ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Bensimon,* 2025 ONPSDT 7
Date: March 2, 2026
Tribunal File No.: 24-028

BETWEEN:

College of Physicians and Surgeons of Ontario

College

- and -

Michael Aaron Bensimon

Registrant

FINDING REASONS

Heard: November 14, 17, 18, 25, and December 8, 2025

Panel:
Sherry Liang (panel chair)
Vincent Georgie (public)
Joanne Nicholson (physician)
Rupa Patel (physician)
Linda Robbins (public)

Appearances:
Kenzie Bunting, for the College
Andrew McKenna and Reem Zaia, for the registrant

RESTRICTION ON PUBLICATION

Pursuant to Rule 2.2.2 of the HPDT Rules of Procedure and ss. 45-47 of the Health Professions Procedural Code, no one shall publish or broadcast the names of patients or any information that could identify patients or disclose patients' personal health information or health records referred to at a hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this restriction.

Introduction

[1] The College alleges that the registrant sexually abused a female patient during a prenatal appointment in September 2022 when he touched the patient's breasts and genitals without a medical basis and in a sexual manner (the parties used the terms "prenatal" and "perinatal" interchangeably, as we do here). The College alleges that the registrant's conduct during this appointment also amounts to disgraceful, dishonourable or unprofessional conduct and failed to maintain the standard of practice of the profession. It did not proceed with the allegation of incompetence in the Notice of Hearing.

[2] For the reasons below, we find that the registrant's conduct during the appointment failed to maintain the standard of practice of the profession and was conduct that members of the profession would reasonably regard as disgraceful, dishonourable or unprofessional. However, we conclude that the College did not prove the allegations of sexual abuse on a balance of probabilities based on clear, cogent and convincing evidence.

Burden of proof and credibility findings

[3] The College called two witnesses, the patient and an expert witness, Dr. David Tobin, who testified about the standard of practice of the profession. The registrant was the sole witness for his case.

[4] The burden of proof is on the College to prove the allegations of misconduct. The standard of proof is the civil standard. This means the College must prove the allegations on a balance of probabilities based on clear, convincing, and cogent evidence.

[5] The Divisional Court observed in *Stefanov v. College of Massage Therapists of Ontario*, 2016 ONSC 848 at para. 62 that:

> [...] sexual abuse is one of the most significant and serious findings that the Panel can make against a member. Given the consequences of such a finding, the Panel is required to act with care and caution in assessing and weighing all the evidence. In doing so, the Panel must ensure that the evidence is of such a quality and quantity to justify a finding of sexual abuse (*Re Bernstein and College of Physicians and Surgeons of Ontario* (1977), 1977 CanLII 1072 (ON SC)[…], at pp. 486-488).

[6] The seriousness of the alleged conduct, and the consequences of a finding, however, do not alter the standard of proof: *F.H. v. McDougall*, 2008 SCC 53 at paras. 40 and 45-49.

[7] The patient and the registrant's testimony about the relevant events differed significantly. In these circumstances, we must assess the credibility and reliability of their evidence to decide the case before us. Credibility means honesty (willingness to tell the truth). Reliability refers to the ability to observe, recall and recount. Even an honest witness can be found unreliable.

[8] Some considerations in assessing a witness's evidence are:

- the witness' demeanour (bearing in mind that "demeanor alone is a notoriously unreliable predictor of the accuracy of evidence given by a witness": *Law Society of Upper Canada v. Neinstein*, 2010 ONCA 193 at para. 66);
- consistency of the evidence with objective facts and common sense;
- partisanship;
- human frailties;
- prior inconsistent statements;
- internal inconsistencies in the evidence;
- tendency to exaggerate.

[9] As set out by the Divisional Court in *The College of Physicians and Surgeons of Ontario v. Beitel*, 2013 ONSC 1599 at para. 30, the panel is not constrained to accept the evidence of the patient or the registrant in its totality, and the question is whether on the whole of the evidence the College has proven its case on a balance of probabilities. At the same time, however, finding the evidence of one of the witnesses to be credible may well decide matters, if it means explicitly or implicitly that the other party was not believed on the important issues in the case (see *McDougall* at para. 86).

[10] The panel must look at all the evidence to assess the impact of inconsistencies on the core issues in the case. A panel may find a witness to be credible and reliable even if there are inconsistencies on peripheral or less material issues. Inconsistencies on minor matters are normal.

[11] The registrant has, for the most part, no independent recollection of his medical appointments with the patient, including the one at which the alleged misconduct took place. His evidence consisted of the patient's chart and his explanation of the meaning of the entries on the chart, as well as testimony about his usual practices.

[12] In medical malpractice cases, the courts have stated that when a physician has no specific recollection of dealings with a patient, he or she is entitled to testify as to what his/her ordinary or invariable practice is. That evidence is considered strong evidence that the physician acted the same way on the day in question (see, for example, *Turkington v. Lai*, 2007 CanLII 48993 (ON SC) at para. 93). It goes without saying that the panel may also consider cogent evidence that the registrant departed from his usual practice on this day. The weight to be attached to the evidence given by physicians of their usual practice is to be determined by the trier of fact, on a case-by-case basis (*Sommerville v. Fine*, 2021 ONSC 5638 at para. 68).

[13] The reliability of a physician's evidence in supporting a conclusion about what the physician did on a particular occasion can be enhanced by contemporaneous records (*Sommerville* at para. 69). Courts have, in malpractice cases, found that medical notes made shortly after the events at issue can be a more reliable representation of the medical encounter than a patient's recollection many years after the fact (*Henry v. Boivin et al.*, 2023 ONSC 663 at para. 55). We also bear in mind, however, that in a case involving allegations of sexual misconduct, it is hardly to be expected that a registrant would record their own improper conduct.

[14] With the above in mind, we turn to the allegations.

Background

[15] The registrant is one of about ten family doctors working at a clinic in eastern Ontario. He described his practice as akin to a "country doctor," serving patients from a large geographic region and providing any care required from birth to end of life. The clinic is also staffed by social workers, nurses and administrative personnel.

[16] The registrant first met the patient when she sought a doctor for her newborn baby in the summer of 2020. In late 2020, she also became the registrant's patient. The patient's medical records, including all the registrant's notes of her appointments with him, are contained in a Joint Book of Documents. At the outset of the hearing the parties agreed that these documents can be used in this hearing without formal proof of their authenticity and that the panel can rely on them for the truth of their contents. The College clarified that while it agreed to this, it takes the position that the documents do not represent the full extent of what occurred during the appointments.

[17] The events leading up to the prenatal appointment are almost entirely uncontroversial. While there were a few points of disagreement about what happened during the earlier appointments, they are peripheral to the issues before us. The registrant's notes show that at the first appointment, he and the patient reviewed her medical history and he performed a routine physical examination. Because of the patient's history, the registrant asked her about her mental state. At the conclusion of the meeting, the plan was made for the patient to have a PAP smear at the next appointment, in about a month's time.

[18] At that next appointment, the registrant performed a PAP smear on the patient, with a nurse present. He described to the panel his usual practice for performing such a procedure, which starts with the nurse greeting the patient, taking her to the treatment room, giving her a gown and drape and asking her to disrobe from the waist down. The registrant enters the treatment room with the nurse once the patient is disrobed, explains the process for the PAP smear and obtains the patient's consent. He then performs the procedure with the nurse's assistance.

[19] The patient returned to see the registrant about a month after this. The registrant discussed the PAP results with her. The patient told the registrant about a concern that led to an examination of her genital area during this appointment. The registrant gave the patient a gown and asked her to disrobe from the waist down. He returned to the room with a nurse and proceeded to examine her genitals, touching her labia as necessary to view the area.

[20] The registrant testified that an examination such as this is done, at least initially, with the patient's legs in a "froggy" position, lying on her back without using stirrups and with her legs splayed out to the side. A nurse is present throughout the examination. The

registrant testified that it is his consistent practice to have a nurse in the room when he conducts genital exams, whether on male or female patients.

[21] The patient returned to see the registrant in July of 2021 for a further PAP smear, as a follow-up to the result earlier in the year. The pathologist reading the results recommended a further PAP smear in six months.

[22] The patient saw the registrant again in September of 2021, and then a few months later. At this later appointment, the patient requested a procedure in her genital area. The registrant testified that he would have given the patient a gown and asked her to disrobe from the waist down. He would have then left the room, returned with a nurse and conducted the procedure with the patient's legs in the stirrups.

[23] The patient returned for a repeat PAP smear in February 2022. Based on his usual practices and the notes of this visit, the registrant testified that while he was in the process of starting the procedure, the patient told him she thought she might be pregnant. He discontinued the procedure, and testing done during the appointment confirmed the pregnancy. The registrant made some visual observations while the speculum was inserted which he noted on the patient's chart.

[24] The registrant referred the patient to the high-risk pregnancy unit at a nearby hospital. However, this pregnancy resulted in a miscarriage. The patient had a phone consultation with the registrant about the miscarriage and then returned to see him in June 2022. At this time, the registrant and patient discussed her ongoing medical issues and the registrant performed a PAP smear.

[25] Following this, the patient's next appointment with the registrant was a prenatal appointment in September 2022, about a new pregnancy. This is the visit that gave rise to the current allegations.

[26] The patient acknowledges that she does not have a detailed memory of her appointments with the registrant, up to the one in September 2022. She recalls that the registrant was kind and did not rush her through appointments. She was comfortable talking to him about her medical issues although she remembered feeling uncomfortable about some of his questions. She felt that certain questions, such as being asked about her relationship with her partner and whether she was safe or in an abusive relationship, were not relevant. She also felt that the registrant raised her previous history of

substance abuse unnecessarily often. The patient also testified that she felt uncomfortable and confused about the number of PAP smears the registrant performed.

The prenatal appointment

The patient's account of the events

[27] On learning in August 2022 that she was pregnant again, the patient made an appointment to see the registrant for a prenatal assessment, in September. She brought her two-year old son with her, as she did to all her appointments with the registrant. The patient testified that she was wearing light gray sweatpants and lace-up shoes that day.

[28] The patient recalls the registrant asking her if she would like to hear the baby's heartbeat with a Doppler (an ultrasound device), to which she readily agreed. She testified that she has had numerous Doppler exams before, while at the high-risk pregnancy clinic with her first son. She expected that she would lay on the exam table, pull her pants to the top of her pubic bone area, get gel on her abdomen and have the machine go over her belly to hear the heartbeat. She stated that she had no expectation that her genitals would be exposed.

[29] The patient stated that she placed her son on a chair by the computer table and gave him her phone. She lay down on the exam table and pulled her pants down to the top of her pubic bone. She testified that the registrant asked her to pull the pants down further and she inched them down a little. In her evidence, the registrant then pulled the waistband of her pants, including her underwear, down to her thighs.

[30] The patient stated that at this point, she was "fully exposed." When asked to clarify what she meant by "fully exposed," the patient stated that her vagina was fully exposed. She stated that she was confused and felt sick and embarrassed. The registrant found the baby's heartbeat, which she was glad to hear, but she still felt really embarrassed and stated that she found it hard to get out her mind that she was fully exposed.

[31] The patient testified that the registrant started asking her questions about her vaginal health, such as odours or discharge, to which she responded she had no concerns. She stated that the registrant told her he would take a look. The patient stated that she did not remember whether it was the registrant or her who pulled her pants

further down but that they ended up at her ankles because he asked her to do “froggy legs,” which she understood to mean feet together and knees to each side.

[32] In her evidence, the registrant put on gloves and proceeded to touch her genital area. She remembers feeling light touching on her labia and that the registrant asked if she had pain. The patient testified that none of the touching by the registrant felt sexual in nature. The patient testified that the registrant told her it looked okay and she then sat up. He gave her something to wipe off the gel and she pulled up her pants.

[33] The patient testified that at this point she had a “list” of things she wanted to ask the registrant. She told him about her acne and he asked her to remove her face mask and inspected her face. The registrant gave her 3 boxes of sample acne cream.

[34] The patient then told him about experiencing back and neck pain. The patient testified that she was standing and fully clothed and the registrant started going down her spine with his fingers, starting at her neck. As the registrant went down her spine, lifting then pressing, he asked if it hurt and she answered yes or no. The patient testified that she understood the purpose of the touching was for the registrant to get an understanding of where she was feeling pain.

[35] She states that when the registrant reached her lower back, she spoke up and told him “not down there” or “not lower,” but he continued to press lower on her back until he reached the tailbone. The patient stated that she repeated herself two or three times, after which the registrant stopped what he was doing. Although in some of her testimony the patient seemed to suggest that the registrant’s fingers went into her “bum crack,” she clarified that his fingers did not go between the bum cheeks and stopped at the tailbone.

[36] The patient stated that she felt like the registrant was “not listening” to her when she told him “no, not there.” After he finished, he did not say anything about the exam apart from telling her to be careful about seeing a chiropractor.

[37] The patient testified that, after this, the registrant asked her if there were any changes with her breasts, whether they were sore, whether her nipples had changed size or colour and whether she had any lesions, to which she replied no. She testified that the registrant started to use his fingers to poke or push the sides of her breasts, while asking if they were sore. The patient stated she was wearing a shirt and bra. The

bra was a stretchy nursing bra without any foam inserts. She testified that the registrant pushed on the breast tissue around her breasts, between the nipple and rib cage, applying medium to light pressure. He did not touch her nipples.

[38] The patient did not recall the registrant giving any opinion or diagnosis about her breasts. She states that the registrant went back to his computer and she collected her bag and son and left the room, thanking the registrant. She does not remember any discussion about the next steps.

The registrant's account of the events

[39] The registrant's notes of this visit are contained in standard form perinatal records issued by the Ontario Ministry of Health and Long-Term Care titled "Ontario Perinatal Record 1", "Ontario Perinatal Record 2" and "Ontario Perinatal Record 3" (Records 1, 2 and 3). Record 1 contains information about the patient's medical history, including yes/no answers to fifty-three questions covering areas including medical history, family history, and mental health/substance abuse. It has an area for comments which, in the case of this patient, was left blank. Record 2 contains information, among other things, about whether certain physical examinations were conducted during the appointment, and the results of lab tests. Record 3 contains other information including the fetal heartrate (obtained through the Doppler) and fundal height, which measures fetal growth.

[40] The registrant testified that when a patient arrives for a prenatal appointment, a nurse greets her and asks for a urine sample. The nurse will weigh the patient and then bring her into the examination room and take the patient's blood pressure. The nurse then processes the urine sample and inputs the patient's data into the perinatal records.

[41] The registrant begins the prenatal visit by going through the Medical History portion of Record 1 with the patient. The patient is usually seated fully clothed at a chair next to a desk, on which is a computer screen. The registrant testified that he usually shows the form to his patients on his computer screen and apologizes for the number of questions he will be taking them through.

[42] The patient did not recall being asked any questions at the beginning of the visit but did not dispute that this happened. The registrant testified about how he would cover some of the questions, based on his practices. He stated that, in relation to Question 16

(breast), he would ask the patient whether she had lumps, bumps, lesions or changes in colour. Under Question 17 (gynecological), he would ask whether the patient had vaginal discharge, pain, bleeding, lesions or pain with sex. Among the questions are those relating to anxiety, depression, substance abuse and intimate partner violence. Most of the fifty-three questions in Record 1 are answered “no.”

[43] The registrant testified that after this part of the appointment he would then examine the patient. Under the heading “Exam As Indicated,” Record 2 contains a list of six types of exams plus “other.” The six exams are: head and neck, breast/nipples, heart/lungs, abdomen, MSK, and pelvic. The perinatal record shows which exams were done by indicating “normal” beside them. The registrant testified (and this is consistent with the information on the perinatal record) that he always performs a head and neck, heart/lung and abdomen exam. He testified that he does not typically perform a “MSK” (musculoskeletal) exam unless the patient has a specific issue. In this case, MSK indicates “normal,” suggesting that this exam was done. The registrant and the patient do not disagree that he examined her spine during this appointment.

[44] The perinatal record also shows “normal” beside breast/nipples, indicating that the registrant examined her breasts. The registrant testified that he does not perform a full clinical exam of the breast/nipples unless there is a reason. However, if a patient has risk factors for self harm, it is his practice to conduct a visual inspection of the breasts. He testified that, because of this patient’s history, he believes he conducted a visual inspection of her breasts.

[45] Record 2 does not indicate that a pelvic exam was conducted. The registrant testified that he only performs a pelvic exam during a prenatal visit if the patient presents with specific issues. In this case, based on the absence of any indication of gynecological issues and the absence of a record of a pelvic exam being performed, he states he did not conduct a pelvic exam. The registrant denies touching the patient’s genitals during this appointment.

[46] Based on the information in the perinatal records, the registrant states that he would have done a fundal height measurement and taken the fetal heartrate with the Doppler. In his evidence, taking the measurement of the fundal height required him to palpate the top of the pubic bone and uterus. The patient would have been lying on the table with her pants and underwear lowered and legs together. He states that while the

pubic area may be exposed, the genitals are not. This was the case for both the fundal height measurement and the Doppler.

[47] The records do not state whether the patient was disrobed and wore a gown during the appointment, or whether a chaperone was present. It does not appear from the patient's chart that it was part of the registrant's practice to record these details. The registrant maintains that his usual practice would have been to give the patient a gown if he was doing a visual examination of their breasts and an examination of the spine. He does not have a specific memory about whether the patient was in a gown at this appointment. He does not recall whether a chaperone was present but he does not believe so.

[48] The registrant remembers the patient complaining of back pain and examining her spine. He states that this stood out because he does not normally examine a patient's spine during a prenatal appointment and because he has specialized training in orthopedic medicine.

[49] The registrant testified that he would have explained to the patient that he was going to palpate each part of the spine, working from the neck down and asking if it hurt at each step. He testified that he would palpate down to the lumbar sacral junction, where the lumbar meets the sacrum. This type of exam would be done while the patient is seated on the exam table. The registrant also states that if the patient had told him "not lower," he would have immediately stopped.

Reconciling the evidence

<u>The registrant examined the patient's breasts</u>

[50] We conclude on the evidence that the registrant performed a cursory, physical examination of the patient's breasts, through her clothing. We do not find reliable the registrant's explanation that he conducted a visual inspection only.

[51] To begin with, we find that the patient was not in a gown during this appointment. We accept the patient's evidence that she spoke to the registrant about her back and neck pain towards the end of the appointment, after the Doppler. In the context of the purpose of the visit, which was a prenatal appointment, we find it likely that the patient thought to mention her other issues after the prenatal assessment had been done. She first spoke to the registrant about her acne and after that, her back and neck pain.

[52] Thus, by the time the patient raised this issue, it was late in an appointment which had already covered a question-and-answer session and several exams. We find it more likely than not that the registrant decided not to give the patient time to disrobe and put on a gown and decided to examine her spine through her clothing. We also find it more likely than not that the registrant then proceeded to conduct a cursory physical exam of the patient's breasts, also through her clothing.

[53] In arriving at this conclusion, we find the patient's evidence about the touching of her breasts to be credible and reliable. She was clear and vivid in her description of how the registrant poked and pushed her breast tissue, through her clothing. Her testimony about the questions the registrant asked just before or while touching around her breasts (whether they were sore or had changed, whether the nipples had changed size or colour and whether she had lesions) is consistent with the types of questions or concerns about general breast health that the registrant and Dr. Tobin describe as part of a prenatal appointment. Her description of the "poking" and "pushing" around her breasts is consistent with palpations of breast tissue during a breast exam.

[54] The patient's accounts of this episode have varied between recalling specifically that the registrant touched her right breast, to referring to touching of her "breasts." The mandatory report from her psychologist, which is the earliest description of the patient's concerns and which she agreed is accurate, states that the registrant touched her "breasts" (see below for a description of this report). Ultimately, in her evidence, the patient acknowledged that she does not remember if the registrant touched only one breast or both. Given the number of times the patient consistently referred to the touching of her "breasts," we conclude it is more likely than not that the registrant palpated around both of her breasts.

[55] We considered whether the patient may have confused a cardiac exam, using a stethoscope, with the breast exam, and find this unlikely. Although a cardiac exam would also involve pressing around the chest area, the patient has been examined with a stethoscope before (as shown in her medical records). This would not have "alarmed" her (the patient's word). The patient testified that she had never had a breast exam before this appointment. Given this, we find it likely that this would stand out in her memory. It lends her avowed surprise and discomfort an air of genuineness.

[56] We also considered whether our finding below that the patient's evidence about the touching of her genitals is unreliable affects our assessment of her evidence about the breast exam. We conclude, for reasons explained below, that it does not.

[57] Finally, the patient's evidence that the registrant touched her breasts is consistent with the entry on Record 2 indicating that the registrant conducted a breast exam. We find that the record is accurate in recording a breast exam, but do not accept the registrant's explanation that the breast exam indicated was a visual inspection only.

[58] The registrant's evidence about his practices in this area was inconsistent. The registrant testified that during a prenatal exam, it is not his standard practice to examine the patient's breasts. However, depending on the circumstances, he might perform one of two different types of breast exams, a clinical exam or a visual exam. If a patient reported symptoms, such as discharges or lumps, he would conduct a clinical breast exam with the patient disrobed. This would involve palpation around both breasts and the lymph nodes. For other patients, he might conduct a visual inspection only.

[59] In his examination-in-chief, the registrant stated that it was his practice to conduct a visual exam of a patient's breasts during a prenatal appointment if the patient presented with multiple risk factors for self-harm, such as a history of substance abuse, mental disorders or financial issues. He referred to this patient's history as containing factors which would have led him to perform a visual inspection of her breasts. However, during cross-examination, the registrant testified that it would not be his standard practice to conduct a visual inspection of a patient's breasts even with a history of substance abuse and mental health issues, unless he had another reason.

[60] The registrant hypothesized that the patient may have said something that caused him to inspect her breasts during this appointment for signs of self-harm. He readily acknowledged that he was speculating, in the absence of any recollection of these events, seeking an explanation for why he conducted a visual inspection.

[61] The registrant's evidence at the hearing was inconsistent with responses he gave to the College during its investigation, in which he stated that his practice is to conduct a visual inspection of a patient's breasts to check for "scars or lesions" and, where the patient has a history of substance abuse coupled with anxiety and depression, to check for signs of self-harm. This response suggests, contrary to the above, that he routinely conducts visual inspections of patients' breasts as part of a prenatal assessment.

[62] The registrant testified that during his residency, he treated many high-risk patients. One woman engaged in self-harm, including to her breasts, with negative outcomes. In his evidence, after dealing with a situation with such tragic consequences, he promised himself to remain more vigilant in the future.

[63] Given the inconsistencies in the registrant's evidence about his usual practices, we find it unreliable in determining what kind of breast exam occurred at this appointment. We do not suggest that the registrant is being less than candid about the events. He acknowledges that he cannot remember what occurred. We find, however, that in searching for an explanation for the type of breast exam he believed he conducted, his evidence belonged more in the realm of speculation than a reliable account of his standard practices.

[64] For these reasons, we do not find reliable the registrant's evidence that he conducted a visual inspection of the patient's breasts. We conclude that where the perinatal records state that he conducted a breast exam, it is more likely than not that it was a physical exam, as described by the patient. This also accords with Dr. Tobin's testimony that when he sees such an entry on Record 2, he assumes that the physician conducted a full breast exam including a manual exam.

The registrant's breast exam did not meet the standard of practice

[65] The "standard of practice" is the standard which is reasonably expected of the ordinary, competent practitioner in the member's field of practice. Expert evidence is generally required in order to establish the relevant standard of practice of the profession (*Hanif v. College of Veterinarians of Ontario*, 2017 ONSC 497). The College relied on the evidence of Dr. Tobin in alleging that the registrant's conduct failed to meet the standard of practice when conducting prenatal examinations.

[66] Dr. Tobin reviewed the patient's clinical records and the patient and registrant's written accounts (including the transcript of the patient's interview). He provided an initial written opinion and two addenda that answered additional questions from the College. He also gave testimony at the hearing.

[67] In his written opinion and first addendum, Dr. Tobin did not give the opinion that the registrant's examination of the patient's breasts failed to meet the standard of practice, even based on the patient's version of the events. He wrote that the registrant

met the standard of practice, noting that the registrant asked the patient about possible breast concerns, including lesions or sores, and performed a physical examination of her breasts. In his second addendum report, Dr. Tobin concluded that the registrant's examination of the patient, if it occurred as the patient described, did not meet the standard of practice, because it was done while she was fully clothed and standing. He referred to medical teaching resources which recommend examining breasts while the patient is sitting and lying down and disrobed.

[68] During his oral testimony, Dr. Tobin gave his opinion that, based on the patient's account of how the registrant palpated around her breasts, the registrant's conduct failed to meet the standard of practice. He described the standard manner of performing a breast exam, including using a gown, palpating the breast tissue, examining for asymmetry and puckering of the nipples, having the patient raise her arms and conducting part of the exam while the patient is lying down on the examination table. Dr. Tobin's opinion was that an examination of a patient who is not disrobed could result in missed findings.

[69] Dr. Tobin testified that the practice with respect to breast exams during a prenatal appointment has changed. He stated that, whereas in the past, it was routine to do a complete head to toe examination, including of the breasts and pelvis (including an internal and bimanual examination), breast exams are now not performed unless there is a reason for concern. He stated that he does not perform a breast exam if there is no reason; however, he also stated that "other doctors" may perform a breast exam. He testified that while many doctors do not conduct a breast exam during a prenatal appointment, it is "up to the discretion of the physician."

[70] We accept Dr. Tobin's assessment and find that the registrant's examination of the patient's breasts through her clothing and while she was standing did not meet the standard of practice of the profession. His evidence does not establish that there was no clinical indication for a breast exam; however, the way it was done was deficient.

[71] The College urged us to find that the registrant touched the patient's breasts without consent. Dr. Tobin did not address this in his report or his oral testimony, despite forming the opinion that, in the patient's version of events, other exams were conducted without adequate consent.

[72] The patient testified that she did not expect the registrant to touch her breasts, and he did not ask her if he could but stated that he "may have" told her he was going to. As we describe above, the registrant has almost no recollection of the appointment, relying on his usual practices and the notes of the appointment. In his evidence, he performs physical exams of patients after explaining what he is going to do and obtaining consent.

[73] The patient's testimony about her reactions of discomfort during and following the exam was credible. She likely would not have had the same reactions of discomfort if the registrant had adequately explained the purpose of the exam. We find it likely that the registrant indicated to some degree what he intended to do but his explanation was not adequate and he did not obtain her informed consent. Given the sensitivity of the breast area, it was incumbent on the registrant to ensure that his explanation of the purpose and scope of the breast exam was clear and detailed. The registrant's failure to do so was a failure to meet the standards of practice of the profession.

The registrant's breast exam did not constitute sexual abuse

[74] "Sexual abuse" of a patient is defined in s. 1(3) of the Heath Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c. 18 (Code), to include touching, of a sexual nature, of the patient by the registrant. The Code specifies that "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

[75] The Supreme Court of Canada in *R. v. Chase*, [1987] 2 SCR 293 at para. 11, found that whether conduct is "sexual in nature" is assessed on an objective standard, by asking whether

> 'viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer'…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, including threats which may or may not be accompanied by force, will be relevant.

[76] To establish that conduct by a physician is "sexual in nature," the College must prove that an objective observer would conclude that the complainant's sexual integrity

was violated, regardless of the registrant's intention: *College of Physicians and Surgeons of Ontario v. Peirovy*, 2018 ONCA 420 at paras. 16-19 and 50.

[77] We recognize that the breasts are an intimate and sensitive part of a person's body and unwanted touching of an individual's breasts will certainly give rise to serious questions. However, in all the circumstances, including the nature of the contact, the situation in which it occurred and the words accompanying the touching, we conclude that the way in which the registrant examined the patient's breasts did not amount to touching of a sexual nature.

[78] In this case, even in the patient's version of the events, the nature of the touching was not obviously sexual. The "poking" and "pushing" she described are like the kind of palpations applied in a standard breast exam. The registrant touched her body through her clothing and did not touch her nipples. Crucially, the patient testified that the registrant's touch felt "clinical" and not sexual.

[79] The circumstances are very different from those in *Chase*, in which the accused entered the home of the complainant, a fifteen-year-old girl, without invitation, seized her around the shoulders and arms and grabbed her breasts. When she fought back, he said: "Come on dear, don't hit me, I know you want it." They are also different from those in *Peirovy*, in which the registrant cupped patients' breasts and deliberately touched their nipples, including placing a stethoscope directly on the nipples and tweaking them.

[80] Based on the patient's account of the exam, Dr. Tobin formed the opinion that, in asking the patient about any possible breast concerns, including lesions and sores, and performing a physical exam of her breasts, the registrant met the standard of practice in the context of a perinatal assessment. In his opinion, the way in which the registrant failed to meet the standard of practice was in performing the exam while the patient was standing and fully clothed. His opinion did not establish, on a balance of probabilities, the absence of any clinical indication for a breast exam as part of a perinatal assessment.

[81] We have no evidence of any sexual motivation on the part of the registrant. Like the patient's view that the touching was clinical and not sexual, this is not a definitive factor. Our finding above that the registrant failed to obtain informed consent for the breast exam is also a factor we considered but did not find definitive. Taking all the

circumstances into account, we conclude that the College has not established that the touching was of a sexual nature.

The examination of the patient's spine did not meet the standard of practice

[82] Some parts of the patient's and registrant's testimony about this exam cannot be reconciled. We explained above why we believe the patient's testimony that she remained fully clothed during the whole appointment. The examination of the patient's spine occurred towards the end of a fairly lengthy session (involving a detailed questionnaire, other physical exams and use of the Doppler). We find it more likely than not that when the patient mentioned her back and neck pain, almost as an afterthought and without any expectation of going through a physical exam, the registrant decided to perform the exam without using additional time for disrobing and gowning.

[83] We also conclude that at some point in the palpation of her spine, the patient told the registrant "not lower" and he continued to palpate lower. The registrant's exam of the patient's spine had a medical basis, because of her complaint of back and neck pain. However, we accept her evidence that during the examination she tried to tell him to stop going lower down her spine and he did not listen. The patient did not feel that the touching was sexual, but she did not feel heard. Her testimony about feeling confusion mixed with a bit of annoyance is consistent with the scenario she describes.

[84] We do not disregard the registrant's evidence as to the customary way he performs this type of assessment. In his evidence, he would not have deliberately continued to palpate lower on the patient's spine contrary to a clear objection. We find it possible that the registrant interpreted the patient's statements "not lower" to be part of the "yes" and "no" responses to his questions about whether she was feeling pain as he moved down her spine.

[85] On balance, we find that while the patient did not use the word "stop," her words conveyed to him and should have been interpreted by him to mean that she did not wish him to continue. The registrant should have listened more carefully to the patient's expression of her wishes, particularly as they concerned an exam that inched close to her sensitive areas.

[86] We find that the registrant's examination of the patient's spine did not meet the standard of practice in that he persisted in his examination despite her clear direction

that she did not wish him to continue lower on her spine. The College did not argue, and we do not conclude that the way the registrant examined the patient's spine amounted to sexual abuse.

The registrant did not touch the patient's genitals during the prenatal appointment

[87] We find the College has not proven on a balance of probabilities the allegation that the registrant touched the patient's genitals in a sexual manner, in that we find the patient's evidence insufficiently reliable to establish that a pelvic exam occurred.

[88] To begin with, the patient's oral testimony is inconsistent with previous statements. A few months after this appointment, the patient told her psychologist about the events during the prenatal appointment, which resulted in the psychologist submitting a report to the College as required by the Code. The relevant portions of this report states:

> [The patient] described that her doctor who regularly made her feel uncomfortable, had clearly crossed some lines in their appointment late September (when she was about 11 weeks pregnant). She had a check up and her young toddler son… was present as she is a stay at home mother. He offered to do a doppler to check the baby and she accepted. She described the following chain of events, documented a such in my notes:
>
> -doppler, pulled pants down and exposed her
>
> -looked at vagina
>
> -changed to asking about breasts: asked about nipples, asked if she has lesions? Touched her breasts
>
> -touched her back, asked about her back pain and touched lower down her back. [The patient] said, "no, not down there" as he went lower and lower. She felt sick. It sounded like the whole experience felt very escalated from past feelings of discomfort.
>
> She was able to end the examination. She left, knowing that there was no medical reason for many of these examinations. I affirmed that doctors are supposed to be very careful not to expose any area needlessly, usually tucking in a sheet around underwear etc and talking through any movements or invasive tests.

[89] The patient confirmed that this report is accurate. The College contacted the patient after receiving the mandatory report. In the initial phone call with the College

investigator, summarized in the investigator's notes, the patient stated that the registrant asked if she wanted a Doppler to listen to her baby's heartbeat and that she didn't expect him to pull her pants down and expose her. She also stated that the registrant asked about and touched her breasts. She also expressed concerns about the number of PAP smears the registrant conducted on her.

[90] In the patient's email to the College, confirming that she wished to proceed with the complaint, she explained that she wanted to complain because she felt very exposed during the process of using the Doppler and that some of the questions and exams that day were not expected or necessary, in her opinion. She stated that she felt very uncomfortable during the appointment.

[91] Following a recorded interview with the patient, the College summarized her concerns in February 2024 to include the examinations he conducted during the prenatal appointment and the fact of his performing repeated PAP smears while she was his patient. The patient confirmed to the College that this was an accurate summary.

[92] Thus, in her initial accounts of her concerns, the patient did not make any reference to the touching of her labia. The mandatory report states that *during* the Doppler, the registrant pulled her pants down and exposed her and that he "looked" at her vagina. During the patient's initial phone call with the College's investigator, she alleges unnecessary exposure, but no touching.

[93] The reference to "looked at vagina" is consistent with the patient's evidence at the hearing in which she stated that her vagina became "fully exposed" when the registrant pulled her pants below her hips in preparation for the Doppler exam, and she felt sick and embarrassed about it. From her evidence, the patient seemed to be under the impression that her vagina was visible during the Doppler exam, while she was lying on the exam table with her legs together and pants below her hips. This suggests that when the mandatory report states that the registrant "looked" at her vagina, it refers to this exposure during the Doppler exam. From this, we conclude that the patient's distress, as conveyed by the mandatory report, resulted from the unexpected degree of exposure during the Doppler.

[94] In contrast to the bare reference to "looking" at her vagina, the mandatory report describes in some detail how the registrant touched the patient's back. In cross-examination, when asked about the phrase "looked at vagina," the patient stated that "I

suppose I left out the touching, I didn't specify." The patient stated that she felt the mandatory report relayed her concerns well.

[95] During re-examination, College counsel asked the patient about her understanding of the phrase "looked at" in that report. The patient stated that she meant "looking and touching, examining it." We give this answer little weight. At this point in the hearing, the patient was aware that registrant believed the wording of the mandatory report to be a significant issue and in the circumstances, we find the question leading.

[96] The patient acknowledged that it was hard to differentiate between some of her appointments with the registrant. While she initially stated she was referring to the ones that did not involve invasive procedures, she agreed that she was mistaken, in one instance, about an invasive procedure having been performed by the registrant and not another physician. We find it possible that, in reflecting on the events of the prenatal appointment as well as her overall history with the registrant, the patient conflated the touching of her labia while she was in the "froggy" position during the prenatal appointment with a previous appointment.

[97] During at least four prior appointments, the registrant performed procedures which involved touching the patient's labia. As described above, during one of these, the registrant examined her genital area while she was in a froggy leg position. The patient did not recall ever using the froggy leg position apart from the prenatal appointment. It is possible that if she remembers being in this position only once, she was remembering the previous appointment.

[98] We also find it likely that the questions the patient remembers the registrant asking about her vaginal health occurred earlier, during the question-and-answer portion of the appointment. The registrant testified that it is his practice to show patients the form, apologizing for the lengthy list of questions, then go through them. In relation to gynecological concerns, he stated that he would ask patients whether they had vaginal discharge, pain, bleeding, lesions or pain with sex. The patient does not remember the question-and-answer session but when shown the form ultimately did not dispute that the registrant went through these questions with her.

[99] We also find that some gaps in the patient's memory about what happened during this appointment influence our assessment of the reliability of her testimony. She was adamant that the registrant did not take a fundal height measurement. The perinatal

records indicate that the registrant measured the fundal height and we were given no reason to doubt the accuracy of this information.

[100] The patient was also adamant that the registrant did not conduct exams of her head/neck and abdomen, both of which are recorded in the perinatal records. Again, we were given no reason to doubt the accuracy of this information and the registrant's evidence about his usual practice.

[101] We find credible and reliable the registrant's evidence that he did not conduct a pelvic exam. The registrant's evidence on this issue is based on his standard practices and the perinatal records, which indicate that he did not conduct a pelvic exam. The registrant testified as to his practice of making notes either during appointments or immediately after, which we accept. Despite lengthy cross-examination, we were given no good reason to doubt the accuracy of his medical records in general, or the perinatal records specifically. As a contemporaneous record of what occurred during the prenatal appointment, we give significant weight to the information in Perinatal Records 1, 2 and 3. While there were minor discrepancies in his records, such as the date of the last appointment, these are to be expected and were peripheral to the issues before us.

[102] We recognize that a registrant is unlikely to record events which may prove allegations of misconduct against them. In this case, the perinatal records indicate that the registrant conducted a breast exam and did not conduct a pelvic exam. If he was motivated to avoid documenting touching of the patient's sensitive areas, we query why he would have recorded one type of exam and not the other.

[103] Both the registrant and the patient testified about many previous exams or procedures of the patient's pelvic region in which the patient was gowned and a nurse was present. The registrant's practices with respect to examinations of this patient's sensitive areas were consistent and longstanding. Not only were the practices consistent, but each examination was documented in the records. Above, we described our reservations about the reliability of the registrant's evidence on other issues. We did not find the registrant dishonest. Instead, our conclusions were based on our unwillingness to give weight to the registrant's speculations about what may have occurred during an appointment about which he had very little memory. We do not have reason to find that the registrant deliberately withheld from the medical records the fact

that he conducted a pelvic exam without a clinical basis and in a manner that departed so strikingly from his standard practices.

[104] We recognize the contrast between our findings about the breast exam (in which we accept the patient's evidence) and the pelvic exam (in which we accept the registrant's evidence). Each witness' evidence bears flaws and inconsistencies. Neither gives a wholly reliable account. In reconstructing what we believe occurred we have regard to the likely course of the appointment, based on the matters covered in the perinatal records and the areas where the witnesses do not disagree. We considered the consistency of their evidence with objective facts and common sense, the potential for human frailties to affect the reliability of the evidence and internal and external inconsistencies in their evidence.

[105] Our ultimate conclusion that the patient's account of the genital touching was unreliable does not detract from her evidence about the breast exam. We find it plausible that she would remember the breast exam clearly because the registrant had never performed one on her before this. In contrast, the registrant had conducted a number of procedures and examinations of her pelvic region, including one in which she was in the "froggy" position.

[106] Likewise, our conclusion that the registrant's evidence about the breast exam is unreliable does not lead us to reject all his evidence. As we stated above, we found the registrant's evidence about the breast exam to be based on speculation rather than a reliable account of his practices. In contrast, his evidence about his standard practices when conducting pelvic exams was credible and reliable and supported by the patient. That evidence supports the conclusion that he did not conduct a pelvic exam during this appointment. Among other things, we find it unlikely that the registrant would have examined the patient's genitals without a chaperone present and failed to document the exam.

[107] We recognize that evidence about a registrant's usual practices may not be compelling where a patient has specific, cogent evidence about departures from those practices. However, in this case, we do not find the patient's evidence sufficiently clear and cogent to outweigh the registrant's evidence.

[108] In arriving at our conclusions, we are also mindful of the myths and stereotypes about victims of sexual abuse that can lead to faulty reasoning. We agree with the

principle expressed by the Supreme Court of Canada, in *R. v. D.D.*, 2000 SCC 43 at para. 65, that “there is no inviolable rule on how people who are the victims of trauma like a sexual assault will behave” and a delay in disclosure, standing alone, does not give rise to an adverse inference against the credibility of a complainant.

[109] In this case, it is not simply the delay in raising the allegation that the registrant touched her labia that leads us to find this evidence insufficiently unreliable. It is the whole context, including the prior appointment where a similar examination was performed, and the perinatal records, which we find to be reliable.

Disgraceful, dishonourable and unprofessional conduct

[110] Under s. 1(1)33 of Ontario Regulation 856/93 under the *Medicine Act,* 1991, SO 1991, c. 30, an act of professional misconduct includes 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. Disgraceful, dishonourable or unprofessional conduct is often referred to as a broad catch-all provision and is intended to capture any improper misconduct that is not caught by the wording of the specific definitions of professional misconduct. The conduct does not have to be dishonest or immoral to fall within the definition. A serious or persistent disregard for one’s professional obligations is sufficient (*College of Physicians and Surgeons of Ontario v. Khulbe*, 2025 ONPSDT 23, at para. 36).

[111] We find the registrant’s conduct in performing a substandard breast exam of the patient without adequate consent to be an act that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. We are satisfied that his conduct showed a serious disregard for his professional obligations. If there was a clinical indication for performing a breast exam, the way he conducted the exam risked (as per Dr. Tobin’s opinion) missing important findings.

[112] The registrant failed to adequately communicate with the patient, leaving her uncertain and confused. While we acknowledge that some patients may feel confused even if a physician ‘does everything right,’ we find that the degree of confusion and consternation the patient experienced means that the registrant did not take enough steps to explain what he was going to do and why and to ensure that he had her informed consent.

[113] The College did not argue that the manner in which the registrant conducted the spine exam was by itself an act that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and we make no finding in this regard.

Conclusion

[114] We find the registrant failed to maintain the standard of practice of the profession and engaged in conduct that members of the profession would reasonably regard as disgraceful, dishonourable or unprofessional. The College has not proven the allegations of sexual abuse.

[115] The Tribunal will schedule a hearing on penalty and costs.

OPSDT Ontario Physicians and Surgeons Discipline Tribunal

TDMCO Tribunal de discipline des médecins et chirurgiens de l'Ontario

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Bensimon,* 2026 ONPSDT 22
Date: June 3, 2026
Tribunal File No.: 24-028

BETWEEN:

College of Physicians and Surgeons of Ontario

College

- and -

Michael Aaron Bensimon

Registrant

PENALTY REASONS

Heard: April 23, 2026

Panel:
Sherry Liang (panel chair)
Vincent Georgie (public)
Joanne Nicholson (physician)
Rupa Patel (physician)
Linda Robbins (public)

Appearances:
Kenzie Bunting, for the College
Reema Zaia and Andrew McKenna, for the registrant

RESTRICTION ON PUBLICATION

Pursuant to Rule 2.2.2 of the HPDT Rules of Procedure and ss. 45-47 of the Health Professions Procedural Code, no one shall publish or broadcast the names of patients or any information that could identify patients or disclose patients' personal health information or health records referred to at a hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this restriction.

Introduction

[1] In our decision of March 2, 2026, we found that the registrant failed to maintain the standard of practice of the profession and that he engaged in conduct that members of the profession would reasonably regard as disgraceful, dishonourable or unprofessional during a prenatal appointment with a patient: *College of Physicians and Surgeons of Ontario v. Bensimon*, 2026 ONPSDT 7.

[2] At the hearing on penalty and costs, the parties provided us with a joint recommendation. We made an order in accordance with the joint recommendation and ordered the registrant to appear before the panel to be reprimanded. We also ordered the suspension of the registrant's certificate of registration for four months and imposed conditions on his certificate, including that he be required to have a practice monitor present whenever he conducts intimate examinations of patients for a minimum of two years. We directed the registrant to pay the College $26,740 in costs.

Background

[3] In our previous decision, we found that the registrant's examination of the patient's breasts through her clothing and while she was standing, as well as his failure to clearly explain the purpose and scope of the breast exam and obtain the patient's informed consent, failed to meet the standard of practice of the profession. We described the patient's feelings of surprise and discomfort at the unexpected touching of her breasts near the end of her prenatal appointment.

[4] We also found that the registrant's examination of the patient's spine did not meet the standard of practice in that he persisted in moving his hand down the patient's spine despite her clear direction that she did not wish him to continue lower. The registrant should have listened more carefully to the patient's expression of her wishes, particularly as they concerned an exam that inched close to her sensitive areas.

[5] The registrant's conduct showed a serious disregard for his professional obligations. Not only did the breast exam risk missing important findings, but he also failed during both exams to adequately communicate with the patient, leaving her uncertain and confused. We found that the degree of confusion and consternation the patient experienced means that the registrant did not take enough steps to explain what he was going to do and why, to ensure that he had her informed consent.

[6] We were not satisfied that the College proved its allegation of sexual abuse.

Joint recommendation

[7] The parties jointly recommend that the appropriate penalty be a direction that the registrant appear before the panel for a reprimand, that the registrant's certificate of registration be suspended for four months and that terms, conditions and limitations be placed on his certificate requiring him to take a course on ethics and boundaries and only perform intimate examinations of patients (including breast, pelvic, genital, perineal, perianal and rectal examinations of patients) in the presence of a practice monitor.

[8] The agreed terms also require the registrant to inform patients of this restriction on his practice and include provisions to support the College in monitoring his compliance with the restriction. The parties agree that after two years, the Registrar of the College should be authorized, in their sole discretion, to remove the restriction from the registrant's certificate.

[9] We are satisfied that the proposed penalty satisfies the principles of sanctioning, including public protection, general and specific deterrence and remediation. It also satisfies the principle of proportionality: that like cases be treated alike.

[10] The misconduct in this case is without a doubt serious. The registrant disregarded the comfort and wishes of a vulnerable young patient who had recently experienced a miscarriage and was early in the stages of a new pregnancy, providing inconsiderate and substandard care. His treatment of her demonstrated a lack of understanding of the power imbalance inherent in the physician-patient relationship and of his responsibility to be particularly attentive to consent and communication when touching sensitive areas of a patient's body.

[11] The registrant was the subject of complaints to the Collège des médecins du Québec, when he practised there in 2018, about his conduct of physical examinations. These resulted in advice from the syndic of the Collège that he pay particular attention to the professional standards that go along with performing a physical exam, especially as they pertain to maintaining the appropriate distance and explaining what he was going to do before conducting invasive or potentially unexpected exams.

[12] The College does not assert that the advice given by the Québec Collège amounts to a discipline history that can be considered an aggravating factor in our

assessment of penalty. It submits however, and we accept, that this demonstrates that the registrant was previously made aware of the importance of explaining what he is going to do before conducting invasive or potentially unexpected examinations. The fact that similar issues have been raised with the registrant in the past elevates the seriousness of the misconduct in this case, supporting a meaningful sanction and rehabilitation measures.

[13] The proposed penalty is proportionate, having regard to other cases. The parties referred us to decisions of this Tribunal concerning registrants who engaged in similar misconduct by engaging in unwanted touching of a patient's sensitive areas without adequate explanation or informed consent, and in a manner that caused distress to the patient (see *College of Physicians and Surgeons of Ontario v. Jolly*, 2026 ONPSDT 14; *College of Physicians and Surgeons of Ontario v. Wardle*, 2022 ONPSDT 4; *College of Physicians and Surgeons of Ontario v. Nahas*, 2020 ONCPSD 37; *College of Physicians and Surgeons of Ontario v. Noza*, 2019 ONCPSD 19; *College of Physicians and Surgeons of Ontario v. Heymans*, 2018 ONCPSD 57; *College of Physicians and Surgeons of Ontario v. Malette*, 2020 ONCPSD 2).

[14] In most cases we were given, the registrant admitted to the misconduct and agreed to a joint recommendation on penalty. The Tribunal ordered suspensions ranging from two to six months, in addition to terms, conditions and limitations on the registrant's certificate of registration. Some decisions resulted in a requirement that the registrant treat patients under the observation of a practice monitor. In *Heymans*, the Tribunal directed that a practice monitor be present for all professional encounters, while in *Malette*, the direction to have a practice monitor applied to certain intimate examinations.

[15] These cases demonstrate that the kind of misconduct the registrant engaged in is treated as a serious matter and results in a suspension, as well as, in some cases, ongoing monitoring of a registrant's practice. While each of the above decisions was based on its own set of unique facts, we conclude that the suspension proposed here is appropriate, given the range of penalties imposed for similar misconduct.

[16] The suspension and reprimand serve the goals of specific and general deterrence. The penalty reminds the registrant of the importance of treating patients with dignity and professionalism, engaging in clear communication and active listening and obtaining a patient's ongoing informed consent during treatment. General deterrence is

achieved by demonstrating to other registrants that maintaining professional standards and always being attentive to the power imbalance between themselves and their patients is essential to continuing to enjoy the privilege of practicing the profession.

[17] The terms, conditions and limitations imposed on the registrant's certificate of registration serve the purpose of remediation and ensure that the registrant will return to practice in keeping with the standards of practice of the profession. The requirement to practise under the observation of a practice monitor is a measured and reasonable rehabilitation measure, being restricted to intimate exams and with the possibility of an end date.

[18] Overall, the penalty shows the public that the College takes seriously its responsibility to govern the profession and enhances public confidence in the College's ability to protect the public.

[19] We do not accept the registrant's assertion that his agreement to a joint recommendation on penalty shows insight and remorse and can be viewed as a mitigating factor. Prior cases of this Tribunal treat a registrant's admission to misconduct or plea of no contest as a mitigating factor in assessing penalty, as it avoids the costs of conducting a full hearing and spares witnesses from the need to testify (see *College of Physicians and Surgeons of Ontario v. Fagbemigun*, 2022 ONPSDT 22 at para. 16). In this case, the registrant contested the allegations, and the Tribunal conducted a five-day hearing on the merits, in addition to a half-day motion and the penalty hearing. We see no reason to view the registrant's decision to agree to a joint recommendation on penalty, after that prolonged process, as a factor arguing in favour of a lesser penalty.

[20] Having regard to the relevant penalty principles as well as the caselaw, we are satisfied that the joint recommendation is the appropriate penalty. We are also satisfied that the proposed costs order, which takes into consideration the mixed result in this case, is appropriate.

Order

[21] We made the following order:

Penalty

1. The Tribunal requires the registrant to appear before the panel to be reprimanded.

2. The Tribunal directs the Registrar to:

    a. suspend the registrant's certificate of registration for four (4) months commencing May 15, 2026, at 12:01 a.m.;

    b. place the following terms, conditions and limitations on the registrant's certificate of registration effective April 24, 2026, at 12:01 a.m.:

        i. Dr. Bensimon will, at his own expense, participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without condition or qualification. Dr. Bensimon will complete the PROBE program within six (6) months of the date of this Order or, if it is not available within that timeframe, will complete it at the earliest available opportunity. Dr. Bensimon 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.

        ii. For a minimum of two (2) years, Dr. Bensimon shall not engage in any intimate examinations, which includes breast, pelvic, genital, perineal, perianal and rectal examinations of patients, ("Intimate Examination" or "Intimate Examinations"), with patients of any age, in any jurisdiction, unless the Intimate Examination takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College (the "Practice Monitor" or "Practice Monitors"), and unless the other requirements provided in this Order are fulfilled. For further clarity, Dr. Bensimon must not perform any Intimate Examinations, for any length of time, without the presence of a Practice Monitor. The Registrar of the College, in their sole discretion, is authorized to remove this restriction from Dr. Bensimon's certificate of registration after a minimum of two (2) years.

        iii. At all times, Dr. Bensimon shall ensure that a Practice Monitor shall:

            a) remain present at all times during all Intimate Examinations, in person or otherwise, with all patients;

            b) carefully observe all of Dr. Bensimon's Intimate Examinations with patients. It is Dr. Bensimon's obligation to ensure the Practice Monitor's view of

all of his Intimate Examinations with patients is unobstructed at all times;

c) refrain from performing any other functions, except those required in the Practice Monitor's undertaking attached as Appendix "A," while observing Dr. Bensimon in all of his Intimate Examinations with patients;

d) maintain a log of all Professional Encounters with patients in the form attached to this Order as Appendix "B" (the "Log") and in the manner described in Appendix "A";

e) initial all corresponding entries in the records of patients noted in the Log to confirm that the Practice Monitor was in Dr. Bensimon's presence at all times during the Intimate Examinations;

f) submit the original Log to the College on a monthly basis;

g) provide reports (as described in the Practice Monitor's undertaking) to the College on at least a monthly basis; and

h) remain free of any conflict of interest with Dr. Bensimon.

iv. Dr. Bensimon shall maintain a copy of the Log and make it available to the College on request.

Practice Location

v. Dr. Bensimon shall inform the College of each and every location at which he practises, delegates, or has privileges in any jurisdiction, including, but not limited to, any hospitals, clinics, offices, and any Out-of-Hospital Premises and Independent Health Facilities with which he is affiliated, in any jurisdiction (collectively his "Practice Location" or "Practice Locations"), within five (5) days of this Order. Going forward, he shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

vi. Dr. Bensimon shall post a sign in all waiting rooms, examination rooms and consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, at all times whether or not he is physically present at the Practice Location, in the form set out in Appendix "C" that states: "Dr. Bensimon must not perform intimate examinations, including breast, pelvic,

genital, perineal, perianal and rectal examinations of patients, of any age, unless in the continuous presence and under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Dr. Bensimon must not be alone during any intimate examinations with any patient. Further information may be found on the College website at www.cpso.on.ca."

vii. Dr. Bensimon shall post a certified translation in any language in which he provides services, of the sign described in paragraph 2(b)(vi) above, in all waiting rooms, examination rooms and consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, in the form set out at Appendix "C."

viii. Dr. Bensimon shall provide any certified translation(s) required by paragraph 2(b)(vii) above to the College within thirty (30) days of the date of this Order.

Notifying Patients

ix. Dr. Bensimon shall ensure that each patient with whom he has a Professional Encounter is directly notified, prior to the Professional Encounter, of the details of the restriction described in paragraph 2(b)(ii) above, in the presence of his Practice Monitor.

Monitoring of Compliance

x. Dr. Bensimon shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan ("OHIP") and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with the provisions of this Order, and Dr. Bensimon shall sign any consents requested by the College to obtain such information from these persons or institutions.

xi. Dr. Bensimon shall submit to and not interfere with unannounced inspections of his Practice Locations and to the inspection of patient charts by the College and to any other activity the College deems necessary in order to monitor his compliance with the provisions of this Order.

xii. Dr. Bensimon shall consent to the College providing any information to the Practice Monitor that the College deems necessary or desirable in order to assist the Practice Monitor in fulfilling their undertaking and in order to monitor Dr. Bensimon's compliance with this Order.

xiii. Dr. Bensimon shall consent to any Practice Monitor disclosing to the College, and to any other Practice Monitor, any information relevant to this Order, relevant to the terms of the Practice Monitor's undertaking and/or relevant for the purpose of monitoring Dr. Bensimon's compliance with this Order.

xiv. Dr. Bensimon shall consent to the College providing this Order to any Chief of Staff, or a colleague with similar responsibilities, at any Practice Location ("Chief of Staff" or "Chiefs of Staff"), and to providing any Chief(s) of Staff with any information the College has that has led to this Order and/or any information arising from the monitoring of his compliance with this Order.

Costs of Implementation

xv. Dr. Bensimon shall be responsible for any and all costs associated with implementing the terms of this Order.

Costs

3. The Tribunal requires the registrant to pay the College costs in the amount of $26,740 in two installments as follows: 50% of the costs amount by May 23, 2026 and the remaining 50% by November 30, 2026.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File No.: 24-028

BETWEEN:

College of Physicians and Surgeons of Ontario

College

- and -

Michael Aaron Bensimon

Registrant

The Tribunal delivered the following Reprimand by videoconference on Thursday, April 23, 2026

*****NOT AN OFFICIAL TRANSCRIPT*****

Dr. Bensimon,

We found that, during the course of a prenatal appointment, the way in which you examined Patient A's breasts fell below the standard of practice and constituted disgraceful, dishonorable or unprofessional conduct. Your examination of the patient's spine also failed to meet the standard of practice of the profession.

You performed a cursory and incomplete exam of the patient's breasts while she was fully clothed and standing without adequately explaining the purpose of the exam and obtaining her informed consent. Proper communication is particularly important when touching a sensitive area such as the breasts. When conducting the spinal exam, you persisted with palpating lower on the patient's spine contrary to her clear objection. In both exams, your failure to provide a clear explanation of what you were doing and why caused Patient A to feel uncomfortable, uncertain, and confused.

Your treatment of Patient A showed a lapse in professionalism and a breach of your responsibilities. You knew that she was especially vulnerable, given her recent and ongoing medical history, and it was incumbent on you to treat her with dignity and respect. The penalty we have ordered, consisting of a 4-month suspension, the requirement to have a practice monitor present for all intimate exams, and the completion of the PROBE ethics and boundaries course, is appropriate and necessary to address the seriousness and nature of your misconduct. During your suspension we expect you to reflect on your misconduct and be prepared to return to practice ensuring that you maintain professional standards at all times.