

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Mary Elizabeth McIntyre, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of patients under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

The Committee also made an order to prohibit publishing or broadcasting the names of the sexual misconduct witnesses under subsection 47(1) of the Code.

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

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

- (a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or
- (b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.
McIntyre, 2015 ONCPSD 25**

**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. MARY ELIZABETH MCINTYRE

PANEL MEMBERS:

**DR. W. KING (CHAIR)
D. GIAMPIETRI
DR. E. STANTON
S. BERI
DR. C. CLAPPERTON**

Hearing Dates:	February 2, 4 to 6, 17 to 18, 2015.
Decision Date:	July 6, 2015
Release of Written Reasons:	July 6, 2015

Penalty Hearing Date:	December 11, 2015
Penalty Decision Date:	March 22, 2016
Release of Written Reasons on Penalty:	March 22, 2016

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on February 2, 4 to 6 and February 17 to 18, 2015. At the conclusion of the hearing, the Committee reserved its finding.

ALLEGATIONS

The Notice of Hearing alleged that Dr. McIntyre committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that she has failed to maintain the standard of practice of the profession;
2. under clause 51(1)(b.1) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18, in that she has engaged in the sexual abuse of patients; and
3. under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

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

RESPONSE TO ALLEGATIONS

Dr. McIntyre admits the allegations in the Notice of Hearing, except for the allegation of sexual abuse of one patient, which she denies, and the alleged boundary violations with the patient that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, which she also denies.

The College withdrew the allegation of incompetence.

The Facts

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

PART I – FACTS

1. Dr. McIntyre is a 56 year-old family physician who practised at all material times as a sole practitioner in City 1, Ontario. The allegations arise from six public complaints received regarding her conduct, as well as a Registrar's investigation into her practice.

Conduct with respect to Patient A and her three children

2. Patient A and her three children were patients of Dr. McIntyre from 1990 until January 2011.

3. As a result of Dr. McIntyre ceasing to practise in 2011, Patient A and her three children suddenly had to find a new family doctor in their area. As a result, they required copies of their medical records. Patient A made multiple requests of Dr. McIntyre's office to provide a copy of her and her children's medical records, but none of these requests were answered.

4. Patient A was also concerned that Dr. McIntyre had failed to refer her to a psychiatrist, a rheumatologist, and a chronic fatigue specialist despite Dr. McIntyre's assurances to her that she would make these referrals in the Fall of 2010.

5. Patient A was also concerned about the safety and effectiveness of various immunizations that Dr. McIntyre had administered to her children, given that she had twice observed public health officials attend at Dr. McIntyre's office to remove boxes of expired and improperly stored vaccines.

6. The College received a letter of complaint from Patient A dated June 9, 2011. The College investigator notified Dr. McIntyre of Patient A's complaint on June 27, 2011 and asked her to provide the requested medical records and, if she wished to provide a

response, to do so by August 24, 2011. By October 7, 2011 the College had still not received any response from Dr. McIntyre, nor had the patients' medical records been provided. As a result, the investigator advised Dr. McIntyre that her failure to cooperate with the College could result in a referral of allegations of professional misconduct to the Discipline Committee.

7. By letter dated March 5, 2012, Dr. McIntyre's counsel advised the College that Dr. McIntyre's patient records were being held in a secure storage facility and gave instructions on how the records could be retrieved. Despite following those instructions, the investigator was still unable to obtain the requested records. At no time did Dr. McIntyre or a member of her office provide the patient, or the College, with a copy of the requested medical records.

8. During a concurrent investigation into Dr. McIntyre's practice under s. 75(1)(a) of the Health Professions Procedural Code, the College investigator completed a chart retrieval at Dr. McIntyre's storage facility. During this search, paper charts were retrieved for two of Patient A's children. The charts for Patient A and her other child were not located.

9. City 1 Public Health Unit confirmed to the College investigator that, as a result of Dr. McIntyre's ongoing failure to store vaccines safely at the proper temperature, officials at City 1 Public Health Unit had attended Dr. McIntyre's practice on four occasions between July and November 2010 and removed them. City 1 Public Health Unit ultimately suspended Dr. McIntyre's vaccine privileges on October 14, 2010. The letter from City 1 Public Health Unit dated October 18, 2010 is attached at Tab 1 [to the Agreed Statement of Facts and Admission].

10. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct and failed to maintain the standard of practice by: failing to respond appropriately to requests by the College and the patients for the patients' medical records, failing to appropriately maintain those records, improperly storing vaccines, not responding to the patient's care concerns and failing to appropriately make referrals for the patient.

Conduct with respect to Patient B and her son

11. By letter dated June 13, 2011, Mr. M, counsel for Patient B and her son, advised the College that he had been writing to his clients' family doctor, Dr. McIntyre, "for a couple of years" in an effort to obtain copies of his clients' medical records. Mr. M was representing Patient B and her son in a lawsuit relating to a motor vehicle accident in which they were involved, and for which he required their medical records. Dr. McIntyre had failed to provide the patients' records, or even to acknowledge the requests, and Mr. M was seeking the College's assistance in obtaining the records.

12. Mr. M had spoken with Dr. McIntyre's staff, communicated his requests in writing to Dr. McIntyre, and volunteered to pick up the records in person, photocopy them, and return them the same day. However, he never received a response from Dr. McIntyre or anyone on her behalf.

13. The College tried to assist Mr. M to obtain the patients' medical records from Dr. McIntyre. The College investigator notified Dr. McIntyre of the complaint on June 27, 2011 and asked for the records and any response to the complaint to be provided by August 24, 2011. By October 7, 2011, there was still no response to the complaint. The investigator advised Dr. McIntyre that her failure to co-operate with the College could result in a referral of allegations of professional misconduct to the Discipline Committee.

14. On March 5, 2012, Dr. McIntyre advised the College, through her counsel, that the patient records were being held in a secure storage facility. The College investigator followed Dr. McIntyre's instructions for retrieving the patient records by submitting a written faxed request to Dr. McIntyre's assistant. This was attempted on multiple occasions over the course of multiple days. On each occasion a message was received that the fax line was "busy" or there was a "poor connection." As a result, the records were not obtained.

15. The College investigator wrote to Dr. McIntyre, through her counsel, advising of the College's unsuccessful attempts to retrieve the patient charts, and giving Dr. McIntyre

one final opportunity to provide the records to the College by no later than April 13, 2012. The patient records were never provided.

16. During a chart retrieval in a concurrent s.75(1)(a) investigation, the College investigator searched the storage facility where Dr. McIntyre was keeping her patients' records, but was unable to locate records for Patient B or Patient B's son.

17. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct by failing to respond appropriately to requests by the College and the patients for the patients' medical records, and failing to appropriately maintain those records.

Conduct with respect to Patient C and her husband

18. On July 9, 2010, the College received a letter of complaint about Dr. McIntyre from Patient C, on behalf of herself and her husband. Their complaint related to their efforts to obtain their medical records from Dr. McIntyre and her failure to complete a form that Patient C's husband required for Veterans Affairs Canada in order to receive his pension. Dr. McIntyre had indicated three months earlier that she would send the form to Ottawa for him, but failed to do so.

19. Between July 2010 and December 2010, Patient C and an Advisor from the College's Physician Advisory Services made numerous attempts to contact Dr. McIntyre, her office, and Dr. McIntyre's counsel, to obtain the patients' medical records and to have the Veterans Affairs Canada form completed. None of these efforts was successful.

20. In September 2010, Patient C's husband attended a new family doctor and had him complete the Veterans Affairs Canada form "as best he could" given that, in the absence of his patient chart, the doctor did not have access to his medical history.

21. Finally, in December 2010, a formal complaint was opened and a College investigator took over the matter.

22. By letter dated May 13, 2011, the College investigator requested that Dr. McIntyre provide the records for Patient C's husband by no later than June 17, 2011.

23. Following the College investigator's advice that the matter was scheduled to be considered by the ICRC on July 4, 2011, counsel for Dr. McIntyre provided a partial copy of Patient C's husband's medical record on June 30, 2011, and advised that he would forward a copy of Patient C's medical records once he was in receipt of same. On October 7, 2011, the College investigator again requested the *complete* copy of both the records for Patient C and her husband.

24. It was not until December 21, 2011 that Dr. McIntyre, through her counsel, provided partial medical records of Patient C and Patient C's husband. Patient C's records contained few, if any, consult requests and reports, prescription copies, investigative results, or correspondence from the period of 1999-2010. Likewise, Patient C's husband's records contained no progress notes after 2008, even though he and Patient C continued to be Dr. McIntyre's patients until 2010.

25. To date, complete copies of the records for these patients have not been provided by Dr. McIntyre.

26. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct and failed to maintain the standard of practice by: failing to respond appropriately to requests by the College and the patients for the patients' medical records, failing to appropriately maintain those records, and failing to complete a Veterans Affairs Canada form required by the patient.

Conduct with respect to Patient D

27. On May 12, 2010, the College received a letter of complaint from Patient D about her family doctor, Dr. McIntyre. Patient D described concerns about Dr. McIntyre's unprofessional conduct in the brusque and dismissive manner in which she spoke to Patient D and her husband, who was also Dr. McIntyre's patient.

28. Patient D further complained about the manner in which Dr. McIntyre ran her practice, including, among other things: lengthy wait times, failure to respond to telephone calls in a timely manner, failure to ensure privacy and confidentiality when Dr. McIntyre discussed their health concerns in the office, rude and discourteous behaviour by Dr. McIntyre and her staff and Dr. McIntyre's failure to appropriately arrange appointments for the patients to be seen by specialists.

29. In April 2010, Dr. McIntyre terminated Patient D and her husband's care without notice or justification.

30. The College investigator provided Dr. McIntyre with a copy of the letter of complaint on May 19, 2010 and provided further clarification of the concerns raised by way of letter dated July 7, 2010. Dr. McIntyre was asked to provide the medical records for Patient D and her husband, and any response to the complaint by August 10, 2010.

31. By August 24, 2010, Dr. McIntyre had still not provided the patients' records, nor a response to the complaint. The College investigator gave Dr. McIntyre an extension until September 13, 2010.

32. It was not until October 26, 2010 that Dr. McIntyre provided part of the medical records for Patient D and her husband. The records provided by Dr. McIntyre did not constitute the full patient charts. Patient D's chart was missing a front sheet, copies of referral forms and requisitions, progress notes, consent forms, and copies/logs of prescriptions.

33. By letter dated January 6, 2011, the College investigator again wrote to Dr. McIntyre's counsel to advise that the College was still waiting for Dr. McIntyre's response which, two months' prior, her counsel had indicated Dr. McIntyre was in the process of finalizing.

34. On January 24, 2011, Dr. McIntyre, through her counsel, provided the College with a copy of Patient D's additional medical records. Her counsel again indicated that Dr. McIntyre was in the process of finalizing her response and that it would be provided

to the College "in the near future." Patient D's medical records included test results from 2006-2010, and records from 1998-1999. However, the records did not include any progress notes, and did not cover the period from 2000-2006. Patient D's husband's chart included records from 2000-2008, but did not include any progress notes or records for 2009.

35. It was not until May 12, 2011, one year after Dr. McIntyre had been notified of this complaint, that she provided her response to the College.

36. By letter dated October 11, 2011, the College investigator wrote to Dr. McIntyre, through her counsel, advising that the College had still not received the missing portions of the medical records for Patient D and her husband, and advising Dr. McIntyre that failure to cooperate with the College's investigation could result in a referral of allegations of professional misconduct to the Discipline Committee.

37. The material missing from the medical records was never received.

38. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct and failed to maintain the standard of practice by: behaving rudely to Patient D and her husband, discharging them without justification or notice and without following the College policy, leaving the patients waiting for hours on more than one occasion, failing to safeguard the patient's privacy, mismanaging appointments with specialists, failing to respond appropriately to requests by the College and the patients for the patients' medical records, and failing to appropriately maintain those records.

Conduct with respect to Patient E

39. The College received a letter of complaint from Patient E, dated January 3, 2013, in which she advised that she had been trying to obtain her medical records from her family doctor, Dr. McIntyre, for the past six months and had still not received them.

40. Dr. McIntyre had a recorded message on her voicemail directing patients who wished to obtain their medical records to make the request in writing and to fax the request to a specific number. Patient E followed Dr. McIntyre's recorded directions and,

after trying to obtain her records for over six months without success, she contacted the College for assistance.

41. On January 11, 2013, a copy of Patient E's letter of complaint was sent to both Dr. McIntyre and her counsel with a request for a response by February 19, 2013. No response was received until June 25, 2013, at which time her counsel advised that Dr. McIntyre informed him that she had provided Patient E with her patient chart "some time ago."

42. On June 27, 2013, Patient E confirmed with the College investigator that, to date, she had not received her medical records, nor had she been charged by Dr. McIntyre for a copy of it.

43. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct by failing to respond appropriately to requests by the College and the patient for the patient's medical records, and failing to appropriately maintain those records.

Conduct with respect to Patient F

44. Patient F was a patient of Dr. McIntyre's for twelve years. On October 31, 2012, he wrote a letter of complaint to the College outlining his numerous unsuccessful attempts for over two years to obtain a copy of his medical records from Dr. McIntyre. Dr. McIntyre was notified of the complaint on November 14, 2012.

45. On February 7, 2013 the College investigator wrote to Dr. McIntyre advising her that she had an opportunity to provide written submissions to the ICRC in response to Patient F's complaint, and requesting that she forward a copy of the patient's chart to the College by March 14, 2013.

46. By June 25, 2013, the College had still not received a copy of Patient F's medical record from Dr. McIntyre. The College investigator wrote again to Dr. McIntyre through her counsel, reminding her of her obligation to cooperate with the College investigation.

47. Ultimately, the College received a copy of a part of Patient's F's medical record from the patient himself. The medical records Patient F received from Dr. McIntyre were not in chronological order, were missing third party consultation notes, WSIB forms, copies of prescriptions, investigative results, requisition forms, and contained no progress notes nor a cumulative patient profile.

48. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct by failing to respond appropriately to requests by the College and the patient for the patient's medical records, and failing to appropriately maintain those records.

Registrar's Investigation – Clinical Care

49. On the basis of the public complaints against Dr. McIntyre, the Registrar of the College appointed investigators to conduct an investigation of Dr. McIntyre's practice under s.75(1)(a) of the HPPC. In the course of that investigation, the College obtained a selection of charts from Dr. McIntyre's practice and retained an expert to opine on Dr. McIntyre's care of patients. Dr. Z's reports are attached at Tab 2 [to the Agreed Statement of Facts and Admission], and form part of this Agreed Statement of Facts.

50. As concluded by Dr. Z, Dr. McIntyre failed to maintain the standard of practice of the profession and/or engaged in disgraceful, dishonourable or unprofessional conduct with respect to her clinical care and treatment of patients, her failure to maintain boundaries, her failure to maintain proper records, her failure to comply with public health requirements including unsafe storage of vaccines, and her failure to respond in a timely way to requests for patient records.

51. The deficiencies in Dr. McIntyre's practice and record keeping, as noted by Dr. Z, included (but were not limited to) the following:

(a) The Patient Profile was frequently incomplete, making it difficult to determine the general medical health of the patient from the chart;

(b) The charting of medications was unusual, with a separate sheet listing medications prescribed in an alphabetized format, as a summary of the medications the patient is taking regularly, but with no diagnosis associated with the medication. There was no way of determining the amount of medication prescribed at each visit;

(c) The most significant concern was that the lines of professionalism and relationships were often blurred, with Dr. McIntyre showing the greatest lack of judgment in cases of patients with whom she had some type of relationship outside the doctor-patient context.

52. In respect of the concerns regarding public health requirements, the College obtained extensive documentation from City 1 Public Health Unit documenting Dr. McIntyre's repeated failures to comply with public health requirements and repeated breaches of public health protocols (incorrect refrigeration temperature, incorrect vaccine storage, failure to maintain log books, maintenance of expired vaccines). After attempted and failed remediation plans, Dr. McIntyre's office was ultimately suspended from the public health programme through which physicians receive vaccines to administer to their patients.

Registrar's Investigation - Disgraceful, Dishonourable, Unprofessional Conduct

53. In January 2011, investigators were appointed to inquire into and examine Dr. McIntyre's personal and professional relationships with Mr. X.

54. Mr. X was a patient of Dr. McIntyre's for about 20 years. Among other conditions, Mr. X suffered from a mental illness and was recovering from substance abuse. During the course of the doctor-patient relationship, Dr. McIntyre and Mr. X became close friends, and she introduced Mr. X to her family, with whom he formed personal relationships.

55. In or around 2010, in part due to their increasingly close personal relationship, Dr. McIntyre and Mr. X terminated their doctor-patient relationship. Dr. McIntyre and Mr. X

became increasingly closer. Approximately 12 months after the end of the doctor-patient relationship, they began a sexual relationship.

56. Dr. McIntyre admits that she engaged in disgraceful, dishonourable or unprofessional conduct by failing to maintain appropriate professional boundaries with Mr. X, both during and after the doctor-patient relationship.

PART II - ADMISSION

57. Dr. McIntyre admits the facts set out above, and admits that, based on these facts, she has failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, and has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional under paragraph 1(1)33 of Ontario Regulation 856/93.

FACTS AND EVIDENCE

Findings on the Admitted Facts

The Committee accepts the facts in the Agreed Statement of Facts and Admission and finds that those facts established that Dr. McIntyre failed to maintain the standard of practice of the profession, and engaged in disgraceful, dishonourable or unprofessional conduct in her dealings with six patients and their families by:

- Failing to respond appropriately to requests by the College and the patients' for their medical records;
- Failing to appropriately maintain patient records;
- Improperly storing vaccines;
- Not responding to patients' care concerns;
- Failing to appropriately make referrals for patients;
- Failing to complete forms required by patients;
- Behaving rudely to patients and discharging them without justification or notice and without following the College policy;

- Leaving the patients waiting for hours or more on one occasion;
- Failing to safeguard the patient's privacy; and
- Mismanaging appointments with specialists.

The Committee also accepts the admission of Dr. McIntyre and finds that Dr. McIntyre failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct with respect to her clinical care and treatment of patients, her failure to maintain boundaries, her failure to maintain proper records, her failure to comply with public health requirements, including unsafe storage of vaccines, and her failure to respond in a timely way to requests for patient records.

The Committee also accepts the admission of Dr. McIntyre and finds that with respect to her patient, Mr. X, Dr. McIntyre engaged in disgraceful, dishonourable or unprofessional conduct by failing to maintain appropriate professional boundaries with Mr. X during the doctor-patient relationship (by engaging in a close friendship) and after the doctor-patient relationship, by commencing a sexual relationship with him approximately twelve months after the end of the doctor-patient relationship. Mr. X had been Dr. McIntyre's patient for 20 years, suffered from a mental illness and was recovering from substance abuse.

CONTESTED ALLEGATIONS

The professional misconduct allegation of sexual abuse regarding a single patient, Ms Y, was contested, as was the allegation that Dr. McIntyre engaged in boundary violations with Ms Y that constituted disgraceful, dishonourable or unprofessional conduct. The issues to be decided are:

1. Did Dr. McIntyre engage in boundary violations with Ms Y?
2. Did Dr. McIntyre's conduct constitute sexual abuse of Ms Y?
3. Did Dr. McIntyre engage in conduct, or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members to be dishonourable, disgraceful or unprofessional?

Summary of the Evidence

The Committee heard from six witnesses who testified about the relationship between Dr. McIntyre and Ms Y. Dr. McIntyre's medical chart for Ms Y, consisting of five large volumes, was filed in evidence on consent. The OHIP record of payment was also filed in evidence as well as affidavits attesting to attempts to serve a summons on Ms Y to attend the hearing into this matter. Ms Y was summonsed but she did not appear at the hearing.

The Witnesses***Ms N***

Ms N was a patient of Dr. McIntyre from 1989 until 2011, with the exception of the years from 1992 to 1997, when she had moved away. In 2003, when Dr. McIntyre adopted a baby girl, she began to work for the doctor caring for the infant. Ms N testified that she continued to work in the doctor's home as well as her office doing various jobs until 2010.

According to Ms N, after she began to work for Dr. McIntyre, she became a friend of the doctor and they would sometimes talk on the phone. When Dr. McIntyre returned home from work, Ms N often stayed to socialize and have dinner with the family. She did this almost every day until 2008. In 2008, however, Ms Y started to come to Dr. McIntyre's home and would be there three to five days a week. When Ms Y began coming to the home, Ms N testified that she no longer stayed for dinner, as she no longer felt welcome.

Ms N travelled with Dr. McIntyre when she took her two daughters to dance or skating competitions. After 2008, Ms Y would sometimes come as well. On one occasion, she recalls Ms Y sharing a bed with Dr. McIntyre, while she shared a cot with the youngest daughter. Ms N testified that on that occasion, Dr. McIntyre was in bed wearing only a towel and Ms Y was in a nightie. Ms Y often accompanied Dr. McIntyre to competitions and Ms N no longer went after 2008.

Ms N testified that she never saw Dr. McIntyre and Ms Y engaging in kissing, hugging or any sexual contact.

Ms O

Ms O is the 22 year old daughter of Dr. McIntyre. She has an eighteen month old son. She testified that she does not live with her mother but she sees her mother regularly. In her testimony, Ms O acknowledged that Ms Y was a friend of her mother's and was like an aunt to her and her sister Ms P. Ms Y travelled with her mother and her sibling when they travelled to City 2 or City 3 for dance or skating competitions. On those occasions, her mother and Ms Y usually would share a bed and she shared one with her sister.

Ms Y socialized with her mother and came over to the house about five or more times a month, but Ms O was not sure how often they saw each other. Ms Y often stayed for dinner, according to Ms O. Ms Y ran errands for her mother and helped around the house.

Ms O said that she had been angry with her mother in the past. She was upset when her parents separated and divorced. When asked if she blamed her mother for the divorce, she replied "not necessarily." She denied that she felt Ms Y was taking on the role vacated by her father. Her mother and Ms Y remain close friends and sometimes go to dinner together; although she was not certain if they travelled together any longer.

Ms O described an incident in November or December 2010, where she opened the door to her mother's bedroom. She testified that she thinks she did so because she wanted to ask her mother something. When she opened the door, she found Ms Y and her mother lying on the bed nude, with perhaps a towel over them. She testified that her mother told her that they had just taken separate baths. Ms O testified that because of the location of her room, she could hear if the bath water was running in her mother's bathroom and she had not heard that sound. She testified that she did not recall her mother's reaction when she walked in, but she recalls feeling confused and overwhelmed and called her father immediately afterwards to tell him. She stated that she asked him to come and get her, and he did. She said that she assumed that Ms Y and her mother, Dr. McIntyre, were

engaged in a lesbian relationship. However, she testified that her motivation in calling her father about the incident was not to make him angry. Indeed, she testified that she was not sure if it would make him angry.

Later, when Ms O asked her mother about what was going on, her mother denied anything was going on and stated that they had taken separate baths prior to Ms O seeing them nude on the bed. She testified that she was tempted to spy on her mother because she did not believe her mother's story.

After the above incident, which occurred in November or December 2010, Ms O testified that she was curious about what she had seen and was 'snooping' about three weeks later. She looked through a hole in her mother's bedroom door. It was not a keyhole but a small hole that had been made with a drill or a nail. The bed was directly across from the door, the lights were on and the view was not obstructed by anything, she testified. She stated that she saw her mother and Ms Y lying on the bed, close to each other, although not really close to each other, and they kissed on the lips for a few seconds. It was a "romantic kiss", she said.

During Ms O's cross-examination, counsel for Dr. McIntyre suggested to her that there was a cupboard placed in front of the bedroom door such that it would have been impossible for her to see across the room through the hole in the door; however, Ms O's evidence was that there were no cupboard in front of the hole and there was nothing that obstructed her view of her mother and Ms Y kissing on the bed. The Committee accepts that evidence. There was no evidence adduced to the contrary.

Ms O testified that she used marijuana with her friends in her basement around this time. She also had an issue with possession of magic mushrooms. She was tearful when she admitted to also using cocaine and ecstasy. Ms O acknowledged that cocaine, ecstasy, and magic mushrooms can alter perceptions, including perceived sexuality; however, she denied that she was on any drugs at the time that she saw her mother on the bed kissing Ms Y.

Ms O testified that as a teenager, she and her friends at the time had stolen money from her mother's bedroom. She admitted that she used to use drugs with her friends; however, she denied that her perceptions were altered by drugs on either occasion when she saw her mother on the bed with Ms Y.

Ms Q

Ms Q is the daughter of Ms Y. She worked for Dr. McIntyre from 2004 until 2010 in the doctor's office. Initially, her work was very part-time and later became regular employment from 9 to 5. She did what she termed typical office work (i.e., administrative tasks).

Ms Q testified that she too was Dr. McIntyre's patient but she stopped being her patient about a year before the doctor stopped practising in 2010. She testified that her mother was also a patient of the doctor and they developed a very close relationship and they saw each other often. Her mother occasionally travelled out of town with Dr. McIntyre when Dr. McIntyre took her daughters to skating and dance competitions.

She testified that her mother had a mental illness and she was fine when on her medications, but "erratic" when off of them. Ms Q testified that Dr. McIntyre prescribed her mother's medications, as did another doctor.

Ms Q testified that her mother had been hospitalized for about three months prior to 1999 and one other time after that. She was not certain of the dates and thought it was 1995 and 2006.

Ms R

Ms R testified that she was a patient of Dr. McIntyre from 1991 to 1998 and 2002 until 2010 when Dr. McIntyre ceased practising. She also worked for the doctor in her office doing office work in 1997 and 1998. She returned to work for the doctor in April 2010 and stopped working for her in November 2010 when Dr. McIntyre ceased practising.

Ms R testified that Dr. McIntyre had two offices, a home office in her family room where she sometimes saw patients who were friends. Her other office was in City 1. Ms R worked at both offices, she said. In 2010, Ms R's work hours varied considerably and she never knew from one day to the next what hours she would be working. Occasionally she worked until 11:00 p.m.

She testified that she socialized with Dr. McIntyre and would sometimes get together with other women friends and the doctor and go to a bar. Ms Y would also be there.

Ms R testified that Ms Y was at Dr. McIntyre's house almost daily in 2010 and she would socialize with them both by sitting on the porch and talking. She stated that Ms Y drove one of Dr. McIntyre's vehicles and performed chores and ran errands for the doctor.

Sometime between April and October 2010, Ms R had to go to Dr. McIntyre's bedroom for something and she recognized Ms Y's glasses on Dr. McIntyre's headboard. She testified that she had not seen them engage in any kissing or sexual touching.

Ms S

Ms S is the sister of Ms Y and she testified that she occasionally took her sister to Dr. McIntyre's house for medical appointments and sometimes she was at her sister's house when Dr. McIntyre attended for a house call. Her sister was a patient of Dr. McIntyre from the late 1980's or early 1990's, she testified, and continued as her patient until Dr. McIntyre closed her practice. The doctor and her sister have been friends since the 1990's, she said.

Ms S testified that occasionally, Dr. McIntyre came to Ms Y's house to socialize. Dr. McIntyre also visited if Ms Y thought something was wrong with her and sometimes Dr. McIntyre came if Ms Y was out of medication. Ms S recalled that on one or two occasions, Dr. McIntyre injected Ms Y with what Ms S believed was Demerol. She said Ms Y had needles in her house that Dr. McIntyre had given her, which Ms S believed contained Demerol and something for Ms Y's stomach.

Ms S observed that her sister and Dr. McIntyre were “extremely close. It was like Ms [Y] was Mary’s puppy dog.” She testified that Dr. McIntyre and Ms Y saw each other on a daily basis. Ms S testified that whatever the doctor wanted, Ms Y did it, including feeding the dog and fetching groceries or whatever else.

Ms S testified that her sister was diagnosed as bipolar and she takes a lot of medication to the point that sometimes her words are slurred. She testified that her sister has been hospitalized three times for manic episodes.

Ms T

Ms T was a patient of Dr. McIntyre’s since the 1990’s, and started working for her in 2003 when Dr. McIntyre adopted her daughter Ms P. She continued working for her until 2011, she testified. She was employed at her home cleaning, doing laundry and general housework. She also ran errands and took Dr. McIntyre’s daughters to lessons. She worked in the home office filing papers into patient charts as well. Her hours were irregular, she said.

Ms T testified that she knew Ms Y as she was a patient and also a friend of Dr. McIntyre. Ms Y used to look after Ms P one day a week, according to Ms T.

Ms T testified that Ms Y and Dr. McIntyre were good friends but she observed something near the end of her employment that she felt indicated that they were more than just friends. On one occasion, she went to Dr. McIntyre’s bedroom and found the doctor and Ms Y sitting up on opposite sides of the bed with regular clothing on their tops and the covers pulled up to their waists. When she looked back at them, she noticed that Ms Y was wearing only pantyhose, with no underwear, and her jeans were on the end of the bed. She was not sure what the doctor was wearing. She knew the jeans belonged to Ms Y as Ms T folded the laundry and knew Dr. McIntyre was a much smaller size. The time of her observation was late summer or early fall of 2010 since the weather was still warm.

Dr. McIntyre's Medical Record for Ms Y

According to the medical record, Ms Y became a patient of Dr. McIntyre in 1991. Her records show that she had a long history of mental illness with two hospitalizations on a Form 1 in 1996 and 1997.

Dr. McIntyre prescribed Lithium and a variety of anti-depressants for Ms Y as well as narcotics. Dr. McIntyre provided repeated counseling sessions for her as well over the years with her last individual psychotherapy session in May 2010, according to the OHIP billing record.

Dr. McIntyre's medical record is incomplete as the last OHIP billing for Ms Y was in October 2010. There is no evidence in the Medical Record, to establish the termination of the doctor-patient relationship.

The medical record also has records of financial arrangements between Dr. McIntyre and Ms Y:

- a) there was a note written on Dr. McIntyre's prescription pad, dated a Thursday in February 1999, stating, "Received today from M. McIntyre \$200.00 cash loan repayable on receipt of government [two illegible words] or when able". Another note on the same page on the same prescription pad, dated a Thursday in March 1999, reads: \$50 dollars cash Thursday in March -99 followed by see [illegible word] a Friday and Monday in March. Both notes were apparently signed by Ms Y. (Ex. 3, Vol. 3, pg. 23);
- b) another note, dated a Tuesday in February 1999, had the name Ms Y at the top and below states \$ Plan and lists money from CPP, expenses of mortgage, hydro and car repairs and a balance (Ex. 3, Vol. 3, pg. 39);
- c) another note, dated a Thursday in March 2000, is headed Ms Y. Below it states: "received 17,000.00 in repayment for loan regarding old debts." Other pages

- related to monetary matters follow which appear to be related to Ms Y's sale of a house and the debt she apparently owed Dr. McIntyre. (Ex. 3, Vol. 2, pg. 143);
- d) another entry is a typed letter to Ontario Disability Support Program, dated a Wednesday in November 1999, and apparently signed by Ms Y, giving permission for Dr. McIntyre and another person to handle her financial affairs. (Ex. 3, Vol. 2, pg. 156);
 - e) another letter, dated a Thursday in May 1998, to a Ms U explains that Ms Y has been hospitalized and was unable to carry out the responsibilities assigned to her of committee ship of her grandfather. In the letter, apparently signed by Dr. McIntyre, she asks, "due to the fragility of the patient's medical condition, I ask that any further correspondence in this matter be addressed to me. I enclose the patient's instruction for this." (Ex. 3, Vol. 2, pg. 166);
 - f) another entry, apparently authored by Dr. McIntyre, is a request for a bank to open a joint account with Ms Y. (Ex. 3 , Vol. 2, pgs. 105 and 209);
 - g) there are several entries pertaining to bills of Ms Y. (Ex. 3, Vol. 2, pg 103 and Ex. 3, Vol. 1, pgs. 371 and 372);
 - h) another entry is a letter, apparently from Dr. McIntyre, dated a Wednesday in September 1998, relating to an overpayment to Ms Y by the Ministry of Community and Social Services. (Ex. 3, Vol. 2, pg. 310); and
 - i) Dr. McIntyre wrote the Bank of Commerce a letter, dated a Tuesday in May 1999, requesting that someone contact her office if any non-sufficient fund cheques or pre-authorized withdrawals occur for amounts not covered by funds in Ms Y's account (Ex. 3, Vol. 1, pg. 336).

FINDINGS ON THE CONTESTED ISSUES

Legal Principles

The Committee recognizes that the College has the onus of proving its case against Dr. McIntyre to the requisite standard, on the balance of probabilities, that is, it is more likely than not that Dr. McIntyre engaged in either or both: (1) boundary violations that members would find disgraceful, dishonourable or unprofessional; and/or (2) the sexual abuse of a patient. The evidence must be clear, cogent and convincing in order to satisfy this test.

The College's Policy Statement #4-08, entitled *Maintaining Appropriate Boundaries and Preventing Sexual Abuse*, serves as a guide to help physicians understand and comply with the legislative provisions regarding sexual abuse. Trust is the cornerstone of the physician-patient relationship and in order to maintain that trust, physicians must avoid making or responding to sexual advances from patients. Sexualizing a doctor-patient relationship is a clear breach of trust.

Summarizing from the policy, there is an inherent power imbalance in the doctor-patient relationship. Physicians must establish and maintain appropriate professional boundaries with patients and act in the patient's best interest. Sexual activity and romantic interactions interfere with the goals of the doctor-patient relationship and can obscure the physician's objective judgment concerning the patient's health care. Public trust in the medical profession is eroded when physicians engage in sexual abuse of their patients.

Subsection 1(3) of the Code of the *Regulated Health Professions Act* states it is an act of professional misconduct for a physician to sexually abuse a patient. "Sexual abuse" of a patient by a member is defined as follows:

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

Credibility and Reliability of the Witnesses

The Committee found all of the witnesses credible and their testimony reliable. All of the witnesses testified in a straightforward and candid way. All of them had the opportunity to see Ms Y and Dr. McIntyre together by virtue of their employment and/or friendship with the doctor or their relationship to Ms Y, as was the case with her sister Ms S. The evidence each of them gave was consistent, that a close friendship existed between Dr. McIntyre and Ms Y and that they spent a lot of time with each other. There was no apparent reason for any of them to lie. None appeared to be motivated by malice. The details of the glasses on the head of the bed recounted by Ms R and the details of what Ms T saw, that is the doctor and Ms Y sitting up in bed with the covers pulled to their waists and Ms Y only wearing pantyhose and no underwear on her bottom, was found by the Committee to be credible and reliable.

Credibility and Reliability of the Evidence of Ms O

Ms O saw her mother and Ms Y naked on Dr. McIntyre's bed on one occasion, and kissing in a romantic way on the bed on another occasion. The Committee found her account believable and accepts her evidence. There were some aspects of her testimony that enhanced her credibility. First, Ms O readily admitted to her own past character faults. She admitted that as a teenager she stole money from her mother's bedroom and smoked marijuana with her friends, sometimes in the basement of her home. She admitted as a teenager to having used cocaine and ecstasy and that she had been often angry with her mother. Ms O was straightforward throughout her testimony. Her willingness to be honest and candid about her own history and shortcomings supported her credibility and the reliability of her testimony in recounting what she observed between her mother and Ms Y.

Although demeanour is often noted to be a notoriously poor predictor of credibility, there was one incident in Ms O's testimony that stood out for the Committee. Ms O was asked about the use of cocaine and ecstasy after she had already admitted to using marijuana and possessing magic mushrooms. When she was asked this, she became tearful and appeared to hold back tears. Although the Committee cannot ascribe exact meaning to the

witnesses' emotion, Ms O appeared, in the Committee's view, embarrassed, ashamed and remorseful. An involuntary physiological response of tearfulness was congruent with an emotion behind it and suggests to the panel that the witness was not sophisticated in the art of deception, or attempting to engage in it, and she was therefore unlikely to be lying in her testimony. The Committee is of the view that this was not a staged emotion. Ms O had no apparent reason to be less than truthful. Her account of seeing her mother and Ms Y in bed together, on two occasions, was accepted as truthful and accurate. It is buttressed by Ms T's account of seeing them in bed, covered to the waist, on another occasion.

Ms O recounted that at the time of her testimony that she and her eighteen month old child are in regular contact with Dr. McIntyre and no evidence was presented that there was any malice on her part towards her mother. Although she admitted to having been angry with her mother when she was a teenager, she denied any current acrimony. She denied being impaired by drugs at either time that she saw her mother in bed with Ms Y. The Committee accepted Ms O's testimony as credible and reliable.

The Issues

1. Did Dr. McIntyre engage in boundary violations with Ms Y?

a) Engaging in a close personal friendship with her patient

All of the witnesses testified that a close personal friendship existed between Dr. McIntyre and Ms Y. Ms O described Ms Y as being like an aunt to her and her sister and being involved in their lives for many years. She travelled with them and testified that her mother and Ms Y socialized and went to dinner together.

Ms T described the two women as "close friends" who would socialize and go out to dinner, and she described Ms Y as being at the doctor's house often.

Ms R testified that Ms Y was at Dr. McIntyre's house almost every day and that they all socialized together and sometimes sat on the front porch of Dr. McIntyre's house.

Ms N described the close personal friendship between the two women and said Ms Y was often at the doctor's house.

Ms S, Ms Y's sister, described her sister's relationship with Dr. McIntyre as "extremely close" and she said that "Ms Y was Mary's puppy dog". She testified that they saw each other on a daily basis.

Ms Q, the daughter of Ms Y, described her mother's relationship with Dr. McIntyre as "very good friends" who saw each other often and sometimes they travelled together to dance competitions.

All of the witnesses' testimony indicates to the Committee that a close personal relationship existed between Dr. McIntyre and her patient, Ms Y. Accordingly, the Committee so finds.

b) Involving herself in her patient's personal and financial dealings

The medical records filed make it clear that Dr. McIntyre was extensively involved in Ms Y's financial affairs. There was no evidence contradicting the notes in Ms Y's patient chart. There was also no evidence to suggest that they were not accurate, contemporaneous or reliable records. There was ample evidence in Ms Y's patient chart that Dr. McIntyre was involved in her personal and financial affairs and the Committee makes this finding.

c) Travelling and sharing a bed with her patient

The witnesses testified that Dr. McIntyre and Ms Y travelled to City 2 and City 3 with Dr. McIntyre's children for competitions. During these trips, the doctor and Ms Y shared a bed according to Ms O and Ms N who were sharing the room with them on those occasions.

The Committee finds that Dr. McIntyre and her patient Ms Y did share a bed.

d) Engaging her patient to care for her children and assist her with household responsibilities

Some of the witnesses testified that Ms Y assisted Dr. McIntyre with child care and household duties. Ms T testified that Ms Y looked after Ms P one day per week. Ms S, Ms Y's sister, said that Ms Y did whatever Dr. McIntyre wanted her to do, such as pick up the children, feed the dog or get groceries.

The Committee finds that Ms Y was engaged in caring for Dr. McIntyre's children and performing household chores for Dr. McIntyre.

e) Having her patient in bed, partially unclothed in 2010

Ms T testified that in the late summer or early fall of 2010, she went upstairs looking for Dr. McIntyre and found her in bed with Ms Y with the covers pulled up to their waists. She observed that they were wearing regular clothing on their tops but when she went to check on Ms P, who was asleep on a bed on the floor, she saw that Ms Y was wearing pantyhose with no underwear on her bottom. Ms Y's jeans were on the bed. She knew they were hers because Dr. McIntyre's size was much smaller, which she knew because of her duties folding the household laundry.

The Committee finds that this incident happened as Ms T testified.

f) Being naked in bed with her patient in 2010

Ms O testified that she saw her mother and Ms Y in bed nude together with perhaps a towel covering them. She saw this in the fall of 2010. When she asked her mother what was going on, her mother replied that they had taken separate baths. Ms O knew that this was not true because her bedroom was near the baths and she had not heard the bath water running.

As outlined above, the Committee found Ms O to be credible and her evidence to be reliable. The Committee accepts her evidence and finds that Dr. McIntyre and Ms Y were in bed together in the nude.

Summary of Findings on Issue 1 - Boundary Violations

The Committee finds that the above conduct of Dr. McIntyre as described in (a) through (f) above constitute boundary violations with a patient during the doctor-patient relationship.

2. Did Dr. McIntyre's conduct constitute sexual abuse of Ms Y?

a) Kissing

Ms O testified that she saw her mother and Ms Y on the bed fully clothed engaging in a romantic kiss on the lips for a few seconds. The Committee accepts the testimony of Ms O as truthful and finds that this incident did take place as described by Ms O. Ms O testified that, before she witnessed the kiss, she had seen her mother and Ms Y being physically affectionate with each other and "touching each other more than usual".

In closing argument, counsel for Dr. McIntyre referred to *R. v. Lorette* at para 42. He argued that because the conduct in issue was being merely being observed and was not reported from or explained by either Ms Y or Dr. McIntyre, extra caution must be exercised. The aforementioned case is a criminal case of sexual assault (requiring proof beyond a reasonable doubt) and not a disciplinary case in the regulatory context (requiring proof on a balance of probabilities). Even exercising such extra caution, the Committee is satisfied that Ms O was accurate in her account of what she witnessed. Her evidence was clear, cogent and convincing and was believed by the Committee.

b) Did a doctor-patient relationship exist at the time of the sexual kissing incident?

The OHIP record for Ms Y indicates that Dr. McIntyre's last billing for a medical visit for her was in October 2010. Counsel for Dr. McIntyre argued that there was no evidence that the doctor-patient relationship was ongoing in November or December 2010 (i.e., when the kissing incident took place). Most patients have gaps in time when they have not had a medical visit with their doctor and there were such gaps in Dr. McIntyre's chart for this patient. Because a patient is not seen for a month, or months, does not mean the

doctor-patient relationship has been terminated. The College's Policy Statement #3-08 on Ending the Physician Patient Relationship provides that the physician is responsible for documenting the termination in the patient's chart and arranging alternative services for the patient. Although counsel for Dr. McIntyre submitted in closing argument that the patient had terminated the relationship, there was no evidence in the medical chart or otherwise presented that established this. The absence of a chart entry as to a termination or transfer of responsibility, and the nature of the patient's mental illness, establishes to the Committee's satisfaction that the doctor-patient relationship was ongoing. Given the nature of the medical treatment of Ms Y as evidenced in her patient chart, the mental illness being treated was serious, longstanding and ongoing. The Committee finds on the record before it that the doctor-patient relationship with Dr. McIntyre had not ended at the time of the kissing incident in November or December, 2010.

Summary of Findings on Issue 2 - Sexual Abuse

The Committee finds that Dr. McIntyre and Ms Y kissed in a romantic way while on Dr. McIntyre's bed. In the view of the Committee, this constitutes touching of a sexual nature and therefore sexual abuse of a patient. The Committee finds that Dr. McIntyre engaged in sexual abuse of a patient.

3. Did Dr. McIntyre engage in conduct, or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members to be dishonourable, disgraceful or unprofessional?

The Committee finds that Dr. McIntyre engaged in boundary violations with her patient Ms Y. The Committee also finds that Dr. McIntyre's conduct would reasonably be regarded by members as dishonourable, disgraceful or unprofessional. In coming to this conclusion, the Committee relies on the evidence of witnesses who they found to be credible and whose testimony to be reliable. Dr. McIntyre allowed herself to become a close friend of the patient, engaged Ms Y to work for her performing child care and household chores, travelled with Ms Y, shared a bed with her, and was in bed nude with

Ms Y. Dr. McIntyre was also involved in the financial affairs of her patient, helping her with loans, financial issues and her bank account. Dr. McIntyre engaged in sexual touching by kissing Ms Y on her bed. In the circumstances, such conduct would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and the Committee so finds.

ADVERSE INFERENCE

College counsel submitted that an adverse inference should be drawn against Dr. McIntyre for failing to testify.

Justice Sopinka noted in *The Law of Evidence in Canada*, Third Edition, at para. 6.449, that an adverse inference can be drawn in civil cases when,

“in the absence of an explanation, a party litigant does not testify, or fails to provide affidavit evidence on an application, or fails to call a witness who would have knowledge of the facts and would be assumed to be willing to assist the party. In the same vein, an adverse inference may be drawn against a party who does not call a material witness over whom he or she has exclusive control and does not explain it away. Such failure amounts to an implied admission that the evidence of the absent witness would be contrary to the party’s case, or at least would not support it.”

The Committee finds that the College established a *prima facie* case. Indeed, this Committee finds that there was sufficient evidence, without having to resort to an adverse inference, to find on a balance of probabilities that Dr. McIntyre committed acts of professional misconduct, including sexual abuse of her patient, Ms Y, and boundary violations with her that constituted disgraceful, dishonourable, or unprofessional conduct.

The Committee recognizes that the onus is, and always remains, entirely on the College to prove the allegations on a balance of probabilities, and based on clear, cogent and convincing evidence. There is no onus on the physician to prove or disprove anything.

That said, a physician subject to discipline does not enjoy a “right to remain silent” and accordingly the decision not to testify in her own defence permits the Committee to draw an adverse inference, where that is appropriate (see *Re Rathe*,¹ *Re Lambert*,² *Re Liberman*,³ and *Golomb v. College of Physicians and Surgeons of Ontario*⁴). This does not involve any speculation by the Committee as to the content of the missing testimony, or any reliance upon the substance of that presumed testimony. It is simply a statement of the common sense proposition that if the College’s evidence establishes *prima facie* proof of a fact, and the physician chooses not to testify to answer that evidence, it is open to the Committee to draw an adverse inference from her failure to testify.

Dr. McIntyre had relevant evidence that she could have provided to the Committee through her testimony. This Committee found that she engaged in sexual abuse by kissing Ms Y. The Committee draws the reasonable inference that Dr. McIntyre’s own evidence on this point would have been unhelpful to her case and would have assisted the College. Although counsel for Dr. McIntyre submitted that the doctor-patient relationship had been terminated sometime in or around October 2010, no evidence was tendered in this regard and Dr. McIntyre did not testify to that effect. The Committee considers that it is appropriate in this case to draw the inference that the evidence of Dr. McIntyre would have been contrary to her termination argument, or at least, not support it. The Committee can draw an adverse inference from the failure of Dr. McIntyre to testify regarding both the sexual touching (the inference being that it did occur as Ms O stated) and the alleged termination of the doctor-patient relationship in or around October 2010 (the inference being that it did not occur). In any event, it is the Committee’s view that the allegations against Dr. McIntyre have been proven to the requisite standard without relying upon any adverse inference being drawn with respect to either of these issues. The findings are even stronger when an adverse inference is drawn.

1 [2011] O.C.P.S.D. No. 11.

2 [2011] O.C.P.S.D. No. 27.

3 [2011] O.C.P.S.D. No. 22.

4 [1976] O.J. No. 1707 (Div. Ct.).

SUMMARY

The Committee accepted as true the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee finds that Dr. McIntyre has failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct.

Dr. McIntyre was cavalier and did not respond appropriately to requests by the College and her patients for their clinical records. She failed to appropriately maintain the patient records and did not respond to patient care concerns. She did not make referrals appropriately for her patients and did not complete forms for them when required. In doing so, patients faced inconvenience and hardship in some cases.

The Committee also finds that Dr. McIntyre was sometimes rude to patients and discharged them from her practice without justification or notice and without following College policy. She left patients waiting for hours, without reasonable justification, on more than one occasion. She did not safeguard patients' privacy and mismanaged appointments with specialists. She improperly stored vaccines as well.

The Committee also finds that Dr. McIntyre failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct with respect to her clinical care and treatment of patients, her failure to maintain boundaries and her failure to maintain proper records, her failure to comply with public health requirements, including the unsafe storage of vaccines, and her failure to respond in a timely way to requests for patient records. The Committee finds that Dr. McIntyre failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct with respect to the above issues.

The Committee also finds that Dr. McIntyre engaged in disgraceful, dishonourable or unprofessional conduct by failing to maintain appropriate professional boundaries with Mr. X during the doctor-patient relationship (by engaging in a close friendship) and by

commencing a sexual relationship approximately twelve months after the end of the doctor-patient relationship in circumstances where it was inappropriate to do so.

The allegation of sexual abuse with respect to Ms Y has been proved. Dr. McIntyre engaged in the sexual abuse of a patient and in disgraceful, dishonourable, or unprofessional conduct with respect to that patient.

Ms Y was a vulnerable patient due to her longstanding psychiatric illness. She had been a patient of Dr. McIntyre for many years and the doctor took advantage of her position of power to become involved with her socially and ultimately, sexually.

All of these actions or omissions are serious in the Committee's view. The repeated nature of them with multiple patients over a significant period of time is a great concern to the Committee. Dr. McIntyre was not only cavalier in what she did with patients, for example, by not referring to specialists when she said she would, or by keeping them waiting for hours, or not providing forms or records that they needed, but she ignored the College's requests for records as well. Her actions, along with the boundary violations with her patient, Mr. X, demonstrates a lack of concern for the welfare of her patients, as well as disdain for her professional regulatory body whose duty it is to protect the public from physicians who do not comply with their obligations.

PENALTY AND REASONS FOR PENALTY

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") delivered its written Decision and Reasons for Decision on Finding in this matter on July 6, 2015. The Committee found that Dr. McIntyre has committed an act of professional misconduct in that: she engaged in the sexual abuse of a patient; she failed to maintain the standard of practice of the profession; and, she engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee heard submissions on penalty and costs on December 11, 2015, and reserved its decision.

SUBMISSIONS ON PENALTY

A. *Preliminary Issue: Bifurcated Penalty Process vs. Global Penalty*

At the hearing on finding, Dr. McIntyre admitted to certain misconduct and the parties submitted an Agreed Statement of Facts and Admission with respect to the admitted misconduct, which is reproduced in the Committee's Decision and Reasons for Decision of July 6, 2015. Dr. McIntyre contested other allegations, namely, the allegation of sexual abuse regarding one patient, Patient Y, and the allegation that she engaged disgraceful, dishonourable or unprofessional conduct by violating boundaries with Patient Y. In result, the Committee made findings with respect to the admitted misconduct and additional findings with respect to the contested misconduct, including a finding of sexual abuse.

Defence counsel informed the Committee that prior to the hearing on finding, the parties had agreed on what would be an appropriate penalty for the admitted misconduct. Specifically, he submitted that they had agreed to a 12 month suspension, supervised practice with weekly meetings and chart reviews, a reassessment following one year of supervision, practice restricted to a group setting, a prohibition from treating family members and courses regarding boundaries, communication, record keeping, and ethics.

As a result of this agreement, defence counsel submitted that the Committee should separate its penalty decision into two components. First, the Committee should treat counsels' prior agreement on penalty as a joint submission on penalty for the admitted misconduct. Second, only after making a decision on penalty for the admitted misconduct should the Committee go on to decide the issue of penalty for the contested misconduct, which resulted in additional findings, including the finding of sexual abuse.

College counsel objected to the proposed bifurcated penalty decision process. While the College acknowledged that it had agreed on an appropriate penalty for the admitted misconduct, it submitted that the landscape had changed substantially because of the Committee's additional findings in relation to the contested misconduct.

The College submitted that it was not reneging on its agreement with defence counsel regarding an appropriate penalty for the admitted misconduct. Rather, the College argued that the Committee should take all of the facts and circumstances into consideration – including the admitted and additional findings – and determine an appropriate global penalty for Dr. McIntyre's misconduct.

The Committee agreed with the submissions of the College. It is not the Committee's practice to treat individual allegations as if they were counts on an indictment. In *Re Stevens and Law Society of Upper Canada*, 1979 Can LII 1749 (ONSC - Div Ct), the Court found that charges brought by a professional body should not be approached as counts in an indictment.

The Committee's practice is to take all of the findings and the submissions of the parties into consideration to determine a penalty that is proportionate and appropriate to the facts and circumstances of the case (see also *Re Cwinn and the Law Society of Upper Canada*, 1980 Can LII 1694 (ONSC- Div Ct)).

The Committee decided not to divide the penalty decision into two components because doing so would be tantamount to dealing with the allegations as counts in a criminal case and lead to a technical adding-up of sanctions. As will be discussed below, the Committee must consider many factors in fashioning an appropriate penalty.

Requiring the Committee to separate its penalty into multiple components would unduly impede the Committee in fulfilling its mandate. Repetitive misconduct, such as breaches of trust, boundary violations, and preying on vulnerable patients, that occurs over time with multiple patients would be split up and dealt with in an incomplete manner that would not truly reflect the context and dynamics of the physician's misconduct.

An important factor in assessing penalty is examining the nature of the behaviour. In Dr. McIntyre's case, her repeated boundary violations over many years with two separate patients require the Committee to examine her misconduct globally.

The Committee found that the College's position was consistent with its prior agreement with defence counsel. College counsel was clear in her submission that if the Committee had made a finding on Dr. McIntyre's admitted conduct alone, then the appropriate penalty would be what she and defence counsel had agreed upon. Given the additional findings, however, her submission was that the Committee should fashion a global penalty that takes into consideration all of the findings. The Committee agreed.

B. Position of the Parties on Penalty

The College sought revocation of Dr. McIntyre's certificate of registration, a reprimand, costs, and the posting of an irrevocable letter of credit or other security acceptable to the College for funding of counselling under section 85.7 of the Code. The College submitted that this penalty was warranted given the nature of Dr. McIntyre's professional misconduct.

Counsel for Dr. McIntyre argued that the penalty of revocation was excessive. He argued that the additional finding of sexual abuse involved a single kiss, which did not warrant revocation. He submitted that a reprimand and two months further suspension was sufficient, in addition to the penalty agreed upon between the parties for the admitted misconduct as detailed above.

DECISION AND REASONS ON PENALTY

Penalty Principles

The Committee carefully considered both the parties' submissions and the case law provided.

The Committee's penalty determination is based on the guiding principle of protection of the public. An appropriate penalty should be proportionate to the misconduct and must also serve as a general deterrent to the profession and specific deterrent to the member. The penalty should express the profession's denunciation of the misconduct, and uphold the profession's honour and reputation. The public's confidence in the profession's ability to self-regulate in the public interest is also an important penalty principle. Where appropriate, the penalty should also allow for rehabilitation of the member.

The Committee also considered the nature and context of the misconduct. Conduct which takes place over a period of time, involves a breach of trust, and includes preying on vulnerable patients warrants significant sanction.

The Findings

In its Decision and Reasons on Finding dated July 6, 2015, the Committee found that Dr. McIntyre failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct in her dealings with six patients and their families by:

- Failing to respond appropriately to requests by the College and patients for their medical records;
- Failing to maintain appropriate patient records;
- Improperly storing vaccines;
- Not responding to patients' care concerns;
- Failing to appropriately make referrals for patients;
- Failing to complete forms that patients required;
- Behaving rudely to patients and discharging them without justification or notice and without following the College policy;
- Leaving the patients waiting for hours or more;
- Failing to safeguard the patient's privacy; and
- Mismanaging appointments with specialists.

The Committee also found that Dr. McIntyre failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct with respect to her clinical care and treatment of patients and her failure to maintain appropriate boundaries with patients.

Further, the Committee found that Dr. McIntyre engaged in disgraceful, dishonourable or unprofessional conduct by failing to maintain appropriate boundaries with Patient X during the doctor-patient relationship. Dr. McIntyre did so by engaging in a close friendship with Patient X and by commencing a sexual relationship with him several months after the end of the doctor-patient relationship in circumstances where it was inappropriate to do so. Patient X had been Dr. McIntyre's patient for many years and suffered from several mental health issues.

Finally, the Committee found that Dr. McIntyre sexually abused Patient Y and engaged in conduct that would be considered disgraceful, dishonourable or unprofessional. Patient Y was vulnerable due to her longstanding mental health issues. She had been Dr. McIntyre's patient for many years. Dr. McIntyre took advantage of the power imbalance in her physician-patient relationship to become involved with Patient Y socially, financially, and sexually.

Legal Authorities

In considering an appropriate penalty, the Committee reviewed the decisions provided by the parties. Some of these cases are discussed below:

In *CPSO v. Minnes*, [2015] ONCPD 3, the Committee made two separate findings of professional misconduct for conduct that was found to be disgraceful, dishonourable, or unprofessional. Dr. Minnes admitted to the first allegation, which consisted of repeated boundary violations with female nursing staff at the hospital where he worked as a pediatrician. His behaviour consisted mainly of unwanted and inappropriate touching.

The Committee also found that Dr. Minnes engaged in overt and intrusive sexual behaviour with a 17-year-old female counselor at a summer camp where he was the camp physician – an allegation he denied. The camp counselor was not his patient.

The Committee in *Minnes* commented that the hospital incidents on their own warranted a penalty consisting of a public reprimand; the suspension of Dr. Minnes' certificate of registration for three months; and a remediation requirement with respect to boundary issues, including pursuing therapy. However, the Committee found that the summer camp incident on its own warranted revocation. The Committee stated that an even stronger case for revocation was made out when both the hospital and the camp incidents were considered together. Similar to *Minnes*, the multiple findings of professional misconduct in Dr. McIntyre's case create a stronger case for revocation.

In *CPSO v. Totsoni - Flynn* (May 21, 2002), the physician and the patient were involved in psychotherapy for several months. Within a month or two after terminating the psychotherapeutic relationship, they began a close friendship, which ultimately evolved into a sexual relationship. Revocation and a reprimand were ordered. In *Totsoni – Flynn*, both the doctor-patient relationship and the sexual relationship began and ended within a few months. In the present case, Dr. McIntyre has engaged in boundary violations with Patient Y for many years. Although the time of the commencement of the sexual relationship is unknown, it nonetheless started when Patient Y was still a patient of Dr. McIntyre and dependent on her for care.

In *CPSO v. Carter* 2012 ONCPSD 14, the physician began a romantic relationship with a very vulnerable patient prior to the termination of the doctor-patient relationship. This became a sexual relationship very shortly after the official termination. The mitigating factors in *Carter* were that Dr. Carter took responsibility for his actions; he did not contest the allegations; and he completed the boundaries course on his own initiative. Dr. Carter was also young and inexperienced at the time. His certificate of registration was suspended for 18 months and he was required to receive therapy.

In *CPSO v. Marks* [2012] OCPD 19, the physician pled no contest to hugging and kissing three patients during psychotherapy sessions. The Committee found that he sexually abused these patients. In addition to terms and conditions to mitigate any residual risk that Dr. Marks posed, his certificate of registration was suspended for four months. He also was required to complete ethics and boundaries courses and provide notice to each female patient of the Penalty Order. *Marks* is not analogous to Dr. McIntyre's case because Dr. Mark's misconduct was short-lived. On the other hand, Dr. McIntyre's boundary violations were long-standing and intrusive. They include:

- developing a close personal friendship with her patient;
- involving herself in her patient's personal and financial dealings;
- engaging the patient to care for Dr. McIntyre's children and assisting Dr. McIntyre with her household responsibilities;
- travelling with the patient; and
- being in bed partially unclothed with the patient; and
- being naked in bed with her patient.

In *CPSO v. Muhammad*, [2013] OCPD 14, the physician hugged and kissed a receptionist once. He had seen the receptionist on five occasions as a patient. The case resulted in a reprimand, a suspension of his certificate of registration for two months and an appropriate individualized education plan. *Muhammad* differs from the McIntyre case since Dr. McIntyre's misconduct occurred in various forms and on multiple occasions.

In *CPSO v. Tennen*, [2013] OCPD 46, a psychiatrist transgressed boundaries with two vulnerable patients by hugging and kissing them, making inappropriate comments to them, and asking to view a surgical scar. There were no longstanding boundary violations in this case. The doctor also took responsibility for his actions, which was a mitigating factor. In addition to terms, conditions, and limitations, the Committee reprimanded Dr. Tennen and ordered his certificate of registration suspended for a period of three months.

In *Hajcsar (Re)* [2014] OCPD 10, the doctor breached boundaries by kissing a vulnerable patient on more than one occasion. This case is markedly different from Dr. McIntyre's because Dr. Hajcsar's transgressions were short-lived. He also took steps to take a boundaries course before the hearing started. He also admitted his responsibility, which was a mitigating factor. He was suspended for two months and was reprimanded.

In *CPSO v. Henderson*, [2005] OCPD 30, the physician admitted to engaging in professional misconduct by sexually abusing a patient. He made inappropriate remarks of a sexual nature to the patient regarding her appearance, kissed her and fondled her breasts on two separate occasions, years apart, and hugged and kissed her outside the office. The Committee reprimanded Dr. Henderson, ordered him to take an ethics course, and ordered his certificate of registration suspended for nine months. The Committee found that *Henderson* differs from Dr. McIntyre's case because of the lack in *Henderson* of an ongoing relationship and the intermittent nature of the sexual misconduct.

CPSO v. Nagahara, [1996] OCPD No. 8, involved egregious, intrusive sexual abuse during a physical examination. Dr. Nagahara was also criminally convicted of sexual assault for this incident. The College ordered his registration suspended as well as other terms, conditions and limitations to address the risk he posed for sexual re-offence. *Nagahara* is nearly 20 years old, and our understanding the devastating implications of sexual assault has substantially shifted in the years since. Accordingly, suspending Dr. McIntyre's certificate of registration would neither meet the mandate of public protection nor maintain the credibility and reputation of the College based on the facts of this case.

Aggravating Factors

The Committee found that Dr. McIntyre's boundary violations with Patient Y were not isolated incidents but they rather took place over a lengthy period of time. Patient Y was Dr. McIntyre's close friend and took care of many of Dr. McIntyre's needs around the

home. The kiss was only one aspect of this abusive relationship. They were clearly in an intimate relationship at the same time Patient Y was Dr. McIntyre's patient.

Dr. McIntyre sustained close personal relationships with both Patient Y and Mr. X concurrently with her doctor-patient relationship. The doctor-patient relationship was terminated with Mr. X before the sexual relationship commenced. However, with Patient Y, the doctor-patient relationship continued during their sexual relationship.

Both patients were vulnerable. Patient Y had previous hospitalizations. Her mental illness was serious and ongoing. It was inappropriate for Dr. McIntyre to be prescribing medication and continuing to treat Patient Y because of their personal relationship, which involved kissing and other boundary violations. The Committee was disturbed by the abuse of power and control in this situation.

Mitigating Factor

It is to Dr. McIntyre's credit that she admitted the facts in the Agreed Statement of Facts and Admission, obviating the need for an undoubtedly lengthier hearing.

Least Restrictive Option

Counsel for Dr. McIntyre submitted that the Committee should impose "the least restrictive sanction appropriate in the circumstances." Defence counsel relied upon Lee (Re), [2010] OCPD No. 8 (at para 5) for this proposition:

"In *R. v. Solowan*, [2008] 3 S.C.R. 309, the Court wrote (at para 3), "*Unwarranted resort to maximum sentences is adequately precluded by proper applications of those principles*

notably the fundamental principle of proportionality” and noted that it was appropriate “to impose the least restrictive sanction appropriate to the circumstances.””

Solowan was a criminal case. The concept of the least restrictive option is not a governing principle in the realm of regulated health professions. In *Iacovelli v. College of Nurses of Ontario*, 2014, ONSC 7267 (Div Ct), the member argued that that college’s Inquiries, Complaints and Reports Committee was restricting the member’s rights and should instead use the “least restrictive and least onerous option” when ordering an independent medical assessment of fitness to practise.

The Divisional Court in *Iacovelli* held that this language is unsuitable to a professional college whose mandate is to protect the public interest, not impose the least restrictions on its members. The Court stated at para.53:

“The words “least onerous and least restrictive” occur nowhere in the *RHPA* and form no part of the legislature’s intention in drafting s. 59(2). They are plainly unsuitable to the functions of the health profession College, whose overarching duty is not to pose the least restrictions on its members, but rather to protect the public. All of the College’s actions are taken to serve and protect the public interest. A member’s interest in practicing without restrictions must necessarily take second place to this overriding duty.”

Further, as stated in *Adams v. Law Society of Alberta*, 2000 ABCA 240 (Alta.CA) at para.6:

“A professional misconduct hearing involves not only the individual and all the factors that relate to the individual, both favourably and unfavourably, but also the effect of the individual’s misconduct on both the individual client and generally on the profession in question. This public dimension is of critical significance to the mandate of professional disciplinary bodies.”

Proportionality

The Committee agreed with defence counsel that Dr. McIntyre's penalty should be commensurate and proportional to her misconduct. The Committee must look at the nature of the conduct that is being considered. Defence counsel argued that Dr. McIntyre's misconduct amounted to a single kiss, and therefore the sexual abuse in this case was at the low end of the spectrum through a proportionality lens.

The Committee found that the conduct in this case was not at the low end of the spectrum. In the context of that kiss, it is clear that Patient Y was a vulnerable patient who was socially and financially tied to Dr. McIntyre.

Dr. McIntyre continued to medically treat Patient Y, as she had for many years. Sexual abuse compounded the abuse of power and control. The context of the sexual abuse was not a single kiss, but a part of the dynamic of this dependent relationship.

Dr. McIntyre had a pattern of using her patients to fulfill her own needs. She did not have peer relationships with Mr. X and Patient Y, and could not have, by virtue of her position as their physician. These patients were also especially susceptible to Dr. McIntyre's attention to them because of their precarious mental health.

PENALTY

The Committee found that penalty agreed upon by counsel for the misconduct Dr. McIntyre admitted to in Agreed Statement of Facts and Admission would have satisfied the penalty principles had those been the only findings. However, in light of the additional findings on the contested sexual abuse allegation, including the dynamics that came to light regarding Dr. McIntyre's abuse of her power and control, neither that penalty nor the penalty now proposed by defence counsel is sufficient.

Dr. McIntyre's misconduct involved boundary violations that continued for years. Patient Y was a vulnerable woman with mental health issues who required hospitalizations, and

ongoing medication, among other assistance. Mr. X was also vulnerable with significant mental health issues. In both cases, Dr. McIntyre was in a position of trust and had power and control in the relationship.

The College has a mandate to govern its members. When physicians engage in professional misconduct, as Dr. McIntyre did, the public loses confidence in the profession. If the penalty is not proportional with the seriousness of the misconduct, the profession is further tarnished.

Revocation in this case is appropriate because of the nature and context of Dr. McIntyre's boundary violations with vulnerable patients, which took place over years, and her breach of the trust of her patients, the public, and the profession. Revocation serves the purpose of maintaining public protection and confidence in the profession. It should also serve as a deterrent to the membership in general.

A reprimand is mandatory under the Code when there is a finding of sexual abuse.

COSTS

The College maintained that costs reflecting the tariff for six days are in order since the contested allegations were proved. College counsel noted that the tariff does not cover all of the College costs.

Counsel for Dr. McIntyre argues that the hearing could have been completed in two days if there had not been undue delays and a re-arguing of a motion, and that costs for two days would therefore be more appropriate.

The Committee agreed that there were delays in this hearing that should not be borne by Dr. McIntyre. The Committee orders costs in the amount of \$13,380.00, which reflects two days of hearing and one day of penalty, at the current tariff of \$4,460.00 per day.

ORDER

The Discipline Committee orders and directs that:

1. The Registrar revoke Dr. McIntyre's certificate of registration, effective immediately.
2. Dr. McIntyre appear before the panel to be reprimanded. The reprimand should be scheduled within three (3) months from the date the Order becomes final.
3. Dr. McIntyre reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, and post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within sixty (60) days of the date this Order becomes final, in the amount of \$16,060.00.
4. Dr. McIntyre pay costs to the College in the amount of \$13,380.00 within sixty (60) days of the date this Order becomes final.