**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Henry, 2019 ONCPSD 41**

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

**IN THE MATTER OF** a Hearing directed by
the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

**B E T W E E N:**

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

**- and -**

**DR. RICHARD ANTHONY HENRY**

**PANEL MEMBERS:**

**DR. J. WATTERS**
**MS. C. TEBBUTT**
**DR. R. SHEPPARD**
**MR. M. KANJI**
**DR. D. HELLYER**

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

**MS. SIMMY DHAMRAIT**

**COUNSEL FOR DR. HENRY:**

**MR. A. MCKENNA**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MS. JENNIFER MCALEER**

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| **Hearing Date:** | **July 22, 2019** |
| **Decision Date:** | **July 22, 2019** |
| **Release of Reasons Date:** | **September 16, 2019** |

## DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on July 22, 2019. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

## THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Richard Anthony Henry committed an act of professional misconduct under:

(i) clause 51(1)(b.1) of the Health Professions Procedural Code which is schedule 2 to the Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (the "Code") in that he engaged in sexual abuse of a patient; and

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

## RESPONSE TO THE ALLEGATIONS

Dr. Henry admitted the second allegation in the Notice of Hearing, that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The College withdrew the first allegation in the Notice of Hearing.

## THE FACTS

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

## BACKGROUND

1. Dr. Richard Anthony Henry ("Dr. Henry") is a sixty-one (61) year-old anesthesiologist who currently practices in Kingston, Ontario. Dr. Henry received his certificate of registration authorizing independent practice in 1994.

2. In addition to his anesthesiology practice, Dr. Henry has provided care and treatment to patients for acute and chronic pain,

## A. PATIENT A: DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

3. Patient A was a patient of Dr. Henry's from 2009 to 2015.

4. In 2009, Patient A was referred to Dr. Henry for treatment of severe pelvic and hip pain. She initially saw Dr. Henry at the chronic pain clinic at St. Mary's of the Lake Hospital in Kingston. In 2011, the pain clinic was relocated to Hotel Dieu Hospital ("HDH"). From September 2011 to October 2015, Patient A saw Dr. Henry at the chronic pain clinic at HDH in Kingston,

5. Dr. Henry's treatment of Patient A included pelvic floor injections, and trigger point local anesthetic injections to various pain sites in her body. These treatments were very painful for Patient A and she sometimes expressed her pain by making loud noises during the appointments.

6. Over time, Dr. Henry became increasingly casual in his communications with Patient A. Dr. Henry and Patient A engaged in banter during the appointments which Patient A started to

find was inappropriate. As she required treatment for chronic pain, she continued to attend appointments with Dr. Henry.

7. On July 16, 2015, Patient A attended an appointment with Dr. Henry at the chronic pain clinic at HDH. During the appointment, Dr. Henry administered multiple trigger point injections into multiple pain sites in Patient A's body, including her neck, shoulder area, thighs, and calves. A sheet covered areas of her body that were not being injected. A female nurse chaperone was present during the appointment,

8. Patient A was sweating and felt overwhelmed by the injections. Patient A made loud guttural noises as a result of the pain she was experiencing.

9. Dr. Henry and the nurse chaperone were standing together near the treatment table. At some point after Patient A made loud noises, Dr. Henry turned to the nurse and made an inappropriate, unprofessional, and crude comment regarding the noises Patient A was making,

10. Dr. Henry states he was attempting to make light of the situation.

11. Patient A was shocked by Dr. Henry's comment and was very uncomfortable.

## B. ADMISSION

12. Dr. Henry admits the facts set out in paragraphs 1-11 above, and admits, for the purposes of the College proceedings, that he engaged in professional misconduct, in that:

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

## FINDING

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

found that he committed an act of professional misconduct in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

**PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order which included: suspending Dr. Henry's certificate of registration for a period of two months; a public reprimand; terms, conditions and limitations on Dr. Henry's certificate of registration including successful completion of the PROBE Ethics and Boundaries Program offered by the Centre for Personalized Education for Professionals, and payment of costs to the College in the amount of $6,000.00.

The Committee retains discretion to accept or reject a joint submission on penalty, but the Committee is aware that the threshold for rejecting a joint submission is high. As set out by the Supreme Court of Canada in *R. v. Anthony-Cook,* 2016 SCC 433, a joint submission must be accepted unless the jointly proposed penalty would bring the administration of justice into disrepute, or is otherwise contrary to the public interest.

It is incumbent on the Committee to impose a penalty which expresses the well-recognized guiding penalty principles. Protection of the public is the foremost consideration. The penalty imposed should also express the Committee's denunciation of the misconduct, be proportionate to the misconduct, and serve as a deterrent both to the member and to the membership as a whole. Further, the penalty should serve to maintain the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest. Where possible, the penalty should also address the rehabilitative needs of the member.

In deciding whether to accept the joint penalty proposed by the parties, the Committee carefully considered the nature of the misconduct as described in the Agreed Statement of Facts and Admission, the penalty principles referred to above, the aggravating and mitigating factors

discussed below, prior cases of this Committee which bore similarities to Dr. Henry's case and the fact that this was a joint submission.

**Aggravating Factors**

The fact that Patient A was a vulnerable chronic pain patient was an aggravating factor. Dr. Henry's crude and offensive comments regarding Patient A were inexcusable. Dr. Henry's actions reflect a very serious breach of his professional obligation to treat a vulnerable patient, who was in both physical and emotional distress, with sensitivity and respect. Dr. Henry's conduct had a lasting negative impact on his patient, disrupting the therapeutic alliance which had previously been established with her, subverting the course of her therapy, and leaving her with diminished feelings of trust towards health care providers.

**Mitigating Factors**

The Committee accepts as a mitigating factor that Dr. Henry admitted to his misconduct and has taken responsibility for his actions. This in turn reduced the duration of the hearing and spared the complainant the stress of having to testify. Further, Dr. Henry has no prior disciplinary history with the College, which is also a mitigating factor

**Prior Cases**

The Committee was provided with a Joint Book of Authorities containing prior decisions of this Committee: *CPSO v. Jones (2018), CPSO v. Choptiany (2011), CPSO v. Szozck (2019),* and *CPSO v. McInnis (2011).* The Committee is not bound by prior decisions of this Committee but accepts as a general principle that like cases should be treated alike.

While the Committee recognizes that prior decisions may be of assistance in determining an appropriate range of penalties, each case will have unique facts or circumstances which must be taken into account in determining the just and appropriate penalty. Having reviewed the cases provided, the Committee is satisfied that the jointly proposed penalty falls within the range

established by previous decisions of this Committee and is proportionate given the nature of the misconduct and the aggravating and mitigating factors.

**CONCLUSION**

The Committee finds that the jointly proposed penalty effectively expresses the principles of penalty referred to above. The suspension of Dr. Henry's certificate of registration, and the public reprimand, will serve to denounce Dr. Henry's wrongful conduct and send a clear message to him and to the profession and the public that this type of misconduct is unacceptable and will not be tolerated. Specific and general deterrence are thereby addressed, as is public confidence in the College's ability to regulate the profession in the public interest. Dr. Henry's completion of the PROBE Program in ethics and boundaries should also protect the public by minimizing the risk of recurrence.

**ORDER**

The Committee stated its finding in paragraph 1 of its written order of July 22, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

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

3. The Registrar suspend Dr. Henry's certificate of registration for a period of two (2) months, commencing immediately.

4. The Registrar place the following terms, conditions and limitations on Dr. Henry's certificate of registration:

    (i) Dr. Henry shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "A" to this Order; and

(ii) Dr. Henry will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Henry will complete the PROBE program within 6 months of the date of this Order, and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (I) month of completing it.

5. Dr. Henry pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

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

**TEXT of PUBLIC REPRIMAND**

**July 22, 2019**

**in the case of the**

**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**

**and**

**Dr. Richard Anthony Henry**

Dr. Henry,

The panel is deeply disturbed by the improper comments you made about a patient under your care, conduct that the profession would regard as disgraceful, dishonorable and unprofessional. Dr. Henry, you were in a position of power in respect of your patient and you allowed the proper boundaries in your relationship to become unclear. Then, with your comment, you violated the trust that she had in you and in the profession as a whole. Physicians must act with competence, respect, and in the patient's best interest. You breached the boundaries that are fundamental to a proper and effective professional relationship.

The panel is particularly troubled by the fact that your conduct affected a vulnerable patient who required ongoing treatment for chronic pain, treatment that was itself painful for her. She continued to see you for care even as she came to feel that your conversations were becoming inappropriate. She found your inappropriate, unprofessional and crude comment about her to be shocking and, understandably, it made her very uncomfortable. It has had a profound and lasting impact on her life and served to end what was a useful treating relationship for her, and has led her to have diminished trust in our profession in general.

The panel finds that your conduct was shameful and it will not be tolerated.

We trust that the PROBE course will assist you and that this experience and the penalty of a reprimand and suspension, will deter you from any such conduct in the future.