, to terminate the relationship. She did return once to see him after receiving an invoice from his office which she thought was too high. When she arrived at the office, she testified that Dr. Smith took the invoice from her and said he would take care of it.

Ms. B. did not see Dr. Smith again after leaving his office on that occasion, except for a casual encounter several years later in a grocery store. In December 2002, she read a newspaper article reporting on the current discipline hearing involving Dr. Smith. As a result of that, she decided to come forward with her complaint.

Ms. C

Ms. C. was a patient of Dr. Smith's for two years from December 2000 to December 2002. She understands that she suffers from Bipolar Disorder and was referred to Dr. Smith by her family doctor for renewal of her medications and ongoing treatment. She saw him at weekly or biweekly intervals over the course of her therapy with Dr. Smith.

Ms. C. testified that Dr. Smith talked a lot about sex during their sessions. He asked her repeatedly about her own sex life. This made her very uncomfortable, but she felt incapable of communicating that to him. When she left the office, Dr. Smith would regularly put his arm around her and reassure her. This ultimately progressed to him giving her hugs and 'pressing himself against my chest' at the termination of each visit.

On one occasion, Ms. C. remembers feeling desperate and suicidal. She called Dr. Smith at a number he had given her to use for emergencies. Dr. Smith then drove over to her apartment. After this event, Ms. C. was hospitalized for a serious overdose attempt. Upon discharge, she asked her family doctor for referral to another psychiatrist. The doctor declined and encouraged her to return to Dr. Smith because 'he was a good doctor'. Ms. C. therefore returned to Dr. Smith to obtain renewals of her prescriptions, but would repeatedly cancel subsequent appointments as often as she could.

On cross-examination, Ms. C. was asked about a Christmas card she sent to Dr. Smith. She maintained that she sent this to him in December of 2001. When it was pointed out to her that she was hospitalized in December of that year, she replied that she always did her cards in October or November to get it out of the way and that her daughter likely mailed it for her while she was in the hospital. She denied the possibility that she could in fact have sent the card in December of 2002.

Evidence for the Defence

Dr. Gerald Dixon Smith

Dr. Smith graduated from medical school in 1964. He then completed post-graduate studies, which included a four-year residency in psychiatry at the Menninger Institute in the United States. He attempted the fellowship examinations for psychiatry on four occasions but was not successful. In 1970, he opened a medical practice in Ottawa that was limited to psychiatry, and has continued in practice there until the present time.

Dr. Smith currently works weekdays from 7:30 a.m. to 7 or 7:30 p.m. He used to work Saturday mornings as well but stopped approximately 10 years ago because of the OHIP cap on physician billings. He employs a secretary on a half-time basis, who works in the office from 8 a.m. to noon.

Dr. Smith testified that he first saw complainant #1 in July 1976 for problems related to post-partum depression. It soon became evident that she had deep-seated problems in her life that required intensive psychotherapy to stabilize. He stated that he diagnosed her as having a Histrionic Personality Disorder with narcissistic features, requiring her to be the centre of attention. She demonstrated seductive behaviour, was overly dramatic and emotionally labile.

In one of his notes, Dr. Smith recorded that complainant #1 had confessed to a romantic attraction to him when he recorded that she was demonstrating “erotic transference”. Later on, he recorded that she was “resistant to working through her transference feelings”. He elaborated that patients in this situation often feel rebuffed and can be resentful and angry towards their therapists. Ultimately, he believed these transference feelings died away.

During cross-examination, Dr. Smith agreed that it was essential for any therapist to be aware of transference and countertransference feelings, and it was the therapist’s responsibility to be vigilant in cases where it came into play during therapy. He also accepted that clear boundaries are very important in the doctor-patient relationship and

that it is up to the therapist to delineate these limits. Dr. Smith agreed that he discussed mutual personal interests with complainant #1 during therapy but only in the context of creating an informal and relaxed environment which would encourage her to discuss difficult feelings more easily.

Dr. Smith denied that he ever requested complainant #1 to remove her dress so he could see her figure. He also denied that he ever kissed her or that there was ever anything sexual between them. In fact, he testified that he was very careful in his demeanour with her because of her flirtatious nature. He also denied that he ever drove her anywhere in his car, nor that he ever asked her not to wear makeup or perfume to the office.

Dr. Smith testified that complainant #2 had many characteristics of Borderline Personality Disorder (BPD), including preoccupation with abandonment, emotional lability and fluctuating between idealizing and devaluing people in her life. He offered the opinion that victims of childhood sexual abuse like herself would inevitably develop BPD later in life. However, in cross-examination, Dr. Smith admitted that he never charted such a diagnosis in his clinical note. As he explained, this diagnosis is “inferential” and not a treatable condition. Since he was not treating her for BPD, but rather the symptoms that accompanied the disorder, he did not feel it necessary to document the diagnosis in the clinical record.

Dr. Smith stated that he did, on occasion, show video clips to patients. In his opinion, this often helps to put patients in touch with their feelings and, in this regard, serves a therapeutic purpose. In complainant #2’s case, she and Dr. Smith shared an interest in vintage comedies and he would play segments of these during their sessions. He vehemently denied ever showing a pornographic video to her and denounced the suggestion that he would even own such a tape. He repeated this denial in cross-examination and reiterated that he owned no pornographic movies “either now or then”. When it was pointed out that he had testified in a previous hearing about owning pornographic movies for his personal enjoyment, he replied that he had in fact owned them in 1976 and before, but that he had since decided that he did not want that to be a continuing part of his life.

Dr. Smith also denied telling any lewd or sexual jokes to complainant #2. He viewed such behaviour as unprofessional. He also denied any escalating pattern of physical contact. “That is not the way I remember it. It was she who wanted a hug at the end of each visit. And this was nothing more than a brief social hug”.

With respect to the incident in which complainant #2 alleged that Dr. Smith became aroused during physical contact with her, he offered that he recalled putting his arm around her shoulder to comfort her in a situation where she was particularly distraught. In his opinion, she seemed comforted by his gesture, while at the same time being overwhelmed by the emotion, prompting her to ask him to return to his chair. Dr. Smith stated that he did so immediately. He denies any arousal on his part during the encounter. He observed that, at the next visit, complainant #2 actually thanked him for his expression of concern during the preceding session.

Complainant #3 initially presented to Dr. Smith with symptoms of depression and substance abuse. Dr. Smith described her impulsivity, erratic behaviour, fears of abandonment and antisocial behaviour as typical characteristics of a patient with BPD. He admits that he never charted this diagnosis but, as with complainant #2, he believed this was inferential.

Dr. Smith accepted that he traded comedy videos with complainant #3 but did not agree that this had no therapeutic purpose. He felt that this made her feel valued and, hence, had therapeutic intent. He acknowledges that he frequently sat beside complainant #3 in order to “draw her out of herself”, but the only physical contact he initiated would have been a hand on her shoulder or holding her hand. He admitted that she often expressed discomfort with the physical contact, but that he felt it was a legitimate therapeutic tool to attempt to desensitize her from her fear of men. He did engage in social hugs with her at the end of sessions, but only at her request.

Dr. Smith specifically recalled the incident during which he brushed flakes of skin off the front of her dress because he felt embarrassed about it. He describes his actions as a

simple flicking of the flakes with the tips of his fingers. He touched only the top of the bodice of her dress and vehemently denied contacting her breasts.

Dr. Smith acknowledged that he was aware that complainant #3 was obsessively attracted to him. He agreed that in this context a therapist must observe boundaries very closely. He did not agree that the physical contact he had with complainant #3 violated such boundaries.

Ms. B. became a patient of Dr. Smith's in February, 1976 for symptoms of depression. He denied that she ever talked about or showed him a pair of exotic panties. He denied ever picking her up and taking her to an apartment. He agreed that he did own two apartments in the same complex following his marital separation. He lived with his partner in one apartment and used the second for visitations with his children, the youngest of whom was about 5 ½ years old at the time. He insisted that he never discussed his family with Ms. B., nor did he ever reveal to her that he suffered from a chronic skin condition. He denied ever driving Ms. B. to a park and stated that he does not even know where the subject park is. He denied ever having any sexual contact with Ms. B. Furthermore, Dr. Smith denied having any physical contact whatsoever with Ms. B.

Dr. Smith testified that he owned a cell phone, which he kept in his consulting office and only used for outgoing calls or calls from colleagues. He denied ever giving a phone number to patients whereby they could contact him in an emergency.

Dr. Smith testified that Ms. C. became a patient of his in December 2000 for treatment of depression. He denied having any physical contact with her at all, including hugs, since she was so severely withdrawn. He denied ever receiving an urgent call from her or driving over to her apartment. Dr. Smith recalls receiving a Christmas card in December 2002 from Ms. C., not 2001. In spite of the fact the card is undated, he is certain of when he received it since it was during the initial stages of this hearing and was actually on his mantel when the complaint from Ms. C. was received at the College.

Dr. D.

Dr. D. graduated from medical school in Europe. He qualified as a specialist in psychiatry in 1975 and moved to Canada in 1986. He was the Chief of Psychiatry at Hospital A. from 1986 to 1991 and is currently an Associate Professor of Psychiatry at Hospital B. The Committee accepted Dr. D. as an expert in psychiatry qualified to give opinion evidence in respect of the standard of care of a psychiatrist practicing psychotherapy.

From his review of the clinical notes and Dr. Smith's training background, Dr. D. was of the opinion that Dr. Smith has been practicing as a psychiatrist since 1970 in spite of his failure to achieve his certification. Dr. D. also opined that Dr. A. is not capable of giving an informed opinion on the standard of Dr. Smith's care, since she has no formal training in psychiatry and has limited patient experience.

Dr. D. testified that he believes Dr. Smith kept excellent clinical records that were legible, concise and relevant. Dr. D. was of the view that Dr. Smith's diagnostic accuracy is good, based on his stated treatment plans. Dr. D. acknowledged that Dr. Smith did not often chart his diagnostic impressions. Dr. D. stated that multi-axial diagnoses are not necessary in the clinical record of a psychiatrist practicing in the community.

In Dr. D.'s opinion, all of Dr. Smith's patients whose files he reviewed would meet the diagnostic criteria for personality disorders. These patients are notoriously difficult to treat. Virtually all personality disorders have sexual hang-ups and frequently have sexual feelings toward their therapists. To Dr. D., it is a measure of Dr. Smith's success in treating these patients that he is able to keep them in therapy for an extended period of time.

Dr. D. testified that the rigid boundary rules recommended by Dr. A. are really for "beginners". With experienced therapists, such boundaries can be overridden, especially with difficult patients with personality disorders. Dr. D. was of the view that this is necessary in many cases in order to "get the patient to like you". In Dr. D.'s opinion, it is

permissible to use personal disclosures in order to put the patient at ease in emotional situations. He was of the opinion that the showing of video clips as a therapeutic tool may be totally appropriate. Similarly, coming to sit beside a patient and touching them can be useful in overcoming professional distance. While Dr. D. acknowledged that it is an accepted general rule in psychiatry not to touch, this boundary must be softened in dealing with personality disorders, particularly during long durations of treatment. Hugs at the end of sessions are admittedly dangerous and open to misinterpretation, but some patients seek this form of reassurance and it is almost impossible to avoid.

Dr. D. testified that personality disorder patients frequently fantasize about relationships with their physicians. In his opinion, if such a patient described having sex with their therapist after observing him pick the skin off his penis, or could not say if the therapist was wearing a condom, this would be more likely a fantasy than reality. Dr. D. also opined that it was unlikely that a complainant would keep quiet about such an event for many years if it truly happened. Later in cross-examination, he accepted that delayed reporting of sexual abuse cannot be attributed to a lack of truthfulness.

In Dr. D.'s experience, he has never known it to happen that a clinical therapeutic relationship will continue between a patient and therapist once the sexual relationship ends.

Dr. D. stated that it is unfair to consider the numbers of complainants as indicative of anything since it is well known that personality disordered patients will be particularly offended by stories that link their therapist to sexual abuse and they are notoriously motivated to complain.

With respect to complainant #1, Dr. D. opined that her allegations are more likely to be fantasy than reality. She had articulated other such fantasies to Dr. Smith (sex with her boss). She admitted her attraction to Dr. Smith. When she read of him having an affair with another patient, Dr. D. would expect her to feel betrayed. In that state, he hypothesized that she would be very angry and her fantasies of having sex with Dr. Smith

may well have become reality to her. Dr. D. also viewed her descriptions of the sexual events as having more characteristics of fantasy than of a real event.

Dr. D. opined that Ms. B. also met all the criteria for a serious personality disorder. Dr. D. had observed in one of his reports that Ms. B. was an extremely dysfunctional individual who, at the age of 37 was prostituting herself, had no home of her own and had no husband or consort. In cross examination, defence counsel pointed out that in 1976, Ms. B. was actually 20 years old, not 37. Dr. D. admitted he had made a mistake about her age, but that did not change his opinion with respect to her diagnosis. One feature he cited in support of his conclusion was the lengthy period of time she had been in therapy with Dr. Smith. When taken to the record, he accepted that in fact, Ms. B. had only been a patient for 3 or 4 months. He admitted that it would be very difficult for a psychiatrist to make a conclusion about long-term dysfunction in a patient only 20 years old.

Defence counsel asked Dr. D. what material he relied upon to make his assessment of Ms. B. He replied that he had relied upon her evidence given in the *voir dire*. He admitted that he had only read the transcript of this evidence and accepted that the guidelines for forensic psychiatry stipulate that psychiatric experts should not give testimony “solely based on observations in a courtroom”. He also accepted that giving evidence on the basis of transcripts alone is even less reliable. When asked whether he had reviewed the clinical notes on Ms. B., he was unable to remember. He recalled receiving them but was unsure whether or not he actually read them. When asked where he obtained the evidence that Ms. B. did not own a home or have a husband or consort, he was unable to recall.

Dr. D. was not present when Dr. A. testified. When asked if he had reviewed Dr. A.’s evidence, Dr. D. replied that he had received the transcript, but did not have time to fully read it prior to testifying at the hearing.

Dr. D. offered the opinion that complainant #2 fit the characteristics of personality disorder. In support of this conclusion, he stated that her reaction in learning of Dr. Smith’s allegations in a College discipline hearing was not that of a normal individual.

He maintained that a normal person should not have experienced the betrayal of trust that she purports to have felt after reading the newspaper article. On cross-examination, Dr. D. appeared to say that there was no evidence to support the existence of either a personality disorder or any personality problems.

Dr. D. accepted College counsel's proposition that, if the most serious events occurred as alleged by the complainants, then Dr. Smith had failed to meet the appropriate standard of practice.

FINDINGS IN RESPECT OF THE SPECIFIED ALLEGATIONS

The Committee found that Dr. Smith had committed acts of professional misconduct:

- (a) under paragraph 26.28 of Ontario Regulation 577/75 as amended, R.O. 1975 ("O. Reg. 577/75" and under paragraph 27.29 of Ontario Regulation 448, R.R.O. 1980 ("O. Reg. 448"), in that he engaged in sexual impropriety with a patient;
- (b) under paragraph 26.20 of O. Reg. 577/75 and paragraph 27.21 of O. Reg. 448, in that he failed to maintain the standard of practice of the profession; and
- (c) under subsection 1(1)33 of O. Reg. 856/93, under paragraph 26.31 of O. Reg. 577/75 and under paragraph 27.32 of O. Reg. 448, in that he engaged in conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee concluded that the allegation of sexual abuse under the Code was not established, for the reasons described below. The Committee also found that the allegation of professional misconduct under the *Medical Act* was not established as that Statute was no longer in force at the time of the incidents in question. Finally, the Committee found that the allegation of incompetence was not established.

FINDINGS AND REASONS**THEREFOR****The Witnesses**

The Committee found the three complainants, as well as the two similar act witnesses, to be very credible witnesses. They all gave their testimony in a direct and forthright manner. Their evidence was internally consistent, consistent with other known facts, and inherently plausible. Although each expressed a degree of anger towards Dr. Smith, there was no vindictive component to their testimony. All were consistently unshaken when subjected to vigorous and skillful cross-examination. In instances where complainant #1 and Ms. B. may not have had totally accurate or detailed memories of certain events surrounding their encounters with Dr. Smith, the Committee accepts the College's position that this can be accounted for by the passage of over 20 years' time, and should not diminish the general reliability of their evidence.

Dr. Smith vehemently denied any untoward behaviour in respect of any of the complainants, and specifically and emphatically denied any sexual relationships with them. Although he admitted to some personal disclosures and touching of a minor and reassuring nature, he did not accept that this represented any form of boundary violation. The Committee did note that nowhere in his records does he document any diagnoses of personality disorders for any of the complainants with the exception of complainant #1. The Committee accepts the position of the College in this regard that this is a diagnostic construct made many years after the fact rather than at the time of treatment. Furthermore, it would appear self-serving in that the conclusion the defence wishes to be drawn from this is that patients with personality disorders are untruthful.

In his testimony, Dr. Smith agreed that strict boundaries are important and that it is the therapist's responsibility to ensure that these are maintained. He accepted that maintenance of boundaries is even more important in patients who are victims of sexual abuse or with Borderline Personality Disorders, particularly with respect to the use of touch, which he agreed can be easily misinterpreted by vulnerable patients. And yet, he admitted that he insisted on sitting close to complainant #3 during their sessions, holding her hands and putting his arm around her shoulder, even though she clearly indicated that

she was uncomfortable with this. With complainant #2, he accepted that she directed him to go back to his chair when he maintained he simply put his arm around her shoulders to comfort her. He accepted that he hugged each of these two complainants regularly at the end of therapy sessions but it was “always at their request”. Both testified as to the significant discomfort this caused them. Dr. Smith’s own evidence was that each of complainant #3 and complainant #2 gave Dr. Smith specific notice of their discomfort at the time the interactions occurred.

The Committee also took note of Dr. Smith’s response to questioning about the pornographic video. He indignantly rejected the suggestion that he might even own such a tape, let alone have it in his office. He went even further to state that he did not own any such tapes “either then or now”. When reminded of previous testimony in an earlier hearing where he admitted to having such tapes for his personal use, he modified his response to suggest that he was not referring to that time frame when he made his previous statement.

Having considered the evidence of the other witnesses, Dr. Smith’s own evidence, and the other established facts, the Committee found that Dr. Smith was not a credible witness and did not accept his evidence where it differed from that of the complainants and the similar act witnesses.

The Expert Witnesses

With respect to the expert witnesses, the Committee did not place great weight on the distinction between whether Dr. Smith should be viewed as a psychiatrist or a family physician practicing psychotherapy. The standard for any physician performing psychotherapy should represent the minimum standard of practice, whether it be applied to a family physician or psychiatrist. If anything, the psychiatrist, given significantly more training in the field, may be held to a higher standard if indeed there is a difference at all. In the Committee’s opinion, both Dr. A. and Dr. D. were qualified to provide opinion evidence that would be helpful in determining the issues in this case.

With respect to boundaries, the Committee accepted the evidence of Dr. A. over Dr. D. A physician who initiates close physical contact with a patient who has demonstrated a sexual attraction to him is embarking upon a perilous venture that can only invite misinterpretation. Even Dr. D. admitted that doing so is risky and requires great caution. However, on the issue of personal disclosures, the Committee is prepared to accept Dr. D.'s opinion that skilled therapists, engaged in long-term therapy, may cautiously utilize such disclosures in very particular circumstances in a therapeutic context.

The experts disagreed on the issue of boundaries as they apply to patients with personality disorders. Both agreed that these patients are emotionally unstable, prone to develop inappropriate relationships and almost always have problems with sexual issues. The Committee did not accept Dr. D.'s opinion that such patients require a "creative approach to therapy" where boundaries can be overridden. It accepted Dr. A.'s opinion in this regard that even greater vigilance to boundaries should be observed with such patients.

The Committee is obliged to observe a number of concerns with respect to the balance of Dr. D.'s testimony. Dr. D. was unable to recall whether or not he had reviewed the clinical records of the similar act witnesses prior to preparing his report and subsequently giving his testimony. At one point in the hearing, he became sufficiently uncertain about the attribution of his opinions to specific patients that he had to be given a recess in the proceedings to review his material. Although critical of Dr. A.'s opinions, Dr. D. admitted that he had not had time to read the transcript of her testimony that was provided to him in advance of the hearing, and therefore did not know precisely what her evidence had been. Dr. D. made a number of erroneous factual assumptions in formulating his opinions. For example, he incorrectly thought Ms. B. was 37 and not 20 years old at the time of treatment, and that she had been a long-term patient of Dr. Smith's whereas she had been a patient for only four months.

There were occasions when Dr. D.'s evidence tended toward advocacy, notwithstanding his best intentions to be objective. For example, he offered an opinion that all of the complainants' allegations were either false or fantasized as a result of their psychiatric

conditions. He did not offer this as a possible or alternative explanation for their version of events, but rather as the most likely explanation. In the end, the Committee found the opinions expressed by Dr. A. to be more reliable and apposite than those of Dr. D.

Similar Act Evidence

The Committee recognizes that there are no allegations against Dr. Smith arising out of the evidence of the witnesses Ms. B. and LS. Their evidence is relevant only as similar act evidence in respect of the allegations of the complainants.

Counsel for the College submitted that it was open to the Committee to use a “pooling” approach in assessing the validity of similar act evidence. On this approach, the panel may consider all the evidence together, and the “similar act” need not be proved to the requisite standard before being applied to the allegations. The Committee accepted that this approach was open to it. However, the College invited the Committee to adopt a sequenced approach, whereby it must find the similar act evidence to have met the standard of clear, cogent and convincing, sufficient to stand on its own merit, without the necessity of employing the pooling approach.

In the case of Ms. B., the Committee concluded that her evidence was truthful and met the standard of proof in its own right. Her testimony was very credible and unembellished. She testified that Dr. Smith peeled skin off his penis and reassured her that it was simply eczema. Dr. Smith later testified that he suffered from psoriasis and dry skin. He denied having ever told Ms. B. this. He similarly denied ever discussing his living arrangements with her, or taking her to his apartment. However, Ms. B. testified that he took her to an apartment, in a group of high-rise buildings, that had children’s toys (age appropriate for a 4-6 year old) scattered about the living room. Dr. Smith confirmed that he owned such an apartment for the exclusive use of visitations with his children, the youngest of whom was 5 ½ years old. The Committee concluded that Ms. B. could not have had knowledge of this apartment if she had not been taken there by Dr. Smith.

The Committee also accepted as truthful the evidence of LS. It was internally consistent, entirely plausible, and fully credible.

Incidents Involving complainant #1

Complainant #1 gave her testimony in a credible and straightforward manner. Dr. Smith denied her allegations, specifically in regard to engaging in any sexual relationship with her. The Committee is cognizant that the College has the burden to prove her allegations. Dr. Smith is not required to disprove them.

In this case, the Committee was assisted by the similar act evidence. Complainant #1 testified that Dr. Smith cautioned her not to wear makeup or perfume, as did both Ms. B. and complainant #3. Complainant #1 testified that Dr. Smith asked her to remove her dress so he could admire her figure. Ms. B. testified that Dr. Smith asked her to lift up her dress and show him her panties. According to complainant #1, Dr. Smith came around his desk, unzipped his fly and invited complainant #1 to perform oral sex on him. Similarly, Ms. B. testified Dr. Smith requested she perform fellatio. Complainant #1 gave evidence that she called a special telephone number given her by Dr. Smith, as did both Ms. B. and LS. Dr. Smith denied ever providing such a number to any of his patients. Ms. B. then testified that Dr. Smith came and picked her up and took her to an apartment where they had sexual intercourse. Complainant #1 testified that he came to pick her up and took her back to his office where they had intercourse. In the Committee's view, these very notable similarities cannot be explained by coincidence alone. It finds that the incidents involving complainant #1 occurred in the manner described by her.

Incidents Involving complainant #2

Complainant #2 gave her evidence in an articulate, forthright and dispassionate manner. She demonstrated no tendency to embellish her testimony. Dr. Smith acknowledged the veracity of her evidence as it pertains to personal disclosures, viewing of video clips and giving of hugs, although to a significantly lesser degree than what was described by complainant #2. However, he vehemently denied the showing of a pornographic video or telling lewd or sexual jokes. The Committee noted Dr. Smith's apparent untruthfulness with respect to the question whether he ever owned any pornographic material. The

Committee accepted that the incidents described by complainant #2 occurred in the manner she testified. Although it finds the incident described by complainant #2 about Dr. Smith's apparent arousal during close physical contact disturbing, the Committee is prepared to accept that her impression could have been a misinterpretation on her part.

Incidents Involving complainant #3

Complainant #3 was also a very credible witness. Dr. Smith did not deny her evidence that they discussed mutual interests and exchanged videos. He also accepted that he provided comforting hugs to her and used touch in a therapeutic context during her sessions. The Committee found that the incidents described by complainant #3 occurred in the manner she described. Dr. Smith's description of the brushing of skin from her dress clearly differs from her recollection of it. In this instance, the Committee is prepared to accept Dr. Smith's version of events, since the implied "intent" of his actions is clearly open to subjective interpretation.

Conclusions in respect of the Allegations

Allegation 1

The Committee is aware that this allegation of "sexual abuse" is based upon the provisions of the Code, which can only be applied to conduct which occurred after the Code came into force in December, 1993. In this case, the Committee accepted the evidence of complainant #2 that Dr. Smith showed her a segment of a pornographic video and told her sexual jokes during the course of her therapy sessions. The Committee also concluded that the incidents would constitute "sexual abuse" under the Code, if they took place after the Code came into force. In the appendix to the Notice of Hearing, it is alleged that these incidents took place in 1997. However, upon review of complainant #2's testimony, and following further submissions of counsel on the issue, the Committee concluded that there was no evidence as to the year or years that the incidents occurred. Since complainant #2's treatment with Dr. Smith spanned the period of 1987 to 1997, these particular incidents could have taken place prior to the coming into force of the Code in 1993.

The incidents described by complainant #1 took place well before the Code came into force. While Dr. Smith's treatment of complainant #3 began after the Code came into force, the Committee did not find that the incidents described by complainant #3 constituted "sexual abuse" under the Code. While some of these incidents constituted boundary violations, as described above, they did not have a clear sexual element to them.

The Committee therefore found that the allegation of sexual abuse under the Code was not established.

Allegation 2

The Committee accepted the evidence of complainant #1, specifically regarding the 1978 incident involving the removal of her dress, and regarding the sexual relationship between complainant #1 and Dr. Smith beginning in 1980. This relationship involved multiple incidents of oral sex and sexual intercourse. These incidents occurred in Dr. Smith's office during psychotherapy sessions.

Allegation 2 covers a period of time pre-dating the coming into force of the Code and the new regulations thereunder in 1993. There was no evidence establishing whether the sexual-themed jokes and video incident described by complainant #2 occurred during the period of time to which allegation 2 relates.

The Committee, however, concluded that the 1978 incident involving complainant #1, and the sexual relationship between Dr. Smith and complainant #1 which began in 1980, clearly constituted sexual impropriety with a patient, which is contrary to paragraph 26.28 of O.Reg. 577/75 and paragraph 27.29 of O.Reg. 448. On that basis the Committee found that allegation 2 was established.

Allegation 3

The Committee accepted the evidence of Dr. A. that the incidents of sharing personal disclosures, showing comedy videos and providing comforting hugs at the end of therapy sessions represent likely boundary violations for a therapist practicing psychotherapy

with vulnerable patients. However, the Committee does not accept that failing to adhere strictly to such boundaries constitutes a failure to meet the standard of practice. The Committee accepts Dr. D.'s evidence in this regard that a skilled therapist in particular circumstances can take such steps and still meet the minimum standard of practice. However, the Committee does accept Dr. A.'s opinion that the progressive and impassioned physical contact described by two of the three complainants does fall below the standard of practice expected of any physician practicing psychotherapy. This is particularly true when considering that both complainant #3 and complainant #2 testified that they found the contact uncomfortable and that Dr. Smith himself acknowledged that two of the three made it clear to him that his behaviour was not welcomed.

The Committee also accepts Dr. A.'s opinion that the telling of sexual jokes and showing of a pornographic video has no place whatsoever in the context of psychotherapy, whether intentional or accidental. There can be no therapeutic value to such behaviour. The Committee accepts that these are major boundary violations and fall below the standard of practice for any competent therapist.

Both experts agreed that having sexual relations with patients is at the most egregious end of the spectrum of boundary violations and clearly falls below the standard of practice.

There was, however, a problem with the manner in which this allegation was framed in the Notice of Hearing. Allegation 3 in the Notice of Hearing includes reference to the provisions of the regulations covering the period 1975-93, but not thereafter. Thus, the evidence of complainant #3 was not applicable to this allegation. Moreover, and as noted, it was not clear on the evidence whether the incidents described by complainant #2 occurred before or after 1993.

The 1978 incident described by complainant #1 and the subsequent sexual relationship which began in 1980 was accepted by both experts as falling below the standard of practice of the profession, if proven. The Committee accepted complainant #1's evidence regarding these events. The Committee therefore concluded that allegation 3 was established.

Allegation 4

This allegation refers to unprofessional conduct as set out in the former *Medical Act*. That statute was repealed and replaced by the *Health Disciplines Act, 1974*, which came into force in 1975. None of the incidents described by any of the complainants occurred during the period of time that the *Medical Act* was in force. As a result, the Committee found that this allegation was not established.

Allegation 5

In view of the above serious boundary violations and sexual misconduct, the Committee concluded that Dr. Smith engaged in conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Committee relied upon the evidence of all three complainants in coming to this conclusion.

Allegation of Incompetence

With respect to the allegation of incompetence, counsel for the College invited the Committee to make such a finding on the basis of the acts of sexual impropriety. She relied upon the evidence of Dr. A. in this regard that a patient will not improve and will likely get worse where serious boundary transgressions occur. Although the Committee accepted this opinion, it did not find there was sufficient evidence before it to determine whether or not this was actually the case with either complainant #1 or complainant #2. As counsel for the defence pointed out, both patients continued in long term treatment with Dr. Smith, even subsequent to the incidents of sexual impropriety.

The Committee is also mindful that it is obligated to make a finding of currency in determining that a physician is incompetent. In this case, the most serious allegations of sexual misconduct that would have to be relied upon to prove these allegations occurred over twenty years ago.

The Committee therefore finds that the allegation of incompetence is not established on the evidence.

Indexed as: Smith (Re)

**THE DISCIPLINE COMMITTEE OF THE COLLEGE
OF PHYSICIANS AND SURGEONS OF ONTARIO**

IN THE MATTER OF a Hearing directed
by the Complaints Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) of the *Health Professional Procedural Code*,
being Schedule 2 to 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. GERALD DIXON SMITH

PANEL MEMBERS:

**DR. R. MACKENZIE (CHAIR)
DR. M. GABEL
J. MARTEL
R. SANDERS
DR. M. WOLFISH**

PUBLICATION BAN

Hearing dates:

December 16-19, 2002
March 24-26, 2003
September 22-26, 2003
October 31, 2003

Decision Release date:

December 1, 2003

Penalty date:

December 2, 2003

Penalty/ Decision/Released date:

January 20, 2004

DECISION AND REASONS IN RESPECT OF PENALTY

The Discipline Committee of the College of Physicians and Surgeons of Ontario (“the Committee”) heard this matter at Toronto on December 16 to 19, 2002, March 24 to 26, September 22 to 26, and October 31, 2003. By decision released December 1, 2003, the Committee found that Dr. Smith committed professional misconduct:

- under paragraph 26.28 of Ontario Regulation 577/75 as amended, R.O. 1975 (“O. Reg. 577/75”) and under paragraph 27.29 of Ontario Regulation 448, R.R.O. 1980 (“O. Reg. 448”), in that he engaged in sexual impropriety with a patient;
- under paragraph 26.20 of O. Reg. 577/75 and paragraph 27.21 of O. Reg. 448, in that he failed to maintain the standard of practice of the profession;
- under subsection 1(1)33 of O. Reg. 856/93, under paragraph 26.31 of O. Reg. 577/75 and under paragraph 27.32 of O. Reg. 448, in that he engaged in conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee heard evidence and submissions on penalty on December 12, 2003 and reserved its penalty decision.

PUBLICATION BAN

The Discipline Committee ordered that no person shall publish or broadcast the identity of any complainant witnesses and similar act witnesses, or any information that could disclose the identity of those witnesses, under subsection 47(1) of the *Health Professions Procedural Code* (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

The Committee also made orders under subsection 45(3) of the Code, as detailed in its Decision and Reasons for Decision dated December 1, 2003.

PRELIMINARY MOTION

At the outset of the penalty phase of this hearing, defence counsel made a motion that the Committee was without jurisdiction to impose a penalty under the Code (as distinct from the former *Health Disciplines Act*) because the portion of the Notice of Hearing dealing with possible penalties made no reference to the Code. The relevant part of the Notice of Hearing states that “the panel may make one or more orders authorized under subsection 61(5) of the *Health Disciplines Act*, and subsection 40(1) of the *Medical Act*”. In his submissions, defence counsel argued that Dr. Smith was entitled to know in advance what penalties could be imposed if a finding of misconduct were made against him, and that he was therefore prejudiced.

Counsel for the College accepted that a reference to the Code was missing from this portion of the Notice of Hearing, but noted that the Notice clearly set out that the College intended to prove certain allegations of professional misconduct under the Code and that, therefore, Dr. Smith could not possibly be caught by surprise with respect to the penalties being sought. Subsection 6(2) of the *Statutory Powers Procedure Act* states that the “notice of hearing shall include a reference to the statutory authority under which the hearing will be held”. College counsel submitted that this section was complied with. Counsel argued that the panel had authority to impose a penalty under the Code once it made a finding of professional misconduct under the Code. She argued that the penalty flows from the offence, whether or not the penalty section of the Notice of Hearing refers to the Code.

Independent counsel for the Committee reviewed the findings of professional misconduct made by the panel in this case and pointed out that the only one in which the lack of reference to the Code would have any relevance is the finding in respect of allegation 5, the so-called “basket clause”. All other findings were based on the *Health Disciplines Act*, or the regulations thereunder. In respect of allegation 5, the only potential difference in penalty available under the *Health Disciplines Act* and the Code would be the maximum amount of fine permitted. He further advised the Committee that it had jurisdiction to impose a penalty under the Code in respect of allegation 5, unless it concluded that Dr. Smith did not have reasonable notice of the potential consequences of a finding of professional misconduct in respect of allegation 5.

Following deliberation, the Committee ruled that Dr. Smith did have reasonable notice of the adverse consequences that would flow from a finding of professional misconduct. The Notice of Hearing does refer to the statutory authority under which the hearing would be held. Therefore, the Committee concluded that it did have authority to impose a penalty under the Code in respect of the relevant aspect of allegation 5.

EVIDENCE AND SUBMISSIONS ON PENALTY

Counsel for the College filed victim impact statements from patient A and patient B as exhibits to the hearing. In these statements, both complainants expressed anger and distress with respect to Dr. Smith’s behaviour and their perception of the negative impact this has had on their lives.

Defence counsel presented videotape evidence before the panel in which a number of Dr. Smith’s current patients articulated their concerns about the findings made and the

potential impact on their treatment (and on Dr. Smith) should Dr. Smith be unable to continue in practice. In addition, defence counsel filed a Brief of Letters in support of Dr. Smith from 37 separate individuals.

The College sought revocation and a recorded reprimand as the appropriate penalty in this case. College counsel reviewed the principles underlying a penalty order, and argued that in this case the principles of denunciation and protection of the public are of paramount importance. The serious nature of the misconduct, the lengthy period over which it occurred, and the impact it had on the complainants represented major aggravating factors. In considering the likelihood of rehabilitation, College counsel noted that there was no evidence before the panel that Dr. Smith accepted responsibility for his actions, nor has he demonstrated any remorse. She expressed concern about the character references presented on Dr. Smith's behalf inasmuch as the patients and other individuals generally expressed disbelief in respect of the findings made by the Committee.

Defence counsel invited the panel to consider a lengthy period of suspension with monitoring upon return to practice as an alternative to revocation. He noted that Dr. Smith was 63 years of age and had been in practice for 33 years. He has no previous record of misconduct. He has suffered from extensive publicity surrounding this case for several years. Although conceding that the findings with respect to patient B are serious, he argued that these are the furthest removed in time, and that the remainder of the misconduct findings are essentially boundary violations.

ANALYSIS

The Committee carefully considered the penalty submissions made by both parties. It accepts the College position that Dr. Smith's conduct towards patient B (involving

intercourse and oral sex, including sex in Dr. Smith's office during psychotherapy sessions) represents a very grave breach of professional trust and warrants severe sanction, having regard to the principles of specific and general deterrence and public protection. The Committee also accepts that the duration of the misconduct is a significant aggravating factor. As a physician practising psychotherapy or psychiatry, Dr. Smith was in a position of power over vulnerable patients. His behaviour towards patient B, a vulnerable patient, was predatory and served only to satisfy his own gratification. He initiated sexual intercourse on an occasion where patient B came to his office in desperation after she ran out of medication. Dr. Smith's actions represented the most serious form of sexual misconduct. There can simply be no tolerance for such reprehensible behaviour.

Dr. Smith's conduct toward patient C and patient A also demonstrated a pattern of inappropriate behaviour toward vulnerable patients. His conduct in respect of patient C included certain sexual elements. The misconduct continued over a significant period of time and demonstrated that the matters in issue were not isolated incidents.

The Committee recognizes that Dr. Smith was fully entitled to deny the allegations and that this cannot be held against him when considering penalty. The Committee, however, noted the lack of insight demonstrated by Dr. Smith. Although he admitted to some personal disclosures and touching of a minor and reassuring nature, he did not recognize that these could even be viewed as boundary violations. In fact, he was indignant that his conduct should be represented as unprofessional in any way. The Committee concluded that Dr. Smith simply does not accept that boundaries in medical practice apply to him and that this would present a significant impediment to any successful rehabilitation.

The majority of patients who gave oral evidence via videotape or submitted letters of support appeared to have little understanding of the nature of the findings made against Dr. Smith. Many of them represented the allegations or the findings as sexual harassment. In the Committee's opinion, this evidence does little to advance the proposition that Dr. Smith is a good candidate for rehabilitation. This evidence largely speaks to the general standard of Dr. Smith's care. Evidence with respect to Dr. Smith's behaviour towards these particular patients provides little comfort that Dr. Smith would not be at risk to re-offend. Sexual misconduct by physicians almost always occurs in private. The fact that he conducts himself appropriately with one patient offers little assurance that he will do the same with other vulnerable individuals who come under his care.

It is the Committee's opinion that Dr. Smith is at risk to re-offend. In view of the grave and predatory misconduct, and the risk of re-offending, the Committee unanimously concluded that revocation of Dr. Smith's certificate of registration to practise medicine was the only appropriate penalty.

ORDER

The Discipline Committee therefore ordered and directed that:

1. The Registrar revoke Dr. Smith's certificate of registration, effective immediately;
2. Dr. Smith appear before the Committee to be reprimanded, with such reprimand to be recorded on the public register.

Further written submissions with respect to the issue of costs were invited from the parties and will be considered separately from this penalty order.

Indexed as: Smith (Re)

**THE DISCIPLINE COMMITTEE OF THE COLLEGE
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B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. GERALD DIXON SMITH

PANEL MEMBERS: **DR. R. MACKENZIE (CHAIR)**
 DR. M. GABEL
 J. MARTEL
 R. SANDERS
 DR. M. WOLFISH

PUBLICATION BAN

Hearing dates:	December 16-19, 2002 March 24-26, 2003 September 22-26, 2003 October 31, 2003
Decision Release date:	December 1, 2003
Penalty date:	December 2, 2003
Penalty/ Decision/Released date:	January 20, 2004
Cost Decision Released Date:	March 22, 2004

DECISION AND REASONS AS TO COSTS

After the release of the Committee's Decision and Reasons for Decision on penalty, the Committee received written submissions on costs from both parties, advice from independent legal counsel, and the parties' response to that advice. The Committee has carefully considered those submissions and that advice.

The parties both appear to accept that an award of costs represents a reimbursement to a party (in this case, the College) rather than an additional penalty imposed upon a member found to have committed an action of professional misconduct.

In the Committee's opinion, this is an appropriate case to award costs to the College, as provided for in section 53.1 of the *Code*. The factors considered by the Committee in reaching this conclusion, and in fixing the quantum, include the serious nature of the misconduct, the length of the hearing, and the circumstances of the case. The Committee is mindful of previous decisions in which costs were ordered in cases where the hearing related to misconduct that the member knew or ought to have known was unacceptable. The misconduct proven in this case clearly meets that test.

The Committee accepts the College's position that the amount sought by the College is both significantly below the actual costs incurred, and also below the daily amount that is set out in Tariff "A" to the Discipline Committee's Rules of Procedure. The requested amount of \$2,500 per full hearing day is consistent with other costs awards in recent Discipline Committee decisions.

Taking all of these considerations into account, the Committee orders and directs that Dr. Smith pay, within 30 days of the date of this order, the College's partial costs of the hearing, fixed in the amount of \$30,000.