NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Phipps, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name of the office staff witnesses or patients referred to orally and in written documents at the hearing pursuant to 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 the publication, including broadcasting, of the identity of a witness or any information of a witness that could disclose the identity of the witness 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. Phipps, 2018 ONCPSD 48

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) f 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. NIGEL MARK PHIPPS

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MAJOR A. H. KHALIFA
DR. J. WATTERS
MR. J. LANGS
DR. S-M. YOUNG

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

COUNSEL FOR DR. PHIPPS:

MS J. STEPHENSON
MR. J. KATZ

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. MCALEER

PUBLICATION BAN

Hearing Dates:	**July 31, August 1, October 26, 27 and November 13, 2017**
Finding Decision Date:	**August 27, 2018**
Release of Written Reasons:	**August 27, 2018**

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard together, on consent, the matters referred in the Notice of Hearing dated September 7, 2016, January 11, 2017, and May 17, 2017 and in the Notice of Hearing dated October 11, 2017. The hearing took place at Toronto on July 31, August 1, October 26, 27 and November 13, 2017. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

The Notice of Hearing dated September 7, 2016, January 11, 2017, and May 17, 2017 and the Notice of Hearing dated October 11, 2017 alleged that Dr. Nigel Mark Phipps committed an act of professional misconduct:

1. under clause 51(1)(b.1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c.18 (the "Code"), in that he has engaged in the sexual abuse of patients; and

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

RESPONSE TO ALLEGATIONS

Dr. Phipps admitted allegation 2 in the Notice of Hearing, in that 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. He denied allegation 1 in the Notice of Hearing.

BACKGROUND

Dr. Phipps is a 57-year old family physician who has been practising in a town area for many years, including the relevant period of five to six weeks from late August to early October 2014. The allegation of sexual abuse relates to eleven female patients and the allegation of disgraceful, dishonourable, or unprofessional conduct relates to the same eleven female patients and three clinic staff members.

Dr. Phipps showed each patient one or more photographs of himself on his cell phone during a clinical visit. The photographs showed him naked and exposed to varying degrees. He showed the photographs in the context of a story about inadvertent disclosure of an embarrassing photograph on his cell phone. Dr. Phipps is also alleged to have made inappropriate remarks during some of these visits, including, in some instances, sexualized remarks.

Further, it is alleged that Dr. Phipps was sexually aroused during the visits with three patients. Specifically, two patients describe being touched by Dr. Phipps' erect or semi-erect penis during a clinical examination (Patient A, Patient K). The third patient reported observing an erection (Patient B).

In addition, at the end of the clinic's working day on October 1, 2014, it is alleged that Dr. Phipps showed three staff members one of the photographs, in which he was exposed from the waist or groin area up.

THE ISSUES

This case raises three issues:

1. Does Dr. Phipps' conduct with respect to any or all of the eleven patients at the photo visits constitute sexual abuse?
    (a) Did Dr. Phipps engage in behaviour of a sexual nature with respect to any or all of the eleven patients at the photo visits?
    (b) Did Dr. Phipps make remarks of a sexual nature to any of his patients?

(c) Did Dr. Phipps touch any of his patients in a sexual manner?

2. Would Dr. Phipps' conduct at the photo visits with patients and/or clinic staff be reasonably considered by members to be disgraceful, dishonourable and/or unprofessional?

3. Did Dr. Phipps make comments at visits, other than the photo visits, to two of the patients that were of a sexual nature or disgraceful, dishonourable or unprofessional?

FACTS AND EVIDENCE

Summary of the Evidence

An Agreed Statement of Facts: Photographs (Exhibit 2) described three photographs, which Dr. Phipps provided to the College, and a fourth photograph, which he had deleted from his cell phone. The first three photographs were appended to the agreed statement.

Four patients did not testify in person (Patients G, E, J, I). The facts in relation to their interaction with Dr. Phipps were set out in the Agreed Statement of Facts (Exhibits 10, 11, 17 and 18).

Seven patients testified in person (Patients B, D, F, A, H, C, and K). The patients testified about their clinical visits with Dr. Phipps, their prior relationships and any later interactions with him, the impact of the alleged conduct on them, and how they came to give evidence.

Dr. Phipps testified on his own behalf. He described his practice in general terms, the 2012 golf trip with friends on which his story was based, the events described by the patients, and his conduct as he recalled it or as he believed he would have conducted himself.

The three clinic staff members did not testify in person. The facts in relation to their interaction with Dr. Phipps were set out in Agreed Statements of Facts (Staff Members Ms. L, Ms. M, Ms. N).

A number of exhibits were filed. Extracts of the medical chart and employment record of one patient were submitted as an Agreed Statement of Facts (Patient A). Written closing submissions and books of authorities were received from both counsel.

Dr. Phipps admits the facts that are set out in each of the Agreed Statements of Facts and Admissions. The Committee accepts as correct the facts set out in each of the Agreed Statements of Facts.

FACTS and EVIDENCE: PHOTOGRAPHS

The photographs are described in the Agreed Statement of Facts: Photographs, filed as Exhibit 2:

1. In the course of the College's investigation into this matter, through his counsel, Dr. Phipps provided three photographs to the College as follows:

    - Tab A: A photograph that Dr. Phipps took of himself, a "selfie", in which he is naked from mid-thigh to the top of his head;
    - Tab B: A "selfie" taken by Dr. Phipps in a mirror in which his naked buttocks are visible;
    - Tab C: A "selfie" taken by Dr. Phipps that is the same photograph as Tab A, but cropped by him so that he is visible from approximately the groin area, above the genitals, to just below the top of his head.

2. Dr. Phipps advised the College during its investigation that he deleted a fourth "selfie" which was similar to the photograph in Tab A, except that he had a towel over one of his arms.

FACTS and EVIDENCE: PATIENTS

Patients G, E, J, I

The Committee considered Dr. Phipps' conduct in showing the photographs and making comments and remarks to these patients.

Other than acknowledging that he showed photographs to each of these four patients, Dr. Phipps testified only about his interactions with Patient E specifically. A summary of that testimony follows Patient E's Agreed Statement of Facts.

Patient G

The following facts were set out in the Agreed Statement of Facts Evidence of Patient G (Patient G), which was filed as an Exhibit 10:

A. Overview

1. Patient G, in her 30's, has been a patient of Dr. Nigel Mark Phipps ("Dr. Phipps") in his family practice location in Ontario, since she was approximately six years old.

2. Patient G resides in Ontario. Dr. Phipps is friendly with Patient G's family, many of whom are also his patients, although he does not socialize with her or her family outside of his practice.

B. College Investigation

3. Patient G's name was provided to the College in the course of its investigation into Dr. Phipps, by Nurse Practitioner O.

4. Nurse Practitioner O is employed by the Health Team, of which Dr. Phipps was a member at the relevant times. She also works with Dr. Phipps.

5. On December 8, 2014, Patient G advised Nurse Practitioner O that, during a previous appointment with Dr. Phipps, he had shown Patient G an unclothed picture of himself. Nurse Practitioner O told Patient G that she was not the only patient who had seen the picture. Patient G refused permission for Nurse Practitioner O to provide her name to the College and did not want to complain about Dr. Phipps.

6. On May 2, 2016, following discussion with the College investigator, Nurse Practitioner O provided a mandatory report to the College that did not include the patient's name or contact information, in accordance with the patient's request.

7. On July 19, 2016, following receipt of a summons from the College, Nurse Practitioner O provided Patient G's name and contact information.

8. Following receipt of her contact information, the College contacted Patient G on August 29, 2016.

C. Evidence of Patient G

9. The incident that is relevant to this hearing took place when Patient G attended for an office appointment with Dr. Phipps.

10. During the appointment, Dr. Phipps showed her a naked "selfie", which she describes as a full, frontal nude picture in which his penis was visible. Attached at tab "A" [to the Agreed Statement of Facts of Patient G] is a copy of the picture that Dr. Phipps showed Patient G.

11. Patient G was mortified when she saw the selfie. From their conversation, she understood that Dr. Phipps had taken the picture when he was away at a golf tournament. Dr. Phipps

was swiping through pictures on his telephone and when he swiped that picture, he said words to the effect, "oops, we're not supposed to see that". He apologized to Patient G.

12. Other than the above incident, Dr. Phipps has always behaved professionally and in an appropriate manner. Patient G continues to be Dr. Phipps' patient.

13. Although Patient G advised the College on August 29, 2016, that she believed the above appointment occurred when she was pregnant based on the fact that Patient G notified Nurse Practitioner O on December 8, 2014, that Dr. Phipps had shown her the attached picture in a previous appointment, and based on a review of Patient G's patient chart, the parties agree that the appointment most likely occurred in September 2014.

Patient E

The following facts were set out in the Agreed Statement of Facts Evidence of Patient E, which was filed as an Exhibit 11:

A. Overview

1. Patient E, in her 50's, has been a patient of Dr. Nigel Mark Phipps ("Dr. Phipps") in his family practice location in Ontario, for approximately twenty years.

2. Patient E resides in Ontario, with her family, including her husband and children, all of whom are Dr. Phipps' long-time patients. In addition, members of Patient E's extended family are also long-time patients of Dr. Phipps.

B. College Investigation

3. Patient E's name was provided to the College in the course of its investigation by Dr. Phipps in answer to a letter from the College asking for a list of patients to whom he recalls showing the full-frontal nude picture filed in this hearing.

4. Following receipt of Patient E's name, the College contacted and interviewed her on June 3, 2015, June 4, 2015 and on June 3, 2016.

C. Evidence of Patient E

5. At the end of a medical appointment in the fall of 2014, Dr. Phipps and Patient E were discussing something about people taking "selfies" and getting into trouble, such as stars or celebrities. Dr. Phipps showed Patient E a "selfie" on his cellular telephone and explained it was something he had shared with his wife. Patient E did not have a clear recollection of the conversation.

6. The "selfie" that Dr. Phipps showed Patient E was of himself naked from the waist up and included his face and head. When he showed her the "selfie", Dr. Phipps told Patient E that it was a picture of him naked, but he was very careful not to allow her to see more than him naked from the chest up. When he went to show her the picture, he said, "wait a minute, wait a minute", and adjusted the picture on his telephone so that he was only visible from the waist up. It was clear to Patient E that he did not want her to see the whole picture. Patient E looked at the "selfie" for a split second and was not wearing her glasses which she otherwise wears for everything. After viewing the picture, Patient E suggested to him that he should get rid of the picture and left.
7. Patient E was not troubled by what she saw. She thought nothing of the picture he showed her. It was not important to her.

8. Dr. Phipps has provided excellent health care to Patient E and other members of her family, in particular her father. She describes him as very professional and a "good guy".

9. Sometime later, likely in October 2014, Dr. Phipps telephoned Patient E to warn her she might get a call from the College. He advised her to answer whatever questions she was asked by the College, to be honest and tell the College what she could remember. He apologized and stated he hoped he had not offended her.

10. Although Patient E told the College that the appointment occurred in either September or October 2014, based on a review of her medical chart, the parties agree that the appointment at which Dr. Phipps showed Patient E the picture was likely on September 3, 2014.

11. On June 22, 2017, Patient E was shown a picture attached at Tab A [to the Agreed Statement of Facts of Patient E] and filed in this hearing, of Dr. Phipps naked from the groin area. Patient E described the picture as similar but was not sure it is the same one she was shown by Dr. Phipps, which she described as being from the waist up.

12. On July 27, 2017, Patient E provided medical information to the College indicating that she is unable to testify in the hearing.

Dr. Phipps had no recollection of the visit at which he showed a photograph to Patient E ('photo visit'). He did recall that Patient E later phoned to tell him that she had received a call from the College. She had denied seeing the photograph and asked him what to do. He advised her to call the College back and tell them truthfully what had happened. While he did not want it widely known in the community that he was being investigated by the College, he wanted his patients to cooperate with the College because that was his best chance for a favourable outcome.

Patient J

The following facts were set out in the Agreed Statement of Facts Evidence of Patient J, which was filed as Exhibit 17:

A. Overview

1. Patient J, in her 30's, has been a patient of Dr. Nigel Mark Phipps ("Dr. Phipps") in his family practice location in Ontario, since 2009. Her parents, husband and children are also patients of Dr. Phipps.

2. Patient J resides in Ontario, with her husband and their children.

B. College Investigation

3. Patient J contacted the College on August 9, 2017, after a family member showed her an article about Dr. Phipps' discipline hearing that had appeared in the Toronto Star newspaper on July 31, 2017.

4. After reading the article, which contained a description of witnesses' testimony from the discipline hearing, Patient J told her husband for the first time that she had experienced something similar to what she was reading about. She decided to call the College.

C. Evidence of Patient J

5. The incident took place when Patient J attended for a prenatal examination with Dr. Phipps. During the appointment, Patient J was alone in the examination room with Dr. Phipps with the door closed, as was normal in her appointments with him.

6. At the beginning of the appointment, while she waited for Dr. Phipps in the examination room, Patient J was looking at her cellular telephone. Dr. Phipps entered the room and said, "You know, those phones can really get you into a lot of trouble". He proceeded to sit down in his chair and told Patient J that he had been on a golfing trip with friends in Arizona. Dr. Phipps had discussed his annual golfing trips to Arizona with Patient J in the past but never in detail and had never shown her pictures.

7. Dr. Phipps told Patient J that on this particular trip, his wife was also away somewhere else. He and his wife decided to share photos of each other.

8. Dr. Phipps took out his cellular telephone and told her he had been out to dinner with his golf friends and wanted to show them pictures from the trip. He proceeded to show Patient J three or four pictures on his phone. One picture was of a group of men at a table with a

golf course in the background. The last picture he showed her was a "selfie" that looked like it was taken in a hotel bathroom. In the picture, Dr. Phipps was naked from the lower pelvic area up, "just above the pubic bone". It appeared to Patient J that Dr. Phipps was taking a picture of his reflection in a mirror and there was a phone in one of his hands. Patient J was shocked. Dr. Phipps said words to the effect, "Now you can imagine how embarrassed I was when this picture came up because it was meant for my wife". Patient J responded, "Yes, I would be too". He told her, "This is why you need to be careful".

9. When he told the story and showed the pictures, Dr. Phipps seemed very comfortable. When he had told Patient J that he and his wife had exchanged pictures, Patient J assumed that the pictures were probably sexual in nature but she did not anticipate that he was actually going to show her that kind of picture.

10. After showing the pictures, Dr. Phipps completed his examination of her. The picture was not mentioned again in that or any subsequent appointments.

11. After Patient J left the office and sat in her car, she tried to process what had happened. She remembers feeling awkward and thinking, "Should I have seen my doctor's chest?" She justified the incident to herself as being one of good intention and that Dr. Phipps was trying to warn her about looking at pictures in your phone in front of people. Patient J knew there was something about it that was weird but did not want to think about it further.

12. Apart from this incident, Dr. Phipps had been a good family doctor and had not behaved in an inappropriate manner.

13. On August 28, 2017, the College investigator showed Patient J a picture of Dr. Phipps naked from the waist up, filed in this hearing as Exhibit 2C, and attached as Tab A [to the Agreed Statement of Facts Evidence of Patient J]. Patient J advised that the picture is very similar to what Dr. Phipps showed her. However, the picture Dr. Phipps showed her was more "zoomed out" as she was able to see a cream-coloured bathroom counter, a mirror,

fluorescent lighting and a wall. Dr. Phipps' body appeared the same way in both the picture he showed her and Exhibit 2C.

14. Since reading the article in the Toronto Star, the whole incident has come back as a disturbing memory, whereas before Patient J had justified it in her mind. Patient J had a lot of respect for Dr. Phipps and viewed him as an excellent doctor. She now feels a lack of trust in male doctors and is disappointed and angry with Dr. Phipps that he ruined his good work as a doctor by engaging in this conduct.

15. Although Patient J is unsure of the date of the appointment, she believes she was pregnant. She recalls the appointment was a prenatal examination that involved Dr. Phipps measuring her belly and that she was far enough along in her pregnancy that she was showing. Based on Patient J's evidence and a review of her medical chart, the appointment likely occurred during the fall of 2014.

Patient I

The following facts were set out in the Agreed Statement of Facts Evidence of Patient I, which was filed as Exhibit 18:

A. Overview

1. Patient I, in her 50's, has been a patient of Dr. Nigel Mark Phipps ("Dr. Phipps") in his family practice location in Ontario, since approximately 1986.

2. Patient I resides in Ontario, with her husband. She has an adult child who also used to be a patient of Dr. Phipps.

B. College Investigation

3. During the summer, Patient I read articles in the Toronto Star and Toronto Sun concerning Dr. Phipps' discipline hearing, after being alerted to the articles by her adult child. The articles contained references to witnesses' testimony at the hearing. As she had experienced similar conduct from Dr. Phipps, Patient I contacted her former therapist, who advised her to report her information to the College.

4. On August 3, 2017, Patient I contacted the College. On August 4, 2017, the College received a mandatory report from Patient I's former therapist.

C. Evidence of Patient I

5. The incident took place when Patient I attended for a medical appointment with Dr. Phipps. Patient I was alone in the examination room with Dr. Phipps with the door closed, as was normal in her appointments with him.

6. At the end of the medical appointment, as Patient I was getting ready to leave, Dr. Phipps said words to the effect, "Oh, hang on. I want to show you something". Dr. Phipps told Patient I that he had been away with "the guys" for a golfing weekend and decided he wanted to send Shelley a picture. Patient I knew Dr. Phipps' wife and knew that her name was Shelley. He then held out his phone towards Patient I, saying, "This is the picture I sent Shelley". Patient I cannot recall whether or not Dr. Phipps made any additional comments about the golf trip before showing her the picture.

7. Dr. Phipps handed Patient I his phone. Patient I recalls that she saw only a semi-erect penis and testicles in a picture displayed on Dr. Phipps' phone. She cannot recall seeing any other part of the body, face or background in the picture Dr. Phipps showed her. At the time, Patient I felt uncomfortable, but laughed and assumed it was a practical joke. It did not occur to her that it was Dr. Phipps' penis. Her recollection is that she thought he had taken a picture of a penis in a magazine, like "Playgirl". "Playgirl" magazine is an

American magazine that features pictures of semi-nude or fully nude men. Dr. Phipps was smiling as he showed her the picture. He did not seem embarrassed or flustered.

8. Patient I looked away quickly and handed back the phone. Dr. Phipps said words to the effect of, "I've seen yours, now you've seen mine". He made a "shush" motion with his finger to his lips and told her not to tell anyone and that this is "our secret". When she left the appointment, Dr. Phipps gave her a quick, friendly hug.

9. After she left the office and sat in her car, Patient I wondered if Dr. Phipps was making a pass at her. She decided to let it go and not read too much into Dr. Phipps' conduct.

10. There was no further mention of the picture after this appointment. Patient I never discussed this incident with anyone until she saw the media coverage of the discipline hearing.

11. On August 28, 2017, the College investigator showed Patient I the full, frontal nude picture of Dr. Phipps, filed in this hearing as Exhibit 2A, and attached at Tab A [to the Agreed Statement of Facts Evidence of Patient I]. However, the investigator covered the picture to show only the pelvic area including the genitals. Patient I's recollection was that the portion of Exhibit 2A that she was shown by the investigator was the same as what she saw when Dr. Phipps showed her the picture. Next, the College investigator showed Patient I the entire picture filed in this hearing as Exhibit 2A. Patient I's recollection was that she had never seen the full picture, only the penis and genitals. Patient I cannot say whether Dr. Phipps showed her the full, frontal nude picture or not. She only recalls seeing the genitals and did not realize at the time that it was a picture of him.

12. Apart from this incident, Dr. Phipps has been a good family doctor and has not behaved in an inappropriate manner.

13. Patient I feels upset and uncomfortable over the incident. She has suffered from serious gastrointestinal issues for years. After she read the media articles about the discipline

hearing, Patient I suffered a worsening of her symptoms and has trouble sleeping. She now realizes that Dr. Phipps did show her a picture of his own genitalia and describes feeling a "strong yuck factor". She feels very disappointed in Dr. Phipps. Dr. Phipps breached the trust and faith she had in him as a doctor. She no longer views the incident as a practical joke.

14. Although Patient I is unsure of the date of the appointment, she believes the appointment was in the fall of 2014. Based on a review of Patient I's medical chart, the parties agree that the appointment occurred on September 30, 2014.

Patients D, F, H, C, B, A, K

The evidence of each of the seven patients who testified in person is summarized below. The summaries also reflect Dr. Phipps' subsequent testimony when it was specific to that patient. Dr. Phipps' testimony that was not specific to a particular patient is summarized on its own following the patient summaries.

With respect to the first two patients (D and F), the predominant issue for the Committee was Dr. Phipps' conduct in showing the photographs and making various comments and remarks.

Patient D

Patient D is in her 50's. She and her family had been patients of Dr. Phipps for a number of years and continue to see him. Her experience has been that he is an excellent family physician.

At the conclusion of Patient D's appointment on August 29, 2014 (photo visit), in the context of a conversation about 'life and their families,' Dr. Phipps commented that 'there had been a funny incident'. He told her that he had received a photograph from his wife when she was away. Patient D's understanding, before being shown any photographs, was that Dr. Phipps was recounting a 'cute, somewhat silly' story. She did not recall Dr. Phipps being away on a trip as an element of the story.

Patient D recalled that, as part of the introduction to what she termed the ‘story line’, Dr. Phipps told her that he had shown the photograph to another patient and that he had not understood the other patient’s reaction. Dr. Phipps agreed that, at some point, he had told her this. He explained that in doing so, he was trying to excuse his behaviour and defend himself.

Patient D testified that Dr. Phipps then showed her a photograph of his wife in a bathing suit on his cell phone. Dr. Phipps denied doing so. He recalled that the photo he had of his wife on his cell phone was naked or topless and he would not have shown a photograph of his wife topless or naked to somebody else.

Dr. Phipps next showed her a photograph of himself that he had sent to his wife in return. Patient D’s impression of the photograph was that Dr. Phipps was posing with one arm raised, wearing only dark socks. She was not certain that he was fully naked. She acknowledged that her impression when she initially spoke to the College was that Dr. Phipps was wearing a sock over his genitals, reminiscent of a photograph of the Red Hot Chili Peppers. The photograph appeared to have been taken from some distance, as with a timer. Her recollection of the details was limited by the ‘extraordinarily brief period of time’ she looked at it before looking away. She was confident that the photograph was not Exhibit 2A or 2B. Dr. Phipps denied that there had ever been a photograph of him with a sock on his penis.

Patient D characterized Dr. Phipps’ conduct as a lapse in judgment and ‘a private matter between two people who are, kind of, old friends and acquaintances’. She was contacted by the College in June 2015. She had received a call from Dr. Phipps in the fall of 2014 in which he let her know that she might be contacted by the College and encouraged her to cooperate fully.

Patient F

Patient F is in her 60’s. She has been a patient of Dr. Phipps for many years, remains his patient, and described him as always having been a wonderful doctor. She has always found him very professional. She viewed the events in question as ‘definitely a mistake’ and ‘so out of character’ that she was confident they would never happen again.

Patient F was surprised that the photo visit took place as long ago as 2014 but accepted that it was on September 9 or September 23, 2014. She recalled that they were having a brief conversation. She did not recall the subject, only that they were laughing when he asked if she wanted to see a photograph. When prompted, she agreed that he had told her he had been away with friends, but she recalled no other details. She had not connected anything in their conversation to the photographs she was shown.

Dr. Phipps showed Patient F a photograph on his cell phone in which he was exposed from his head to his knees and naked with his penis erect. Patient F described his penis as appearing larger than it would otherwise because of the upward angle at which the photograph was taken. Dr. Phipps then showed her a second photo of himself from his neck to his thighs in which his buttocks were visible. Patient F was shocked, uncomfortable and unable to understand what it meant. According to her College statement in June 2016, she had said to Dr. Phipps, when he closed his cell phone, '… you've seen mine, now I've seen yours'.

Patient F testified that neither of the photographs was Exhibit 2A. The buttocks photograph she saw was similar to Exhibit 2B.

Dr. Phipps did not have any specific recollection of the photo visit. He testified that showing Patient F the full-frontal photograph was intentional because it fit with the golf story, but showing the buttocks photo was unintentional. Dr. Phipps acknowledged in his testimony that he had taken the buttocks photo at his home some time following the golf trip, and thus it did not 'fit' with the story of the golf trip. He denied that there was ever a photograph taken at an upward angle emphasizing the genitals.

Patient F was contacted by the College in June 2015. She had expected this because she had had a call from Dr. Phipps to apologize and to let her know that she might be contacted. Dr. Phipps did not tell her to respond in any specific way. Patient F has tried to forget the events in question because they have been so painful and difficult, not only for her but for Dr. Phipps and his family and the community.

With respect to next three patients (Patients B, K, A), in addition to Dr. Phipps' conduct in showing the photographs, the Committee considered the question of whether or not Dr. Phipps was sexually aroused during their photo visits. Patient K and Patient A each testified that Dr. Phipps had an erection when he touched her. Patient B testified that she observed that Dr. Phipps had an erection during the course of her appointment.

Patient B

Patient B is in her 40's. She and her children had been patients of Dr. Phipps for many years. Patient B agreed that the events of September 4, 2014 (photo visit) were uncharacteristic. Dr. Phipps had been a very good physician and she had had no concerns about his care of her or her children. Neither Patient B nor her children returned following the photo visit.

Dr. Phipps saw Patient B using her cell phone as he came into the exam room on that day. He mentioned that he occasionally found himself in embarrassing situations with his cell phone. Patient B testified that when the clinical assessment had been completed, Dr. Phipps shared with her a story about a golf trip in Florida with male friends. He had wanted to show a waitress a photograph on his cell phone of one of his friends whose head appeared to be superimposed on the waitress's head. Instead, he had mistakenly shown the waitress an embarrassing photograph.

Dr. Phipps then showed Patient B the latter photograph, which showed him naked, exposed from the mid-thigh up. He explained that he and his wife had been on separate vacations and had been sharing naked 'selfies'. He then showed her a second photograph, similar to the first but with a towel over one arm, and a third photograph showing his buttocks. In the first two photographs, Dr. Phipps' penis was exposed and semi-erect. Dr. Phipps scrolled through the photographs quickly, over perhaps five or six seconds.

Dr. Phipps had some recollection of the photo visit. He recalled telling Patient B about his golf trip and the story of the inadvertent disclosure of the naked selfie. He acknowledged showing her three naked photographs of himself, which were in a locked app on his cell phone, accessible only with a code.

Patient B testified that she was shocked, upset, and uncomfortable. She recalled saying, 'That is very embarrassing.' She testified that the photographs filed as Exhibits 2A and 2B were unlike those Dr. Phipps had shown her but acknowledged some similarities.

Dr. Phipps denied that he knew at the time that showing naked photographs of himself to a patient during a medical appointment was inappropriate. He then acknowledged that he was aware it was 'a little' inappropriate. He stated that he did not realize from Patient B's reaction that he done something wrong or that he was going to have a problem. However, in his November 5, 2014 letter of response to the College, he stated that after Patient B had left his office, he was concerned that what he had done may have upset her. In his testimony, he stated that he had not intended to show Patient B the three photographs, but also said that he was unsure what his intention had been. He acknowledged that he was holding and controlling his cell phone at the time. He testified that he had immediately felt badly because he had shown Patient B photographs – the buttocks photo and the towel photo – that weren't related to the golf trip. He stated that he had thought that it was okay to show Patient B a full-frontal photograph of himself as part of the golf story, but that to show the two other photographs was not appropriate.

Patient B wanted to leave the office as quickly as possible. She testified that, as she and Dr. Phipps stood up, she 'realized that Dr. Phipps had an erection'. She stated that '…[it's] a subjective assessment, but it appeared to me that his penis was erect in his pants, that I would typically refer to as an erection'. As she was leaving, Dr. Phipps said to her, 'Now you know more about me than most of my patients'. Patient B was very upset.

Later in the day of the photo visit, Dr. Phipps phoned Patient B, but did not reach her. He testified that if he had, he probably would have apologized for showing the three photographs. He called her a second time, wanting to reassure her that it was just a personal story and had no particular meaning. There was no answer again and he left a voicemail asking her to call him on his cell phone.

Patient B travelled on the day of the photo visit. When she returned the next day and switched on her cell phone, she saw two missed calls and the voicemail from Dr. Phipps. Patient B texted him

to ask if his message was in relation to the photographs. Dr. Phipps responded that this was the case and that he could talk to her the next time she was in the office. Dr. Phipps testified that he had wanted to speak to her in person and did not want to engage in a text message conversation while at home with his wife present. He then blocked any further text messages from Patient B on his phone, believing that she would see that he was no longer receiving her texts.

On September 8, Patient B texted Dr. Phipps again, expressing her shock at his conduct and stating that she and her family would not be returning. She asked that she not be contacted further and has had no further contact with Dr. Phipps.

Dr. Phipps testified that he never saw Patient B's second text message. He first learned that she would not be returning and how upset Patient B was when College investigators came to his office on October 3, 2014. He did not initially know why they had come and was shocked that Patient B had complained.

Patient B testified that she and her partner became very uncomfortable and very aware of their surroundings following these events. They found it very difficult to process and understand what had happened. She contacted a police constable, a friend of her partner, about what to do if Dr. Phipps were to try to contact her again. She contacted her regulatory body to clarify her reporting obligations as a regulated professional.

On about September 14, 2014, Patient B made a complaint to the College. She did not mention her impression that Dr. Phipps had had an erection in her initial phone interview or in her more detailed letter of complaint. She testified that she did not do so because she thought she would not be believed and she wanted to provide 'information that could be factually backed up and corroborated'. She stated that the presence of an erection was very subjective and would detract from her complaint.

Based on his recollection of the photo visit, Dr. Phipps denied unequivocally that he had had an erection. Moreover, he stated that he would have stood up facing away from Patient B if he had

had an erection and not facing toward her. He denied that there was anything he found sexually exciting or stimulating in showing the photographs.

In his response to the College dated November 5, 2014, Dr. Phipps did not address the issue of an erection. He testified that he did not think that he had the College letter in front of him when he drafted his response, and that he was trying to explain what had happened and not 'put in something that didn't happen'.

Patient B contacted the police constable again when she saw a distinctive blue Jaguar drive by her house and was concerned that it was Dr. Phipps. She did not, however, see Dr. Phipps himself. Dr. Phipps testified that the street on which Patient B lives is one he would have driven on very infrequently. He had sold his car, a distinctive 2009 navy blue Jaguar, in 2012 to someone at the golf club who lived close to Patient B and then bought a newer model of the same colour.

Patient B testified that she has been greatly affected by these events and has become very distrustful and extremely questioning of health professionals, even her dentist. Her children share these concerns and they have all lost the continuity of their medical care.

Patient A

Ms. Patient A is in her 50's. She and her family had been patients of Dr. Phipps for a number of years. She had trusted him, felt comfortable and shared personal issues and details with him including sexual history. Patient A testified that Dr. Phipps had always before behaved professionally.

Patient A testified that she had told Dr. Phipps in the past about her history of sexual abuse, but she could find no reference to it in her copy of her medical chart. She was certain that she had told him in 2007, during a work-up, although she could not recall a specific visit when she had done so. In her 2016 College interview, she had talked about sharing this history only in 2011 in relation to an incident at her school, but also said at that time that she was uncertain. In her

testimony, Patient A said that the first occasion she made Dr. Phipps aware of her history was in 2007, that it could have come up at other times, and that she had been on medication and suffering from a lack of sleep at the time of the College interview.

Dr. Phipps denied having known Patient A's history of sexual abuse. He said that it would have been significant in her history. He would have documented it in her chart and potentially offered her referral for counseling.

Patient A was injured in September 2014. She suffered bruised ribs, and may have suffered a concussion. Patient A was taken to the emergency department and later discharged to follow up with her family physician. She was off work and saw Dr. Phipps 'quite a few times' in the following weeks. The first such appointment was September 10, 2014. She saw him again on September 16, 2014 and still had headaches and dizziness at that time. She recalled receiving various documents related to her condition and treatments.

On September 25, 2014, Patient A saw a colleague in Dr. Phipps' absence. She acknowledged that she did not recall the details of every examination on her various visits, but the chart entry for that day gave the diagnosis as concussion and noted an exam of the back of her eyes (funduscopic exam). The physician ordered an MRI scan of her head. Patient A recalled that Dr. Phipps had examined the back of her eyes at one of her visits in September. She accepted that Dr. Phipps would have leant in toward her to do so, but was insistent that he stood at her left side in doing this examination.

On September 29, 2014 Patient A saw Dr. Phipps for the same symptoms of headache and dizziness. Dr. Phipps believes that this was the photo visit. He testified that the photo visit must have been before October 3, 2014 because he 'absolutely' would not have continued to show the photographs following the College visit. Although no exam was documented, Dr. Phipps testified that he would have done a funduscopic exam on that day given Patient A's symptoms.

Dr. Phipps described how he would have conducted such an exam. He stands facing the exact opposite direction the patient faces and to one side of their legs. He leans in to look in one eye

and then walks around to the patient's other side to look in the other eye. Although his right leg and the patient's left leg, and vice versa, are likely touching each other at some point during a funduscopic exam, Dr. Phipps was certain that his penis did not come in contact with Patient A's leg. He also noted that the examining table and thus, a patient's leg, are lower than where his erect penis would be, whereas the objects in his pocket would be at the appropriate height and would rest against the patient. He described typically having in his pockets a cell phone, reading glasses in a soft leather case, a pen, and a handkerchief.

Although the date of the photo visit is in contention, Patient A said that the purpose of the visit on that day was for assessment and a letter of permission for her to return to work. She testified that during the visit, Dr. Phipps told her he had to show her something. He had been talking about golf and sending a photograph back and forth to his wife. He then handed her his cell phone displaying a naked photograph of himself with a 'semi hard-on'. She identified it as Exhibit 2A.

Patient A was shocked, couldn't understand why Dr. Phipps had shown her the photograph. She no longer felt safe with him. She testified that he said, 'Ain't I well-endowed for a man my age' and believed that he was referring to his penis. She did not accept that her recollection of the specific wording might have changed over time, or the possibility that Dr. Phipps may instead have said something more like 'not bad for a man my age' or 'not bad for an old guy'.
Dr. Phipps had no specific recollections of the photo visit, other than Patient A's response 'Oh la la' to seeing the photograph. He believed he may have commented to her something like, 'Isn't that good for a guy my age?' which is a phrase he does use at times, in relation to a golf shot, for example. He would have done so in a lighthearted way and not in reference to his penis. He did not recall Patient A seeming upset then or at two or three later visits.

Afterward, Dr. Phipps did a physical exam. Dr. Phipps testified that he would have examined the back of her eyes (funduscopic exam), as described above. Patient A testified that the examination on that day was done solely to determine whether the bruised ribs were sufficiently healed for her to return to work, and did not include an examination of the back of her eyes. She was seated on the examining table. She stated that Dr. Phipps stood facing her, leaned forward slightly, and

pressed on her ribs with his right hand while lifting her top with his left hand. It was as he was leaning in that Patient A felt what she believed was an erection. She ‘could feel him being excited, a semi hard-on’. She had never experienced anything similar in prior appointments. She was adamant that it was Dr. Phipps’ erect penis that she felt and not an object he may have had in a pocket. She described it as in the front of his body as he was leaning on her, and not on his sides where his pockets were. She moved her leg away very quickly ‘because I couldn’t believe he did just do that’.

Patient A testified that the photo visit ended with the understanding that she needed to return for her letter. She said that she did return, despite these events, because she very much wanted to return to work and needed the letter to do so. To the best of her recollection, the date of the photo visit was October 7, 2014. The chart entry for that date was entitled ‘Absentee Note’. She did not accept that the photo visit could have been earlier than October 7, 2014.

Patient A was confident that she received both the return-to-work letter and an apology from Dr. Phipps on her visit next following the photo visit. This is consistent with her initial College phone call on February 3, 2016. Also, at the next appointment, Dr. Phipps asked Patient A to ‘keep it between the two of us’. She did not accept that she received both the note and apology on October 7, 2014, and thus that the photo visit must have been in September 2014.

Dr. Phipps testified that he saw Patient A on October 7, 2014, at which time she was complaining of chest pain, trouble with focus and feeling down. Dr. Phipps stated that he wrote a return-to-work note on that day to the effect that she might be able to go back to work the following week. He described the process in the EMR by which the note is compiled. The note does not appear in the EMR unless it is printed. The printed copy is given to the patient at the time. Dr. Phipps believed that he gave Patient A the note on October 7, 2014 because the notes are always given to the patient and he would have nowhere to keep them otherwise.

Patient A saw Dr. Phipps again on October 14, 2014 when he completed a work-related ‘Abilities’ form for her school. The paper-clip attachment for the chart entry for October 14, 2014 was ‘Miscellaneous Letter, Received October 14, 2014.’ As well, there was an “Abilities’

form filled out by Dr. Phipps and dated October 14, 2014. Patient A returned to work in October 2014.

Patient A saw Dr. Phipps next and for the last time towards the end of 2015. She needed to have a physical examination and a form completed in order to transfer to a new workplace. She requested that she see someone other than Dr. Phipps. The exam was done by the nurse practitioner.

Patient A testified that she did not report the events of the photo visit at the time because she was shocked, embarrassed, and scared. In 2015, she disclosed the incident to the nurse practitioner in Dr. Phipps' clinic. She did so because she was experiencing nightmares and was more depressed than ever, and because she had learned that she was not the only woman with whom Dr. Phipps had behaved this way. She learned this from the notice posted on his office wall and from asking Dr. Phipps about his chaperone. She formally complained to the College with the assistance of the nurse practitioner. Patient A described the photograph and inappropriate comment and that Dr. Phipps' penis touched her knee in her initial conversation with a College investigator on February 3, 2016.

Patient A acknowledged saying to a College investigator in 2016 that she was having trouble with her memory and needed to write things down to remember them. She attributed this problem to depression, difficulty sleeping, nightmares, and the effect of medication at the time. She stated that she was not having problems with her memory around the time of the photo visit. Asked whether the comment 'trouble with memory concentration' on a sleep lab requisition completed by Dr. Phipps in 2008 was a correct description at the time, Patient A said that she could not remember because it was so long ago.

The following facts were set out in the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A, which was filed as Exhibit 16:

A. Patient Chart

1. Following the testimony of Patient A before the Discipline Committee panel on July 31, 2017, she advised the College that the copy of her patient chart she was shown while testifying [Exhibit 12] was not the same as the copy of her patient chart that she had obtained directly from Dr. Phipps' office at an earlier time.

2. Dr. Phipps uses an EMR (electronic medical record system). When printing from an EMR system, "paperclip attachments" must be checked off in the system or they will not be displayed and printed on the chart. Paperclip attachments on the patient chart indicate that third party documents have been scanned into the EMR.

3. When Patient A's patient chart was printed by Dr. Phipps' office staff for the College, paperclip attachments were inadvertently not checked off. The copy of the chart that was provided to the College and filed as Exhibit 12 in the hearing does not reflect paperclip attachments.

4. The copy of the patient chart obtained by Patient A directly does have paperclip attachments noted in her patient chart.

5. Attached at Tab A [to the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A] is a copy of Patient A's patient chart for September and October 2014, containing paperclip attachments noted in the patient chart.

6. As set out in Tab A, the following paperclip attachments are in the patient chart:

    - October 7, 2014: "Physiotherapist", (p. 12 of Tab A). The note from a physiotherapist who was providing treatment to Patient A for injuries she suffered in September 2014, is at p. 13 of Tab A [to the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A];

- October 14, 2014: "Miscellaneous Letter Received: Oct.14, 2014 ABILITIES FORM see attached", (p. 14 of Tab A). The Abilities Form, filled out by Dr. Phipps, is at pp. 15 - 16 of Tab A [to the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A].

7. Along with her copy of the patient chart, Patient A provided a copy of a note she received from Dr. Phipps, attached at Tab B [to the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A] and dated October 7, 2014. The note dated October 7, 2014, (Tab B [to the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A]), is not contained in a paperclip attachment in the patient chart and is not scanned into the chart.

8. The patient chart entry for October 7, 2014, states "Absentee Note" and records the same content that is in the note attached at Tab B [to the Agreed Statement of Facts Re: Patient Chart and Employment Information – Patient A].

9. It is Patient A's evidence that she received this note from Dr. Phipps on October 14, 2014. It is Dr. Phipps' evidence that he provided this note to Patient A on October 7, 2014.

B. Employment Records

10. Based on employment records provided by Patient A subsequent to her testimony, the parties agree that she returned to work, following the injuries in September 2014, in October 2014.

Patient K

Patient K is in her 40's. She had been a patient of Dr. Phipps since she was a teenager, as were many of her family members. She described Dr. Phipps as having been very caring, compassionate, gentle, intelligent, and extremely trustworthy. She had always been very comfortable with him and found him to have behaved in a professional manner.

Patient K accepted that the likely date of the photo visit was August 29 or possibly September 11, 2014. She was seeing Dr. Phipps for a blood pressure check and follow up. She complimented him on his tan when he came into the examining room, and recalls him saying he'd been away on a golf trip with friends.

At the end of the appointment, in what she understood as an attempt to cheer her up, Dr. Phipps asked if Patient K wanted to hear a joke about something that had happened on his golf trip. She agreed and he told her about a gum commercial in which a man appears to have big hair but is actually bald and the big hair is that of a woman standing obscured behind him. He went on to say that he had taken a similar photograph while away on his trip. Further, he had tried to show it to friends but had accidentally shown them another.

He asked Patient K if she wanted to see the photograph. She expected that it was a photograph of a bald man with big hair. Instead, Dr. Phipps showed her a naked photograph of himself on his cell phone. He initially showed her an image of his upper body. Dr. Phipps told her that it was a private photograph for his wife that she had asked him to send. She testified that he then expanded the image on his phone so that it included his genital area.

Patient K was shocked, felt violated, and was confused. She described Dr. Phipps as being completely naked in the photograph, with the beginning of an erection and his pubic area groomed. He was tanned and looking as if he had just come out of the shower. The photograph showed him in a mirror taking the selfie.

Patient K testified that the photograph she saw was not Exhibit 2A and described several differences. She described Dr. Phipps as looking like a sociopath in Exhibit 2A. He appeared to be posing in the photograph he showed her. She said that the photograph is 'etched in my mind for the rest of my life' and, that three years later, 'I still remember what my doctor looks like naked, which is something I should never know'.

Dr. Phipps did not recall anything about the photo visit. He believed that the photograph he had shown Patient K was Exhibit 2A, and that the photo visit was likely on September 11, 2014. He

denied that there was ever a photograph in which he had one leg up or in which he had groomed his pubic hair. He denied enlarging the image on his cell phone to highlight his genitals when he showed the photograph to Patient K.

After showing her the photograph, Dr. Phipps asked Patient K to 'keep it between the two of us' because he was embarrassed but felt could trust her and wanted to tell her the joke because she would find it funny.

Patient K testified that when she was leaving the exam room, Dr. Phipps gave her a 'sideways hug' from her left side with his right arm. When he did so, she could feel 'the start of an erection' on her thigh or 'waist, hip' area or 'just above [her] waist…ribcage area.' Patient K testified that she was certain that it was Dr. Phipps' penis that she felt. In her earlier College interview, she had stated: 'I wasn't sure if that was what it was, but at that point, that's what it felt like. She agreed that she 'took it as a supportive comforting hug' at the time. Dr. Phipps made consoling comments and asked her again not to tell anyone and to keep it between the two of them: 'he put his finger to his lips, like to tell me to shush, like let's keep this a secret, our secret.'

Dr. Phipps acknowledged that he may have given Patient K a hug at the end of the visit, but asserted that when you hug someone from the side, the only part of you that touches them is your side. His view was that she would have felt the contents of his pockets. Dr. Phipps denied having any sexual interest or intention in telling Patient K the story of his golf trip. He stated that his purpose had been to tell an embarrassing story and that eventually he became embarrassed about showing the full-frontal photograph and cropped it.

When Patient K left the office, she felt shocked, betrayed, and victimized because nobody knew her better than Dr. Phipps and she had trusted him.

Patient K continued to see Dr. Phipps as her physician. She chose to try and move on and put the events aside. He apologized to her at her next appointment. She stopped seeing him, however, after learning about this hearing. Patient K learned of it from a family member who had read

about it in a local newspaper in August 2017. She was shocked and surprised to read that other women had experienced what she had. She understood from the article that a sexual offence had been alleged involving touching and, specifically, leaning against a patient while checking their blood pressure. In her College interview, Patient K had said that she understood that 'Dr. Phipps did not deny anything. He admitted to everything. She did not recall this at the time of giving testimony but accepted the correctness of her earlier statement.

Patient K testified that she felt differently about other incidents with Dr. Phipps when she became aware that other women had had similar experiences. She testified that they 'started to surface', incidents that she had 'been mindful of' but not thought much about as she had had no reason to be distrustful of Dr. Phipps. She further testified that she had found them inappropriate and improper at the time but 'pushed them to the side.' She said that it was not that she now thought they were inappropriate because she had read the article, but that she had always thought they were inappropriate.

Counsel for Dr. Phipps put to Patient K that reading a newspaper article about Dr. Phipps' hearing made her decide that it must have been his penis that she had felt. She denied that she had only begun to see prior events in a sexual light after reading the article, although the portion of her August 25, 2017 interview transcript read to her was not wholly consistent with this. Patient K testified that her interview responses could have been better phrased and that she had not, when they happened, wanted to believe that certain events had had a sexual nature.

At other points in her testimony, Patient K stated that: she had never wanted Dr. Phipps to get into trouble; she had no reason to question that Dr. Phipps was doing anything inappropriate at prior visits; and, she always knew that his pushing, pressing, rubbing up against, swaying motion of his penis at prior visits was sexual stimulation.

Dr. Phipps denied that he ever pushed his penis into Patient K's leg and that it would have been the contents of his pockets that she felt when he was taking blood pressure measurements. He stated that if he were standing at a 90-degree angle to her legs so that he could push his groin into her, he would have been unable to see the blood pressure dial. He stated also that, given his

height and the height of the examining table, the part of her leg that would have been exposed to him would have been at the level of his pockets and not the level of his penis.

Patient K has tattoos on her back and buttock. She testified that whenever she had a check-up, Dr. Phipps would make a comment or some kind of joke. Once she read the article about the hearing, she 'started to see things differently', and 'things started to surface.' At the time, she thought he was just making a joke about the tattoos.

With respect to Patient K's tattoos, Dr. Phipps said that he might have made a comment like, 'Oh, that's a cute tattoo,' but would not have said anything in any way sexual.

On another occasion, during an examination, Dr. Phipps made a comment to the effect that the surgeon who had done her breast surgery some years before had done a great job or an amazing job or an excellent job. Patient K disagreed that he had been expressing a view on the quality of the surgical result. She testified that she had felt uncomfortable at the time and thought that it was inappropriate but did not want to believe that it was. In her College interview, she had stated that she 'didn't think anything of it' and accepted Dr. Phipps' clarifying comment that the surgeon had done 'such a perfect job'.

In relation to Patient K's prior breast reduction surgery, Dr. Phipps testified that he probably commented 'that the surgeon had done a great job on her breasts,' meant in a strictly medical sense, perhaps because the surgeon had done an uncharacteristically good job.

Patient H and Patient C

With respect to the evidence of the remaining two patients (H, C), in addition to his conduct in showing the photographs, the Committee also considered whether or not:

- At a subsequent visit, Dr. Phipps had advised Patient H to deny to College investigators that she had seen any photographs;

- In prior visits, Dr. Phipps had made comments or remarks to Patient C that were inappropriate and/or of a sexual nature.

Patient H

Patient H is in her 40's. She and members of her family had been patients of Dr. Phipps for many years until November 2016. She had never had any concerns with his behaviour until the visit of September 22, 2014 (photo visit).

Towards the conclusion of that visit, Patient H asked Dr. Phipps about his holiday. He told her about having been away golfing with friends and recounted a story about taking a photograph when out for dinner. He then showed her a photograph on his cell phone of a woman with very blond hair who looked like a 'floating ghost.' Patient H thought it was funny and not offensive. Dr. Phipps took the cell phone back from her and went on to talk about wanting to show the photograph to friends when he had returned home. The screen went black when he passed his phone to his friends. When someone swiped it to reactivate it, the phone opened to a naked photograph of Dr. Phipps.

Dr. Phipps showed the photograph to Patient H. She described it as showing Dr. Phipps from the knees up, standing, reflected in a mirror taking a 'selfie' with his phone, naked, the image clear except that his genital area appeared 'fuzzed out.' He was tanned and chiseled, very fit looking, wearing black eyeliner and with his hair gelled and spiky. The photograph was not Exhibit 2A. Patient H was confident of this even though the image on the cell phone was much smaller and her view of it had been very quick. The image was 'ingrained in her head.'

Patient H immediately raised her hands to cover her eyes. She said she was mortified, embarrassed, and uncomfortable. Dr. Phipps laughed at her reaction. He told her that he sends pictures like this to his wife when he's away.

Dr. Phipps had no specific recollection of the photo visit but did not deny that he showed Patient H a naked photograph of himself.

Patient H spoke to her husband following the appointment. They did some online research about how to make a complaint but decided against doing so because of a prior experience with negative community reaction following an incident with a different place.

Patient H next returned to see Dr. Phipps in the winter or spring of 2015. She was sick and had decided he wasn't likely to 'show her anything else.' At the end of that appointment, Dr. Phipps told her that he had shown the photograph to another woman who claimed he was stalking her, driving by her house, and who had reported him. He had also shown it to another patient and she was 'fine with it.' Patient H recalled believing at that time that there were only two other women to whom Dr. Phipps had shown the photograph.

Patient H testified that Dr. Phipps told her then that the College was investigating, and that she should deny having seen any photographs if contacted. She did not accept that his comment might have been something like, 'Let's just keep this between us' or 'Look, I don't want you talking about this,' in a general sense, rather than "I don't want you talking to the College.'

Dr. Phipps was shocked by Patient H's assertion that he had asked her to deny that he had shown her the photograph. He believed that he would have told her that the College would be contacting her and then, as a separate matter, that he 'didn't want her telling everybody', in the sense of preferring that she keep the incident to herself, thinking of the community rather the College. He could see no reason why he would advise one patient to deny seeing a photograph, and said that doing so would be a 'recipe for disaster' in terms of the College investigation.

In relation to Patient H's evidence that he told her about showing photographs to two other patients, Dr. Phipps stated that he would have been trying to justify or minimize what he had done. He testified that he did not tell her that there were additional patients beyond the two he mentioned, nor did he assure her that there were only the two patients.

Patient H again considered making a complaint and looked online for any information about the complaint Dr. Phipps had told her about. She found none. She wanted to discuss it with her therapist, but her therapist said that she (the therapist) would have to report it if Patient H told

her about misconduct by her doctor. Patient H decided she did not want to ‘put it out there’ and did nothing more at that time.

In the fall of 2016, Patient H’s child told her about an online article reporting that six women had complained about Dr. Phipps’ conduct. Patient H decided then to come forward. Her therapist assisted her in reporting to the College. She felt that Dr. Phipps having behaved in this way with other women made his overall conduct that much worse. She did not return as a patient after November 2016.

Patient C

Patient C is a woman in her 50’s who had been a patient of Dr. Phipps for many years. She had severe pain from an injury suffered in a fall and was using an assistive device. She, her then husband, and child were his patients until the photo visit. Patient C accepted that the date of the photo visit was September 3, 2014.

Patient C testified that at prior visits, Dr. Phipps ‘would quite often say inappropriate things about being sexy, smelling good, things like that, looking good.’ However, she also testified that she had never had any concerns about medical examinations. In her initial conversation with a College investigator in June 2015, Patient C had volunteered that the photo visit was ‘the first incident that was questionable that he ever did and was out of character.’ Further, she had denied in her interview shortly afterward that Dr. Phipps had made inappropriate remarks at prior appointments.

Dr. Phipps testified that it was not unusual for him to comment positively on a patient’s clothing, whether a man or a woman, and he may have commented about Patient C’s general appearance, clothing and/or perfume. If he were to comment on a patient’s perfume, it would normally have been when they were wearing too much. Dr. Phipps denied that he would ever have said that he thought someone was sexy.

Patient C attended the photo visit alone, which was not usual as her husband typically accompanied her on her visits to Dr. Phipps. At the outset, Dr. Phipps asked Patient C how long she had been a patient and said that he had a funny story to tell her when the appointment was over. Patient C said she was unable to leave at the end of the appointment as quickly as she'd wished because of her assistive device and because Dr. Phipps held her back to tell his story. He told her about being on a golf trip with friends and he showed her a photograph of his friend, who had little or no hair, standing in front of a woman with big huge hair. Patient C thought it was quite funny, hoped that that was the funny story, and proceeded to try to leave. Dr. Phipps told her to wait, that wasn't what he wanted to show her. He then told her about his wife sending him a photograph of herself in a bikini on a beach. Intending to reply to his wife, he took a naked photograph of himself but inadvertently sent it to friends.

Dr. Phipps then showed Patient C a photograph on his cell phone, in which he was standing naked in front of a bathroom mirror. She identified the photograph as Exhibit 2A. As she tried to leave the room, Patient C had her back turned to Dr. Phipps: "He was pressed up right against my back, and the phone was right in my face.' After showing her the photograph, he said, 'Well, I've seen you naked; you've seen me naked. We're even.' He then he put his finger up to his lips and said, "This is between you and me. You can't tell anybody else."

With respect to pressing up against Patient C's back as she was leaving the room, Dr. Phipps testified that he sometimes opens the door while standing behind a patient, but denied pushing himself up against her.

Patient C was confident in her testimony that Dr. Phipps' penis was fully exposed in the photograph. She had said in her initial College interview that she did not know whether or not there had been a sock on his penis. She testified that she had said this because she was in shock at the time, and reiterated that she was trying to minimize her involvement because of her husband.

With respect to the inconsistencies between her testimony and prior statements to investigators, Patient C testified that her answers in the College interview had been accurate 'to a degree' and

‘about certain things,’ and that she had tried to ‘mitigate’ her involvement because her husband did not want her to be involved. She testified that her husband was very angry and did not want her meeting with or speaking to the investigator. She was trying to keep her marriage going. Patient C’s husband was not present on the initial phone call or subsequent interview.

Dr. Phipps did not dispute that he showed Patient C a naked photograph of himself. He acknowledged that he could have said something like, ‘It’s between us’, with his finger to his lips, when he showed her the photograph, and that he could have said this to any of the patients. He also acknowledged that he may have said something like, “I’ve seen you naked and you’ve seen me naked.’

Patient C did not return following the photo visit. She wanted to report or complain about Dr. Phipps’ behaviour but her husband forbade her to do so. She received a phone call from Dr. Phipps around Christmas. He apologized and told her that he had shown the photograph to another patient who had complained, and so she (Patient C) might be contacted.

Patient C received a number of further calls from Dr. Phipps’ office related to test results and follow up. Dr. Phipps called on August 7, 2015 and left a voicemail offering to arrange for her to see another physician. One option was a female physician in the same clinic, and Patient C did see her for a time. She arranged with the office staff to see this physician at times when Dr. Phipps would not be in the office. She testified that the phone calls made her feel almost as if she were being stalked.

On one occasion when she was seeing the other physician, Patient C believed Dr. Phipps was directly outside the exam room she was in, and was scared that he would come in. She recalled hearing the secretary ask Dr. Phipps why he was in the office. She acknowledged that she had no specific reason to think that he even knew she was there.

Patient C testified that on October 19, 2015, Dr. Phipps called her in response to a message from the clinic staff and said that he understood that she wanted to talk to him, which was not the case. At this point, Patient C decided not to return further to the clinic.

Dr. Phipps testified that he was not aware of the fear Patient C had of encountering him, but he did recall hearing from clinic staff that she did not wish to talk with him. Shortly afterward, he got a message from the clinic staff to the effect that she did want to speak with him. When he called her and learned that she did not in fact, but instead wanted to speak to her new physician, he apologized and ended the call.

Patient C testified that she had suffered a fall years previously, and had had a concussion and memory problems for about a year afterward. She denied in her testimony that she had had any memory problems at the time of the interview and said that, in mentioning memory issues at the time, she was again attempting to 'mitigate her involvement in any way, shape or form.' She stated that she had felt in a very difficult position, trying to be honest with her husband who wanted her to have no involvement while trying to be as honest as she could be with the investigator. She testified that her evidence is not now influenced by her husband as she is no longer married. Patient C acknowledged that her memory of specific events would have been clearer at the time of her College interview than now.

Patient C testified that these events have devastated her life. She no longer trusts men, has a very hard time with a male in any professional setting, and is having therapy.

Dr. Phipps

Dr. Phipps described his training and experience, his practice, and the clinic in which he works. He described a recent health issue that had affected the scheduling of the hearing.

Dr. Phipps described taking an annual seven to ten-day golf trip with male friends and specifically, the trip in April 2012 to Arizona . At one point, when out for dinner, he took a photograph of his friends across the restaurant table. One of the friends, who was essentially bald, looked as though he had on a 'big clown's wig' because of the hair of the woman sitting directly behind him. His friend took Dr. Phipps' cell phone over to the other table to show the photograph to the woman. However, the cell phone screen timed out and went black. When the woman reactivated the screen, the photograph displayed was one that Dr. Phipps had taken of

himself earlier in the day. He had taken it to send to his wife in reply to one she had sent him. The photograph was Exhibit 2A, a naked full-frontal photograph of Dr. Phipps taken in the bathroom of the resort condo where they were staying. Dr. Phipps' friend and the woman at the next table were staring at him and laughing and he then realized that they must have seen the naked selfie.

Dr. Phipps testified that he also had on his cell phone a photograph of his naked buttocks (Exhibit 2B) that he had taken at home at a later time, also for his wife. He testified that towards the end of September 2014, he had become uncomfortable with showing patients the full-frontal photo (Exhibit 2A), and so he cropped it to eliminate his genitalia (Exhibit 2C). This was the photograph he showed on October 1, 2014 to three clinic staff. He agreed with College counsel that on September 30, 2014, he showed a photograph that included his penis and genitals to Patient I. He further acknowledged that on September 3, 2014, he showed photographs to two patients: a cropped or zoomed photograph of his upper body to Patient E and a full-frontal photograph to Patient C.

Dr. Phipps testified that there had been one other naked photograph on his cell phone, taken at the same location as the buttocks photograph; a naked full-frontal photograph similar to Exhibit 2A but with a towel draped over his arm. He was uncertain why he deleted the towel photo from his cell phone but said that he did so in September 2014. He also stated that he deleted the towel photo because he had taken it as a 'one-off' just to make a joke to his wife, whereas the other three naked photographs had a sentimental basis so he kept them. He had already sent the towel photograph to his wife and wasn't planning to show it to anyone else. Once he deleted the towel photograph, he emptied the 'trash' on his cell phone to make sure that the photo 'couldn't inadvertently be found.'

Dr. Phipps went on to describe his experience of 'the three pictures on [his] phone' being transferred automatically to the photo album of his home computer and then nearly transferred inadvertently by his wife to her sister amongst a large batch of photographs. He said that he wanted to be sure this never happened again.

Dr. Phipps testified that these were the only three naked photographs of him on his cell phone and that these were the photographs he had shown to patients. Dr. Phipps specifically denied that there was ever a photograph of him with a sock on his genitals, in a body-builder pose, wearing eyeliner, with one foot raised, or with his genitals blurred out.

Dr. Phipps agreed that the first time he had explicitly made the College aware that he had taken the towel and buttocks photos, not on the golf trip in 2012, but at his home at a later time, was in the week prior to his giving testimony at the hearing. He believed that this had been known to the College.

Dr. Phipps acknowledged that the photographs were taken for his wife and were sexual in nature. He testified that he would not have told the golf story or shown the photographs with children around, and agreed with College counsel that, 'That kind of lewd, sexual picture shouldn't be shown to children.'

When asked by his counsel why he had shown the photographs to patients, Dr. Phipps said that he had thought that the story was humorous and mutually embarrassing – that everyone would be 'fine with it.' Dr. Phipps had retold the story of the April 2012 golf trip and embarrassing photograph in August 2014 when a group of male friends was sitting around after playing golf. Someone asked to see the photographs. Dr. Phipps showed the photograph of his friend 'with the extra hair' and the full-frontal photograph to the group, which included some of the club waitresses. The group responded with laughter. A week later, a longstanding elderly patient came to Dr. Phipps' office, accompanied by a family member who worked at the golf club. He initiated the telling of the golf story by asking her, when the patient was not present, if she had heard about what had happened the week before. She asked to hear the story and see the photographs. Dr. Phipps showed her the 'extra hair' photograph and the naked full-frontal photograph of himself.

Dr. Phipps noted that there were a number of stressors in his life at that time. He and his wife had begun to see a marriage counselor in the summer of 2014. As well, his father was in a long-term

care facility for individuals with Alzheimer's disease and no longer recognized Dr. Phipps. Lastly, Dr. Phipps acknowledged that he had been drinking to excess.

When asked by College counsel why he thought it would be a good idea to share something with patients that would be embarrassing for himself and his patients, he testified that it was supposed to be a 'light-hearted teasing sort of embarrassment' and to provide a certain, small sense of enjoyment. He denied that there was enjoyment or excitement in showing a photograph of his penis. He described the punch line of the joke or golf story as the woman in the restaurant inadvertently coming across a naked photograph, but acknowledged that he felt that showing the naked photograph to patients was a better punch line.

Dr. Phipps chose to show the photographs to female patients with whom he had a longstanding relationship, who he would have considered friends. He could not account for why he showed certain photographs to certain patients or why on some days and not others, beyond that the patients were ones he felt comfortable with. He stated that his actions were not meant in any sort of a sexual way and that he thought that patients would find the story innocuous and funny. He thought that males would not find the story funny.

Dr. Phipps stated he was certain that he had said, 'Let's just keep this between us, or shh, this is between us' or something similar to a number of patients. He said that he did so because it was a personal story, a bit embarrassing, and not for public consumption.

FACTS and EVIDENCE: CLINIC STAFF

Dr. Phipps testified that, in the context of recounting the golf story, he showed three clinic staff members a cropped version (Exhibit 2C) of the full-frontal photograph (Exhibit 2A).

Agreed Statements of Facts: (Ms. L, Ms. M, Ms. N)

The following facts were set out in the Agreed Statement of Facts Evidence of Staff (Ms. L), which was filed as Exhibit 7:

A. Overview

1. Ms. L is employed with one of Dr. Phipps' practice locations, in Ontario.

2. Ms. L has been employed by them for approximately 11 years. She works for Dr. Phipps as well as other physicians in the practice.

B. Evidence of M. L

3. On October 1, 2014, at the end of the work day, Ms. L was at the clinic's reception desk when Dr. Phipps showed Ms. L and Ms. M, another employee, a picture of himself on his cellular telephone. The picture showed Dr. Phipps' bare chest and went from his head to about his waist.

4. Dr. Phipps told them that he was away with friends. They were looking at pictures, and swiped across his cellular telephone and came to this picture. Dr. Phipps told them the picture his friends saw showed more.

5. The picture that Ms. L and Ms. M saw showed Dr. Phipps looking into a mirror and naked from the waist up. He also showed them a picture of the three men he was with on his holiday.

6. After seeing the picture, Ms. L turned away. She was uncomfortable. It was unusual and out of character for Dr. Phipps to share that kind of story and show the picture.

7. After showing the picture to Ms. L and Ms. M, Dr. Phipps showed the picture to Ms. N, another staff member.

8. On July 7, 2017, Ms. L was shown a picture provided by Dr. Phipps to the College during the investigation into this matter, attached at Tab A [to the Agreed Statement of Facts of

Staff – Ms. L]. Ms. L believes that the picture she saw showed Dr. Phipps naked from the waist up, above his bellybutton.

9. Other than this incident, Ms. L finds Dr. Phipps to be very professional.

The following facts were set out in the Agreed Statement of Facts Evidence of Staff (Ms. M), which was filed as Exhibit 8:

A. Overview

1. Ms. M is on staff at one of Dr. Phipps' practice locations, in Ontario.

2. Ms. M has been employed by them for approximately 5 years. She acts as a staff member for the whole office, including Dr. Phipps and other physicians in the practice.

B. Evidence of Ms. M

3. On October 1, 2014, at the end of the work day after the office was closed, Ms. M was tidying one of the examination rooms in preparation for leaving for the day. Dr. Phipps approached her and asked her to come to the reception desk where he was talking with another employee, Ms. L.

4. Dr. Phipps shared a story with Ms. L and Ms. M about being away with a group of friends. He told them he took a picture of his friends. There was a lady with frizzy hair, which looked like a "big afro", who was standing behind one of his friends. Dr. Phipps' friend meant to show the picture of himself with the lady with big hair behind him, and instead showed a naked picture of Dr. Phipps.

5. After telling this story, Dr. Phipps showed Ms. L and Ms. M a picture of himself naked from the waist up. In the picture, Dr. Phipps was holding his telephone in his hand and was reflected in a mirror.

6. Dr. Phipps told them that the picture was between him and his wife.

7. Ms. M was embarrassed and shocked when she saw the picture. She did not know what to do so she just walked away. Ms. M felt it was out of character for Dr. Phipps to do something like that.

8. After showing the picture to Ms. L and Ms. M, Dr. Phipps showed the picture to Ms. N, another staff member.

9. On July 7, 2017, Ms. M was shown a picture provided by Dr. Phipps to the College during the investigation into this matter, attached at Tab A [to the Agreed Statement of Facts of Staff – Ms. M]. Ms. M confirmed that the picture is similar to the one she was shown, although she cannot state it is the exact same photo.

The following facts were set out in the Agreed Statement of Facts Evidence of Staff (Ms. N), which was filed as Exhibit 9:

A. Overview

1. Ms. N is employed with one of Dr. Phipps' practice locations, in Ontario.

2. Ms. N has been employed by them for approximately 13 years. She works for Dr. Phipps as well as other physicians in the practice.

B. Evidence of Ms. N

3. On October 1, 2014, at approximately 5 p.m., at the end of the work day, Ms. N was tidying the clinic in preparation for leaving for the day. Dr. Phipps approached her and told her he wanted to tell her a story about his "selfie".

4. Dr. Phipps told Ms. N that he had been on a trip with friends about two months earlier. Dr. Phipps showed Ms. N a picture of a group of his friends at a bar. In the picture, there was a woman behind the group with big hair and it looked as if her hair was enveloping one of Dr. Phipps' friends.

5. Dr. Phipps told Ms. N that his friend had decided to show the picture to the woman with big hair. When Dr. Phipps' friend clicked to open the picture on Dr. Phipps' cellular telephone, a "private" picture of Dr. Phipps that he had shared with his wife was displayed. The woman and Dr. Phipps' friend started laughing and told Dr. Phipps that they had seen his private pictures.

6. Dr. Phipps then showed Ms. N a "selfie" on his cellular telephone. When he showed her the picture, he placed his hand over the bottom part of the picture.

7. On July 7, 2017, Ms. N was shown a picture provided by Dr. Phipps to the College during the investigation into this matter, attached at Tab A [to the Agreed Statement of Fact – Ms. N]. Ms. N confirmed that the picture is similar to the one she was shown by Dr. Phipps, although she does not recall whether Dr. Phipps had an object in his hand in the picture he showed her.

8. Ms. N found the story funny. The picture threw her off a bit, but she was not upset. It was unusual for Dr. Phipps to share the story and show her the picture as he is not the type to share personal information in the office.

LEGAL PRINCIPLES

Standard of Proof

The Committee recognizes that the burden of proof is on the College to prove the allegations of professional misconduct. The standard of proof is a balance of probabilities, on the basis of

evidence in the hearing which is clear, cogent, and convincing. There is no onus on Dr. Phipps to disprove the allegations.

Each Allegation Must be Proved Separately

The Committee recognizes that although there are allegations regarding multiple patients, the College must prove the allegations with respect to each patient separately, based on the facts related to Dr. Phipps' interactions with that particular patient. The Committee must not and has not engaged in propensity reasoning. Even if the College satisfies its burden of proof with respect to the allegation(s) of one patient, the Committee must not, and has not, inferred that Dr. Phipps is the kind of person who would commit the other alleged acts. The College must prove each allegation separately.

Credibility and Reliability

The Committee recognizes the importance of credibility and reliability. Credibility refers to the witness's sincerity and willingness to speak the truth as he or she believes the truth to be. Reliability relates to the witness's ability to accurately observe, recall and recount the events at issue. The witness's credibility must be assessed along with whether his or her evidence is reliable and can be counted on to be accurate. The Committee appreciates that an honest witness can still be mistaken and, consequently, his or her evidence while sincerely given, may be unreliable.

When assessing credibility and reliability, the Committee should look to the totality of the evidence and assess the impact of any inconsistencies. The Committee accepts that inconsistencies on minor matters of detail between what the witness said at the hearing and what he or she said on other occasions, are normal and to be expected and do not generally affect the credibility of the witness. When inconsistencies are of a material nature about which an honest witness is unlikely to be mistaken, such inconsistencies may demonstrate carelessness with the truth.

There are a number of factors relevant to assessing credibility, including:

- Did the witness seem honest?
- Did the witness have an interest in the outcome?
- Did the witness seem to make accurate and complete observations? What were the circumstances of the observations? Were they unusual or routine?
- Did the witness seem to have good memory?
- Did any difficulty that a witness had seem genuine or made up?
- Did the witness seem to be reporting or simply putting together an account put together from other sources?
- Was the testimony reasonable or consistent?
- Did they say something different on an earlier occasion?
- Did any inconsistencies make the evidence more or less reliable and believable? Was it an honest mistake? Is there an explanation for the inconsistency?
- What was the witness's manner?

The Committee is aware that appearance and demeanor can be highly unreliable in assessing the credibility of a witness.

Sexual Abuse

Sexual abuse is defined in the Health Professions Procedural Code as follows:

1 (3) "Sexual abuse" of a patient by a member means,

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

The allegations in this case relate to s.1(3) (b) and (c), that is, touching, behavior or remarks of a sexual nature. The definition in the Code specifies that "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

In determining whether Dr. Phipps' conduct was sexual in nature, the Committee considered the principles articulated by the Supreme Court of Canada in *R v. Chase*, [1987] 2 SCR 293 with respect to the criminal offence of sexual assault. The test to be applied is an objective one: "viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer".

As set out in *Chase*, the factors to be considered are:

- the body part touched;
- the nature of the contact;
- the situation in which it occurred;
- the words and gestures accompanying the act; and
- all other circumstances surrounding the conduct, including threats which may or may not be accompanied by force.

While intent or purpose, to the extent that it may appear from the evidence, may be a factor in determining whether or not conduct is sexual, it is not a prerequisite to a finding that conduct is sexual in nature. It is one of many factors to be considered in the circumstances.

Disgraceful, Dishonourable or Unprofessional Conduct

The professional misconduct regulation under the *Medicine Act, 1991*, includes a 'catch-all' provision intended to capture serious or persistent disregard for professional values and/or obligations:

> "an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional"

The text 'A Complete Guide to the Regulated Health Professions Act' by Richard Steinecke notes that:

> "… the catch-all definition is not supposed to reflect the values of the general population, but the values of the profession itself. Members of the profession best understand the circumstances in which practitioners operate".

The text further states:

> "The catch-all provision is not intended to capture the legitimate exercise of professional discretion or mere errors of judgment. However, conduct need not be dishonest or immoral to fall within the definition. A serious or persistent regard for one's professional obligations is sufficient."

Both disgraceful and dishonourable conduct carry an element of moral failure, whereas conduct need not involve dishonest or immoral elements to be considered unprofessional. Conduct need not harm the practitioner's client or staff to be unprofessional.

ANALYSIS AND FINDINGS

Each of the patients had some recollection of Dr. Phipps' showing her photograph(s) and of the related conversation and events. Several patients were immediately and greatly affected. Some chose, at least initially, to regard it as a one-time lapse, to try and forget or minimize the significance of the events and remain patients of Dr. Phipps. Patient F, for example, had taken a very forgiving approach. Others were deeply troubled, left his practice and brought complaints to the College at the time or later on. Some were angry.

Dr. Phipps had a specific recollection of some aspects of the photo visit with Patient B and subsequent events. He had few if any specific recollections of which photographs he showed, what comments he made, or what else occurred at the other patients' photo visits. He did not have a reliable recollection of the patients in his practice to whom he had shown the photographs. Dr. Phipps acknowledged where he lacked an independent memory of events. Dr. Phipps acknowledged having made significant errors in judgment and having breached boundaries by showing the photographs to patients and staff and by making certain comments. As detailed below, the Committee finds that Dr. Phipps' testimony on some of the contested issues was reasonably clear and straightforward, while on others, it lacked clarity or consistency and was not credible.

The Issues

1. Does Dr. Phipps' conduct with respect to any or all of the eleven patients at the photo visits constitute sexual abuse?

i) Did Dr. Phipps engage in behaviour of a sexual nature with respect to any or all of the eleven patients at the photo visits?

For the following reasons, the Committee finds that the photographs were sexual in nature and that Dr. Phipps's behaviour in showing one or more photographs to each of the patients was behaviour of a sexual nature, which constitutes sexual abuse.

(a) The nature of the photographs

Dr. Phipps provided to the College three photographs that he had taken and had shown to patients. They showed him to be naked and exposed to varying degrees. He provided information about a fourth, similar photograph. In two of the photographs (full-frontal and towel), his genitals were exposed, in another his buttocks were exposed and in the other, he was visible from his groin area to just below the top of his head. His penis was semi-erect in the full-frontal photograph.

The Committee finds that Dr. Phipps knew that the photographs were highly personal and private in nature:

- Dr. Phipps deleted the towel photo and then emptied the 'trash' on his cell phone to make sure that it 'couldn't inadvertently be found.'

- Dr. Phipps had the experience of the naked photos being automatically transferred to his home computer and then nearly transferred to his sister-in-law. He took steps to be sure this never happened again.

- Dr. Phipps used a separate secure app on his cell phone to store the photographs.

- Dr. Phipps commented to Patient J about how embarrassed he was when the photograph was inadvertently seen by others for whom it had not been intended.

- Dr. Phipps purportedly showed the photographs only to patients with whom he had a longstanding relationship, who he considered as friends.

For the reasons below, the Committee finds that the photographs are sexual in nature.

- Two of the photographs depict Dr. Phipps with exposed genitalia; one with a partial erection, one photograph shows his buttocks and the fourth his naked torso from his groin area.

- Dr. Phipps acknowledged that the photographs, taken to be exchanged with his wife, were sexual in nature.

- Dr. Phipps agreed that, 'That kind of lewd, sexual picture shouldn't be shown to children.'

- Dr. Phipps testified that he became uncomfortable with showing patients the full-frontal photograph, not least because his penis was semi-erect.

Dr. Phipps showed Patient J and Patient E only the cropped photograph. Although the cropped photograph did not show Dr. Phipps' penis or buttocks, the Committee finds that it was also sexual in nature for the following reasons:

- The cropped photograph is the full-frontal photograph altered to show Dr. Phipps naked from his groin upward, and includes pubic hair.

- The purpose for which Dr. Phipps took the original photograph was to exchange with his wife.

- Dr. Phipps' intention in showing the cropped photograph to Patient J and Patient E was the same as in his showing any of the photographs to various patients, i.e., to provoke embarrassment by exposing them to an obviously highly personal and private image.

(b) Dr. Phipps' behaviour in showing the photographs to patients was sexual in nature

The Committee finds that Dr. Phipps' behaviour in showing the photographs to the eleven patients was sexual in nature.

The photographs are of an inherently sexual nature. Dr. Phipps acknowledged showing one or more of the photographs to each patient at a clinical visit.

Further, Dr. Phipps made comments to seven of the patients, which further sexualized the photo encounters. Dr. Phipps acknowledged that he made comments to two patients to the effect that 'I've seen yours, now you've seen mine' or 'I've seen you naked, now you've seen me naked' (Patients C, I). In addition, Patient B testified that Dr. Phipps said to her as she was leaving, 'Now you know more about me than most of my patients.' In the context of having shown one or more naked photographs of himself, these comments highlight the nakedness and explicit sexual

character of the photographs. This characterization is reinforced by Dr. Phipps' acknowledged admonition to at least four patients (Patients A, I, C, K), at one visit or another, to 'keep this between us' or similar comment, accompanied in three instances by a 'shushing' gesture (Patients I, C, K).

Six patients testified, consistent with Dr. Phipps' own evidence, that he told them that he had taken the photograph in order to exchange it with his wife (Patients B, A, I, C, D, J). It is the Committee's view that in doing so, Dr. Phipps promoted the patients' interpretation of the photographs as sexual by indicating that it was part of the sexual intimacy he shared with his wife.

Patient A testified that Dr. Phipps said to her, 'Ain't I well-endowed for a man my age' after showing her the full-frontal photograph. Dr. Phipps denied using such a phrase, although he had almost no recollection of Patient A's visit. He testified that he would have said something more general and that the comment had nothing to do with the size of his penis. In relation to the comment to Patient A, the Committee finds that a reasonable observer would conclude that any comment made by Dr. Phipps referring to his own physique, whether or not he specifically referred to his penis, would reasonably be considered sexual in nature when made just after the patient had been shown a full-frontal photograph of Dr. Phipps with his penis semi-erect and had been told that he had taken the photograph to exchange with his wife.

The Committee finds that Dr. Phipps further sexualized particular patient encounters by making comments such as 'I've seen yours, now you've seen mine' and telling some patients that he had taken the photographs on his cell phone to exchange with his wife.
Further, when Dr. Phipps asked several patients not to tell anyone what he had done and, with some, gestured with a finger to his lips, he was inviting them into a shared intimacy which further sexualized the encounter.

These comments further sexualized the appointments at which each these seven patients was shown the naked photographs of Dr. Phipps.

c) Dr. Phipps' intention

The Committee recognizes that the intent or purpose of the individual whose conduct is at issue may be a factor to be considered in determining whether or not conduct was of a sexual nature. The College need not prove, however, that Dr, Phipps was sexually motivated or derived any sexual gratification as a result of showing the photographs. The Committee further recognizes that there is no onus on Dr. Phipps to disprove the allegations.

Dr. Phipps' testified that his intention was simply to share with trusted patients for whom he cared deeply an innocuous story to which the photographs were simply the punch line. The Committee rejects this assertion, and finds that the primary purpose of the golf story and other introductory remarks was to provide a pretext for showing photographs of a sexual nature to each of the patients.

- Dr. Phipps asserted consistently that his intention was to relate a story that was humorous and mutually embarrassing, and with which everyone 'would be fine.' The Committee, however, could not understand why Dr. Phipps would find showing a naked photo of himself to his patients humorous or why he would want to embarrass his patients. His assertion that he showed the photos for these reasons was not credible. He characterized the story as intimate, but denied any sexual intent, excitement or gratification. He did accept that there were elements of embarrassment and excitement in telling the story and showing the photographs that were gratifying to him. Dr. Phipps knew that the full-frontal photograph he showed to most patients included his semi-erect penis (Patients B, H, A, F, I, C, K, G, D).

  The Committee does not find Dr. Phipps' assertion that his actions were motivated primarily or exclusively by the gratification and excitement of story-telling to be credible.

- Dr. Phipps showed two patients naked photographs of himself that he had taken at his home at a later date. These photographs bore no relationship to the golf trip in 2012. Specifically, he showed Patient B the buttocks and towel photos and Patient F the buttocks photo. Dr. Phipps testified that he had not intended to show Patient B the buttocks and towel

photographs, but he also testified that he was unsure what his intention had been. Similarly, he stated that he had intentionally shown Patient F the full-frontal photograph because it fit with the golf story, but maintained that showing her the buttocks photograph was unintentional. The Committee notes that Dr. Phipps was holding and controlling his cell phone at the time and was in control of which photos were shown to these patients.

- Dr. Phipps chose to show the photographs to female patients and not to male patients, as he believed that males and females would react differently. He stated that he didn't show the photographs to males because men can see each other naked in locker rooms. He thought that the photographs made a better punch line with women than men. He believed that women would find the story and photographs somewhat embarrassing, which was his goal, whereas men might not.

- These statements contrast with Dr. Phipps' description of his 2012 golf trip when it was a male friend who inadvertently saw the embarrassing photograph and was laughing about it with the woman at the next table. As well, at his golf club in August 2014, it was a group of male friends who asked him to show the photographs and who responded with laughter along with the waitresses (3-167).

The Committee finds Dr. Phipps' explanation for showing the photographs only to female patients to be unconvincing and intended to support his assertion that he was simply telling an innocuous story.

d) Patient perceptions

The Committee recognizes that the objective test set out in *Chase* is the appropriate test to determine if conduct or remarks are of sexual nature. A patient's subjective impression is not a primary factor but it is not irrelevant. As stated in *Hanna v. The College of Physicians and Surgeons of Saskatchewan* (1999):

> The subjective perceptions of a complainant are important but they are not determinative of the nature of specific conduct, unless the perceptions are reasonable.

Evidence on how patients perceived Dr. Phipps' conduct during the photo visits, and in particular, whether they perceived it to be sexual or not, was limited overall but clear in some instances:

- Patient E was not troubled and thought the incident unimportant.
- Patient D found the photographs embarrassing but innocuous and not salacious.
- Patient I described feeling uncomfortable, and wondered if it was a practical joke or if Dr. Phipps was making a pass at her.
- Patient G was mortified.
- Patient C described being shocked and devastated.
- Patient H was mortified and embarrassed.
- Patient F was uncomfortable and shocked.
- Patient J assumed that the photograph would be sexual from the introductory story but had not expected such a photograph and was shocked.
- The evidence of Patient B, Patient A and Patient K was that Dr. Phipps had had an erection during the photo visits. Patient B was shocked and upset and didn't understand what had happened. Patient A was shocked. The incident brought back memories of past sexual abuse and she no longer felt safe with Dr. Phipps. Patient K described being shocked, horrified, embarrassed, confused, violated and betrayed.

Patient J, Patient B, Patient A and Patient K perceived a sexual character in Dr. Phipps' conduct during the photo visits. The Committee finds that their perceptions were reasonable in the circumstances. However, the fact that other patients may not have found the showing of the photographs to be sexual in nature does not mean that Dr. Phipps' conduct was not sexual in nature to the objective observer.

e) Context for showing the photographs

Dr. Phipps testified that he told the same story on 'each and every occasion' when he showed the photographs, despite stating that he had little or no recollection of most of the photo visits.

The evidence of many patients is that aspects of Dr. Phipps' 2012 golf trip and the inadvertent disclosure of an embarrassing photograph were part of their conversations. However, there were differences in the patients' descriptions of how the conversation about the golf story began and in the details of the story. Some patients had no recollection of any discussion of a golf trip:

- Two patients (Patients B, J) recalled having been looking at their cell phones when Dr. Phipps came into the room and Dr. Phipps commenting about the trouble one can get into with cell phones. He went on to tell them about his golf trip.
- Patient H asked about his golf holiday and Patient K about his tan.
- With four patients, Dr. Phipps introduced the golf story himself (Patients A, I, C, G).
- Two patients had no recollection of Dr. Phipps having been on a trip (Patients E, D).
    - Patient E recalled discussing selfies and celebrities getting into trouble, but did not have a clear recollection of the conversation.
    - Patient D's recollection was of a conversation and a story about Dr. Phipps exchanging photographs with his wife. She did not recall him having been away as part of the story but was not certain.
- Patient C recalled that Dr. Phipps had been on a golf trip and had wanted to send a photograph back to his wife but had inadvertently sent it to friends.
- Patient F recalled that Dr. Phipps being away with friends was part of their conversation and that he had asked her if she wanted to see a photograph, but she had not connected the two in her mind.

Dr. Phipps' assertion that he always told the same story is more categorical than would be expected given his limited recollections. It is also inconsistent with the evidence of some of the patients as detailed above.

It is not surprising that some of the patients could not specifically recall the discussion leading up to the showing of the photo, given the passage of time and the decision by some to minimize, try to forget, or put aside the events. There would have been no particular reason for patients to remember the details of the conversation as it took place, although seeing the photographs immediately afterward may have made it more memorable.

The Committee finds there were differences in the details of the story that Dr. Phipps recounted to each patient leading up to showing the photographs. The Committee finds that Dr. Phipps used different pretexts to introduce the photos, be it his golf trip, his tan, the taking of selfies or the exchange of photos with his wife.

f) Dr. Phipps' submission that conduct was not predominantly sexual in nature

Counsel for Dr. Phipps suggested that simply because there is a sexual aspect to a member's conduct, it does not necessarily follow that, overall and having regard to all of the circumstances, the conduct was sexual in nature. Counsel submitted that *Muirhead* (2014) and *Taynen* (2008) were instructive cases in this regard, in that no finding of sexual abuse was made.

In *Muirhead*, the member admitted to allegations of disgraceful, dishonourable, and unprofessional conduct and to failing to maintain the standard of practice of the profession. Specifically, he acknowledged hugging patients, expressing love for them, engaging in personal relationships with them, encouraging therapy that included sexual arousal, and encouraging patients to keep secret their relationship. However, allegations of sexual abuse and incompetence had been withdrawn by the College. The hearing proceeded on the basis of a statement of agreed facts and admission and a joint submission on penalty.

In *Taynen*, the member admitted that he had failed to maintain the standard of practice of the profession. Specifically, he had repeatedly shared personal stories with a vulnerable patient thereby fostering eroticization of their relationship, and had told her that he found her attractive and could enjoy a sexual relationship with her in other circumstances. In this case also, the College had withdrawn allegations of sexual abuse and disgraceful, dishonourable or

unprofessional conduct, and the hearing proceeded on the basis of an agreed statement of facts and admission and a joint submission on penalty.

The absence of findings of sexual abuse in *Muirhead* and *Taynen* is of little relevance to the current proceedings in that such allegations were not considered by the Committee.

Counsel for Dr. Phipps submitted that his conduct with respect to any of the patients was not predominantly sexual in nature. To the contrary, the Committee finds that Dr. Phipps' conduct in showing a naked photo of himself to each of his patients was of a sexual nature.

In summary, considering all of the surrounding circumstances, the Committee finds that a reasonable observer would perceive that Dr. Phipps' behaviour during each of the photo visits was of a sexual nature, on the basis of his showing the photographs and making the accompanying remarks and comments.

(g) Five patients were shown additional naked photographs of Dr. Phipps other than the four identified

Dr. Phipps acknowledged showing one or more of the four photographs described above to each of the eleven patients. He specifically denied that there were other photographs with the variations described by patients.

Nine patients recalled being shown a frontal photograph of an adult male with genitalia visible (Patients B, H, A, F, I, C, K, G, D), but the details of their recollections varied:

- All but Patient I recognized or understood the photograph they saw to be Dr. Phipps.
- Four patients agreed that the photograph they had seen was Exhibit 2A ('full-frontal' provided by Dr. Phipps) or similar to it, with Patient I referring just to the pelvic and genital area (Patients A, I, C, G).

- Five patients were confident in their evidence that the photograph they had seen was not the full-frontal photograph provided by Dr. Phipps (Exhibit 2A) (Patients B, H, F, K, D). They each distinguished what they had seen from Exhibit 2A in various ways:

    - surroundings different (Patient B);
    - Dr. Phipps appeared tanned, wearing eyeliner, chiseled, hair was different than full-frontal photograph (Patient H);
    - penis appeared larger because of upward angle at which the photograph was taken (Patient F);
    - pubic area groomed, Dr. Phipps looked tanned and as if he had just come out of the shower (Patient K);
    - posing with one arm raised ('bodybuilder'), wearing only dark socks, not as close up as Exhibit 2A (Patient D).

Patient J and Patient E recalled a cropped photograph. Both of their descriptions are reasonably similar to Exhibit 2C.

Patient B and Patient F recalled being shown a photograph of Dr. Phipps' buttocks, similar (Patient F) or roughly similar (Patient B) to Exhibit 2B.

There is evidence that some patients may have consciously tried to forget the incident and put it behind them. Several patients experienced strong responses to Dr. Phipps' conduct in the form of anger, disgust, loss of trust, feelings of betrayal, feelings of victimization, disruption of personal relationships, and worsening of their medical symptoms (Patient B, Patient A, Patient H, Patient C, Patient K, Patient J, Patient I).

There are a number of reasons why the accuracy of patients' observations and recall of the images shown them by Dr. Phipps may have been imperfect.

- The images on the cell phone screen were small.
- The cell phone was held and controlled by Dr. Phipps for the most part.

- There was evidence that the image was zoomed and centered differently at different times.
- Patients' exposure to the images was brief (e.g. 'extraordinarily' brief according to Patient D).

Moreover, the nature of the images was usually not anticipated. It is thus not surprising that several patients acknowledged uncertainty about details of the photographs. Yet, others described recollections of the images that were clear, even intense and difficult to put aside.

Dr. Phipps has disclosed the existence and nature of four naked photographs of himself. The potential extent of further embarrassment from additional naked photographs seems modest. However, the existence of additional photographs would certainly weaken Dr. Phipps' assertion that the photographs were simply an adjunct or punch line to an amusing story about a particular golf trip. The Committee has not accepted Dr. Phipps' evidence on a number of questions related to the photographs, e.g. that he told the same introductory story to each patient, his explanations of why he showed photographs only to female patients and why he showed photographs he had taken at different times and places, and that he was unaware of the impact of the photographs on patients until the visit of the College investigators (below).

The Committee accepts the evidence of each of the five patients (Patients B, H, F, K, D) who were confident that Dr. Phipps had shown them a frontal photograph that was not Exhibit 2A, each of whom described distinguishing details. The five patients included two who had remained loyal and continued to see Dr. Phipps as his patients, and three who had severed their relationships. Each of the patients had no apparent motive to provide particular details or to embellish her description of the photograph. Considering all of the circumstances, the Committee finds that Dr. Phipps showed Patients B, H, F, K, and D additional naked photographs of himself other than the four photographs acknowledged by him.

(h) Dr. Phipps knew it was inappropriate to show patients naked photographs of himself

The College submitted that if Dr. Phipps had shown Patient A the photo after he had been notified of the College investigation, it undermined his credibility and in particular his position that he did not understand that it was inappropriate to show these photographs at the time that he did so. College investigators came to Dr. Phipps' office on October 3, 2014. Patient A had appointments with Dr. Phipps on September 29, October 7, and October 14, 2014. She returned to work on October 20, 2014.

Patient A was adamant in her testimony that the photo visit occurred on October 7, 2014. Further, she recalled that she left the photo visit with the understanding that she needed to return to get a letter to allow her to return to work. She was clear that Dr. Phipps apologized and she picked up the letter on the same visit, which was her next visit. This is consistent with her original College interviews. Following her testimony, Patient A provided a copy of the return to work letter on which she had written at some point, 'This is the letter I got on Oct. 14, 2014'.

Dr. Phipps believed that the photo visit must have been on September 29, 2014. Dr. Phipps' evidence is that he wrote the return to work letter on the October 7, 2014 visit. He believes that Patient A took it with her on that day because it appears in the EMR chart note when printed, it is office practice to give such notes to patients when they are printed, and there is nowhere to keep them otherwise.

Patient A's medical chart shows that the October 7, 2014 visit is titled 'Absentee Note'. The chart entry records the same content as the letter provided by Patient A. There is a chart entry for October 14, 2014, to which is electronically attached an 'Abilities' form, signed by Dr. Phipps and Patient A and dated October 14, 2014 by both. There is a notation on the scanned 'Abilities' form that the original was taken by Patient A on that day.

Dr. Phipps' asserted that the Patient A's photo visit must have been before the October 3, 2014 visit of the College investigators because he would not have shown photographs to a patient afterwards.

Dr. Phipps indicated that he didn't initially know why the College investigators were there and was shocked to learn of Patient B's complaint. There was evidence in relation to several patients about whether or not, on various dates, Dr. Phipps knew or should have known that his conduct was problematic:

- Patient D testified that, at her visit on August 29, 2014, Dr. Phipps told her that he had shown the photograph to another patient and had not understood her reaction. Dr. Phipps testified that in mentioning this to her he was, 'trying to excuse my behaviour…trying to defend myself.'

- On September 3, 2014, Patient E told Dr. Phipps to 'get rid of' the photograph.

- Patient B's photo visit was on September 4, 2014. Dr. Phipps denied that he knew then that showing naked photographs of himself to a patient was inappropriate. He also testified that he knew at that time that his conduct was 'a little inappropriate' but not 'how vastly inappropriate' it was. He denied in his testimony that he knew that she was upset following the visit, yet in his letter of response to the College, Dr. Phipps wrote that he 'was concerned that what I had done may have upset her.' He testified that he had immediately felt badly because he had shown her photographs that were unrelated to the golf trip. He had thought it was okay to show her the full-frontal photograph as part of the golf story but inappropriate to show the two other naked photographs. As a result of his concern, he twice called Patient B later the same day.

- Dr. Phipps' concern that Patient B would be upset because two photographs bore no relationship to the golf trip makes little sense as she would have had no reason to know that this was the case unless he had told her so at the time. Whether she knew or not, there would be no reason for any urgency in contacting her to disclose this or explain. Yet, in his final text message to Patient B, he said that they could discuss the photographs when she next returned to see him. The Committee finds Dr. Phipps' evidence confusing and/or not credible with respect to Patient B's visit and what he thought was inappropriate, why, and when.

- Dr. Phipps admonished Patient K (August 29 or September 11, 2014), Patient C (September 3, 2014), Patient A (September 29 or October 7, 2014), and Patient I (September 30, 2014) to 'keep this between us.' Dr. Phipps acknowledged that he could have made such a comment to any of the patients.

- Dr. Phipps told Patient H on September 22, 2014 that he had shown the photograph to two other women, one who had complained and claimed he was stalking her, and another who was not troubled by it. He testified that he 'was making - trying to make an excuse for my bad behaviour.'

The Committee finds that Dr. Phipps knew before the visit of College investigators on October 3, 2014 that his conduct was highly problematic. Dr. Phipps' assertion that he only realized the seriousness of his conduct on October 3, 2014 is not credible. Moreover, it is self-serving in that, if accepted, it would tend to mitigate his misconduct – as indeed he acknowledged seeking to do with Patient D and Patient H – and to avoid the potential problem of continuing misconduct in the face of a College investigation.

With respect to the date of the photo visit, the Committee accepts Patient A's evidence that she made a visit following the photo visit to obtain the return-to-work letter and that Dr. Phipps apologized to her on that visit. Patient A had no reason to anchor on a particular date as the photo visit, nor did she know the date of the visit of the College investigators. It is not clear why she was so certain that the date of the photo visit was October 7, 2014, specifically. If that date is correct, then she would have returned on October 14, 2014 to pick up the letter and 'Abilities' form. It is likely that the letter was generated on October 7, 2014, given the 'Absentee Note' title of the chart entry for that day. The letter would have to have been kept in the office until the visit of October 14, 2014, contrary to Dr. Phipps' statement about usual office practice. Patient A's undated notation, on her copy of the letter, to the effect that she received it on October 14, 2014, is not helpful.

It is also plausible that the photo visit took place on September 29, 2014, that Patient A returned on October 7, 2014 when the letter would have been both generated and picked up, and that she returned again on October 14, 2014 for the 'Abilities' form.

Overall, the Committee is not prepared to make a finding that Dr. Phipps showed Patient A a photograph at a visit after the College visit on October 3, 2014.

(i) Dr. Phipps was sexually aroused during two of the photo visits

The College submitted that Dr. Phipps was sexually aroused during the clinical encounters with Patient B, Patient A, and Patient K. The Committee finds that Dr. Phipps had an erection during Patient B and Patient A's visit, but did not make a finding that he had an erection during Patient K's visit.

Patient B

Patient B testified that as she left the examining room on September 4, 2014, she and Dr. Phipps both stood up and she observed that he had an erection. Dr. Phipps unequivocally denied that he had an erection.

Dr. Phipps had some recollection of the visit with Patient B. He denied that there was anything he found sexually exciting or stimulating about showing the photographs. He stated that if he had had an erection, he would have stood up facing away rather than toward her, as if to hide any erection. The suggestion that he would have tried to conceal an erection is somewhat inconsistent, however, with the fact that he had just effectively exposed himself by showing his patient a naked photo of himself.

Patient B's assertion that Dr. Phipps had an erection was based on her observation that his penis was erect in his pants. She acknowledged that the impression was a subjective one. Her explanation for not mentioning her observation of an erection in her initial telephone interview or letter of complaint to the College made sense. Patient B explained that she had been in a state of shock and upset as she was leaving the appointment and had wondered whether she was over-

reacting. She also agreed that she had replayed the events of the appointment in her head in the minutes and hours following. She acknowledged that she had wanted to leave the room as quickly as she could, but she did not accept that the events at the end of her appointment were a 'blur.'

Patient B's evidence was clear and balanced. The Committee finds her evidence credible and reliable. The Committee finds that Dr. Phipps had an erection at the end of the visit in question.

(a) Patient A

As described above, Patient A testified that on the date of the photo visit she was also examined by Dr. Phipps. Patient A testified that as she was seated on the examining table, Dr. Phipps stood facing her, leaned forward slightly, and pressed on her ribs with his right hand while lifting her top with his left hand. It was as he was leaning in that Patient A felt what she believed was an erection. She testified that she 'could feel him being excited, a semi hard-on'. She was adamant that it was Dr. Phipps' erect penis that she felt and not an object he may have had in a pocket. She described it as in the front of his body as he was leaning on her, and not on his sides where his pockets were. She testified that she moved her leg away very quickly 'because I couldn't believe he did just do that'. Dr. Phipps denied that he had an erection while examining Patient A or that he touched her with his penis as she has alleged. The Committee has concluded that Dr. Phipps did in fact have an erection and touched Patient A in the manner in which she has alleged (see analysis below with respect to the allegation that Dr. Phipps touched Patient A in a sexual manner). For these reasons, the Committee finds that Dr. Phipps was sexually aroused during his examination of Patient A, which is behaviour of a sexual nature.

(b) Patient K

Patient K alleges that at the conclusion of the photo visit, Dr. Phipps gave her a hug and that during the course of that hug, she felt that Dr. Phipps had an erection. The allegation that Dr. Phipps touched Patient K in a sexual manner is dealt with below. The Committee was not persuaded that Dr. Phipps had an erection during the course of the hug, for the reasons stated

below. Consequently, the Committee did not conclude that Dr. Phipps was sexually aroused during the photo visit with Patient K.

Similar Fact Evidence

The College submitted that the Committee may use the evidence of Patient B, Patient A or Patient K as similar fact evidence. The purpose would be to address the question of whether or not Dr. Phipps was sexually aroused during any one of the three appointments if the Committee was not satisfied that the College established that he was sexually aroused with respect to each patient separately. The College submitted further that the evidence of the three patients has numerous connecting features and is highly probative to rebut Dr. Phipps' claim that he had no sexual intention and that the patients were mistaken as to what they observed.

Counsel for Dr. Phipps submitted that the high threshold for admissibility of similar fact evidence was not met in that:

- there were important differences in the patients' evidence on the question of erection and sexual arousal;
- Patient K's evidence was influenced by what she had read in the media;
- there was no objective improbability of coincidence between the evidence of Patient B and Patient A;
- the probative value of Patient B's and Patient A's evidence was low.

The Committee considered the oral arguments and written submissions of both counsel with respect to similar fact evidence as well as illustrative cases, particularly *R v. Handy*, [2002] 2 S.C.R. 908, 2002 SCC 56.

Similar fact evidence is presumptively inadmissible. Exceptionally, similar fact evidence may be admissible where the evidence is so highly relevant and cogent that its probative value outweighs

any potential for misuse. A framework for the consideration of the admissibility is summarized in the headnote for *R. v. Handy*:

> The general exclusionary rule that similar fact evidence is presumptively inadmissible has been affirmed repeatedly and recognizes that the potential for prejudice, distraction and time consumption associated with the evidence generally outweighs its probative value. Issues may arise, however, for which its probative value outweighs the potential for misuse. Similar circumstances may defy coincidence or other innocent explanation. As the evidence becomes more focused and specific to the charge, its probative value becomes more cogent. The onus is on the prosecution to show on a balance of probabilities that the probative value of the similar fact evidence outweighs its potential for prejudice.

With respect to the probative value of similar fact evidence, Justice Binnie writes in *R v. Handy* at para 76:

> The principal driver of probative value in a case such as this is the connectedness (or nexus) that is established between the similar fact evidence and the offences alleged, particularly where the connections reveal a "degree of distinctiveness or uniqueness" (B. (C.R.), supra, at p. 735). As stated by Cory J. in Arp, supra, at para. 48:
>
> . . . where similar fact evidence is adduced to prove a fact in issue, in order to be admissible, the trial judge should evaluate the degree of similarity of the alleged acts and decide whether the objective improbability of coincidence has been established. Only then will the evidence have sufficient probative value to be admitted.
>
> Cogency of the similar fact evidence is derived from the improbability of coincidence. The foundation on which admissibility of similar fact evidence is sought, namely that the acts are too similar to be credibly explained by coincidence, is destroyed if collusion is present (Handy, 104). The onus is on the College to disprove collusion where there is an "air of reality" to such assertions.

In considering the probative value of the proposed similar fact evidence, the Committee notes similarities in the circumstances of the three visits, including Dr. Phipps showing one or more naked photographs of him in conjunction with a story and other comments. Each of the three patients was female and a long-term patient of Dr. Phipps. The events took place during a relatively limited time period and were generally acknowledged to be out of keeping with Dr. Phipps' prior behaviour. The evidence of the three patients is similar with respect to Dr. Phipps being sexually aroused in that he had an erection, but differs in that Patient B's evidence was that she observed what she believed to be an erection whereas Patient A's and Patient K's evidence was that they felt what they believed to be Dr. Phipps' penis touching them.

With respect to Patient K's evidence, counsel for Dr. Phipps submitted that it was influenced by what she had read in an online article and that, as a result, there had been inadvertent collusion as described in *R v. Dorsey* (2012). The Committee finds that there is at least an 'air of reality' to this assertion, which the College did not refute. Patient K's evidence with respect to the allegation that Dr. Phipps had an erection is problematic for the reasons outlined above. The fact that the Committee found that he did have an erection in his visits with Patient B and Patient A is of very limited probative value to determining if he had an erection during his visit with Patient K, and any probative value is greatly outweighed by the potential prejudice of using that evidence to support a finding that he had an erection when seeing Patient K. The Committee is not prepared to admit the evidence of Patient B and Patient A as similar fact evidence in support of the allegation that Dr. Phipps had an erection during his visit with Patient K.

ii) Did Dr. Phipps make remarks of a sexual nature to any of his patients during the photo visits?

As discussed above, Dr. Phipps acknowledged that he made comments to two patients to the effect that 'I've seen yours, now you've seen mine' or 'I've seen you naked, now you've seen me naked' (Patients C, I). In addition, Patient B testified that Dr. Phipps said to her as she was leaving, 'Now you know more about me than most of my patients.' Further, Patient A testified that Dr. Phipps said to her, 'Ain't I well-endowed for a man my age' after showing her the full-frontal photograph. Dr. Phipps denied using such a phrase, although he had almost no

recollection of Patient A's visit. He testified that he would have said something more general and that the comment had nothing to do with the size of his penis.

The Committee finds that each of these comments is remarks of a sexual nature and constitutes sexual abuse. Given the context in which each comment was made, specifically after Dr. Phipps had shown each patient a naked photograph of himself, the Committee finds that an objective observer would conclude that each of these comments further sexualized the encounter with these four patients and constitutes sexual abuse.

iii) Did Dr. Phipps engage in touching of a sexual nature of any of his patients during the photo visits?

(a) Patient A

Patient A and Dr. Phipps gave conflicting testimony about touching during the physical examination at the photo visit. As discussed above, the photo visit took place on September 29, 2014 or October 7, 2014; in either case, there is no physical examination recorded in the medical chart.

Dr. Phipps denied inappropriate or sexual touching and denied having an erection at any medical appointment. His recollection of the photo visit was limited. He testified that he would have examined the back of Patient A's eyes (funduscopic exam) because of her symptoms. This is reasonable. His description of such an exam was clear. Touching might well occur but would be between the outside of his leg and the outside of the patient's. Dr. Phipps was also certain that his penis did not come into contact with Patient A because his penis is not at the right level in relation to a patient's leg.

Patient A acknowledged that she did not recall all of the details of the appointments that followed her injuries. However, she said that she would remember 'stuff that's shocking and unprofessional' and that this examination was different than previous ones. She said that Dr.

Phipps had always before conducted exams in a professional manner. She acknowledged that Dr. Phipps had done a funduscopic exam at some point following her injuries but not on this visit.

Patient A was detailed and consistent in her testimony about the touching, including the reason for the examination, how Dr. Phipps stood in relation to her, and how the exam was conducted. She had reported her belief that she felt Dr. Phipps' penis touching her knee in her initial College interview on February 3, 2016. Her shock and her action in moving her knee away very quickly were consistent with her view of what had happened. Her explanation for returning to see Dr. Phipps shortly after these events made sense.

Counsel for Dr. Phipps drew attention to Patient A's statement to a College investigator in 2016 about trouble with her memory. The Committee finds her response to be reasonable, namely that there were specific reasons for memory problems in 2016, that she was not having memory problems around the time of the events in question in 2014, and that she did not recall the circumstances in 2008 because it was so long ago.

Counsel for Dr. Phipps submitted that Patient A's perception of the examination and touching was influenced by her having just been shown the full-frontal photograph of Dr. Phipps with his penis exposed. Patient A acknowledged feeling very upset at the time she felt the touching. She agreed when counsel put to her that that she had linked the touching with the photograph and that she assumed that Dr. Phipps wanted her to feel his penis. However, she maintained her assertion that it was his penis that she felt touching her knee.

The Committee did not find that Patient A's ability to accurately observe, recall and recount the events in question was impaired by her reaction to the photograph or any problem with her memory. There may have been a minor inconsistency between Patient A's testimony regarding Dr. Phipps' use of a stethoscope and her prior statement to a College investigator. Overall, however, the Committee finds Patient A's evidence credible and reliable on the issue of touching during this examination.

Dr. Phipps' reconstruction of the physical examination was not based on a specific recollection of events, but rather (i) on what he asserts would have happened, i.e., a funduscopic exam conducted in a particular way, and (ii) on what he asserts would not have or has never happened, e.g., an erection or inappropriate or sexual touching.

The Committee recognizes that in the face of conflicting evidence, it must not simply accept one version of events but must consider the totality of the evidence, viewed as a whole, and must avoid improperly placing an onus on the physician to establish that he did not commit the alleged misconduct. The Committee finds that, considering the totality of the evidence, Dr. Phipps engaged in touching of a sexual nature of Patient A when he touched her leg with his erect penis during the physical examination conducted after he had shown her the full-frontal photograph.

Counsel for Dr. Phipps submitted that evidence of voluntary conduct of a clearly sexual nature is required to establish the sexual element needed for a finding of sexual abuse within the meaning of the Code. Counsel cited *CPSO v. Ross* (2004).

In *Ross*, the Committee considered whether the presence of an illness affected the determination of the allegations. The Committee said:

> The Committee accepts that "sexual intent" is not a necessary component of sexual abuse. [....] But the touching or conduct must be voluntary, if there is to be a finding of professional misconduct. An accidental fall against a patient, or an involuntary action caused by a disease, does not constitute professional misconduct.

The Committee finds that Dr. Phipps touching of Patient A by his erect penis during a physical examination was voluntary, not inadvertent, and not similar to the examples in *Ross*.

(b) Patient K

Patient K's evidence conflicted with that of Dr. Phipps on the touching that occurred as she left the examining room at the end of the photo visit. In addition, she asserted that he had behaved and touched her inappropriately at prior visits.

Patient K testified that Dr. Phipps gave her a 'sideways hug' as she left at the end of the photo visit. She described feeling 'the start of an erection' as he hugged her. Dr. Phipps was standing on her left side and hugging her with his right arm.

Patient K was confident in her testimony that it was Dr. Phipps' penis that she had felt and that she had thought so at the time. She had reported the touching in her August 25, 2017 College interview. However, the transcript indicates that she was not certain at the time that it was his penis that she had felt.

Dr. Phipps had no specific recollection of the visits in question. He acknowledged that he may well have given Patient K a 'side hug' at the end of the photo visit and that he probably touched her on her side during the hug but denied that he touched her with his genitals. Dr. Phipps' testimony was reasonably clear in relation to contact during a 'side hug'. With respect to prior visits, he described how he would have stood in relation to a patient when doing a blood pressure measurement. He said he would be unable to see the blood pressure dial if he stood in such a way as to press his genitalia to the patient's leg. In addition, he stated that his penis is not at the right level in relation to a patient's leg for contact to occur.

The Committee finds that Dr. Phipps hugged Patient K as she left the examining room. Patient K's description of how Dr. Phipps was standing during the side hug was similar to his description. However, their respective descriptions make it difficult to understand how it could have been Dr. Phipps' penis that Patient K felt touching her. Patient K acknowledges that his pockets could have been up against her waist during the hug.

The Committee was also struck by Patient K's negative comment about Dr. Phipps' looking like a sociopath in the photograph Exhibit 2A, and was concerned about possible embellishment of her evidence. In addition, the Committee finds the certainty in her testimony at the hearing that it had been Dr. Phipps' penis that touched her not consistent with her prior interview evidence. Lastly, her assertion that Dr. Phipps had leaned against her with his semi-erect penis on multiple prior occasions while measuring her blood pressure, and that she had always known that this was inappropriate, was not consistent with her prior statements. Specifically, she had described Dr. Phipps, prior to the photo visit, as having been very caring, extremely trustworthy, and professional in manner. She had felt very comfortable with him. The Committee finds significant inconsistencies in Patient K's accounts of her visits with Dr. Phipps and the events related to touching.

In summary, the Committee finds that the College has not proven, on a balance of probabilities and considering all of the circumstances, that Dr. Phipps had an erection or touched Patient K with his penis in the 'side hug' at the photo visit. Nor does the Committee find sufficient evidence that inappropriate or sexual touching occurred on visits prior to that.

Conclusion regarding Allegation of Sexual Abuse at the Photo Visits

The definition of sexual abuse in the Code is cited above. In this matter, the allegation of sexual abuse refers to conduct under paragraphs 1 (3)(b) touching of a sexual nature, and 1(3)(c) behaviour or remarks of a sexual nature, by the member towards a patient. To establish sexual abuse of a patient by a member, the definition specifies that the touching, behaviour or remarks at issue must be of a 'sexual nature' and not of a clinical nature appropriate to the service provided.

Dr. Phipps did not contest that the eleven individuals were patients at the relevant times.

The Committee finds, as set out above, that Dr. Phipps' conduct in showing one or more naked photographs of himself to each of the eleven patients constitutes behaviour of a sexual nature

towards a patient. The Committee therefore finds that Dr. Phipps sexually abused each of the eleven patients.

The Committee also finds that Dr. Phipps was sexually aroused after showing the photos to two of the patients (Patient B) and (Patient A). This constitutes behaviour of a sexual nature towards a patient. The Committee therefore finds that Dr. Phipps sexually abused Patient B and Patient A by becoming sexually aroused during his interactions with each of these patients.

The Committee also finds that Dr. Phipps made remarks of a sexual nature to four of his patients, namely, Patient A, Patient C, Patient I and Patient B, as detailed above, and constitutes sexual abuse.

The Committee also finds that Dr. Phipps' touching of Patient A was sexual in nature and, therefore, constitutes sexual abuse.

2. Would Dr. Phipps' conduct in showing the photographs to patients and/or clinic staff be reasonably considered by members to be disgraceful, dishonourable and/or unprofessional?

Dr. Phipps has admitted that 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.

(a) Inappropriate Conduct with Patients

Dr. Phipps showed naked photographs of himself to eleven patients, made remarks of a sexual nature to four patients, became sexually aroused during the encounters with two patients (Patient B and Patient A), and touched one patient (Patient A) in a sexual manner. He engaged in this conduct with patients who had come to trust him over many years.

Trust is the cornerstone of the physician-patient relationship. When a patient seeks care from a physician, the patient trusts that the physician is a professional and will treat her in a professional

manner. Physicians must establish and maintain appropriate professional boundaries with patients or the professional relationship is jeopardized and patients are at risk of great harm. Violations of such boundaries, particularly of a sexual nature, can engender in patients a loss of trust in the physician and in the health professions and feelings of betrayal, victimization, anger, shame and guilt. Sexualizing the relationship and sharing highly personal and private material represent a clear and profound breach of trust, and would be viewed by members of the profession as disgraceful, dishonourable and unprofessional conduct.

(b) Discussions with Patient H

It is alleged that Dr. Phipps counselled Patient H to deny having seen the photograph if contacted. Patient H testified that, when she returned to see Dr. Phipps in the winter or spring of 2015, he told her during that visit that the College was investigating and that she should deny having seen any photographs if contacted. Patient H's testimony was consistent and specific. She did not accept that he might have said something more general, i.e., not referring specifically to the College investigation.

Dr. Phipps had no specific recollection of this visit, but agreed that he would have told Patient H that the College would be contacting her. He testified that he believed that, separately, he would have made a general comment about her not 'telling everybody', thinking of the community rather than the College. He could see no reason why he would advise one patient to deny seeing a photograph.

Patient F, Patient D, and Patient E gave evidence that, at various times after the photo visits, Dr. Phipps had called to let them know that the College might or would contact them. He gave Patient F no advice on how to respond to the College. He encouraged Patient D to cooperate fully. He advised Patient E to be honest and tell the College what she could remember. He also telephoned Patient C to say, more generally, 'you may be hearing something from people in regards to this happening.'

The evidence of Patient H and Dr. Phipps conflicts. The Committee finds it unlikely that Dr. Phipps would counsel one patient to deny events and several others to cooperate freely. Notably, as well, Dr. Phipps was aware that interfering with the College investigation would bear significant consequences.

The Committee finds that Dr. Phipps did not counsel Patient H to deny to the College having seen any photographs. The Committee concludes that Patient H, despite her sincerity in stating as much, was simply mistaken with respect to her recollection or interpretation of the conversation on this point.

(c) Inappropriate Conduct with Clinic Staff

Dr. Phipps was in a position of authority with respect to the staff at the clinic. His behaviour in sharing naked photographs of himself with clinic staff was wholly inappropriate and unacceptable. In the Committee's view, it rose well above the level of unacceptable into disgraceful, dishonourable and unprofessional conduct based on the highly personal and private nature of the material and the intent to embarrass. However, whether or not the staff were uncomfortable, shocked or otherwise adversely affected is not relevant: conduct need not be harmful to be unprofessional.

There are boundaries to physicians' behaviour towards patients, colleagues, coworkers and the public. Physicians are expected to strictly maintain those boundaries and if they do not do so, they should expect to be judged adversely. Boundaries in a physician's workplace are essential so as to provide an atmosphere of safety and respect for all. They help control and address issues of workplace harassment, workplace safety, and power imbalance in settings that are often fast-paced, intense, and stressful. Dr. Phipps' conduct crossed such boundaries and constitutes disgraceful, dishonourable, and unprofessional conduct. It cannot be tolerated.

In summary, the Committee accepts Dr. Phipps admission and finds that he committed an act of professional misconduct in that he has engaged in disgraceful, dishonourable and unprofessional conduct in relation to eleven patients and three clinic staff.

3. Did Dr. Phipps make comments at visits other than the photo visits to Patient K and Patient C that were inappropriate and/or of a sexual nature?

(a) Patient K

Patient K testified that Dr. Phipps had made comments or a joke about her type of tattoos on past occasions. Dr. Phipps testified that he might have made a comment but would not have said anything in any way sexual.

Patient K testified that, on a past visit, during an otherwise appropriate physical examination, Dr. Phipps made an inappropriate comment about her previous breast surgery. She alleges that Dr. Phipps said something to the effect that the surgeon who had performed her breast surgery had done a perfect, great, amazing or excellent job. Dr. Phipps had no specific recollection, but stated that he had probably made a comment about the quality of the surgical result.

The Committee finds that the evidence about Dr. Phipps' comments to Patient K about her tattoos and results of her breast surgery is not clear, cogent and convincing evidence of sexual abuse that is of remarks being made of a sexual nature to a patient. Further, the Committee was not persuaded that these comments amounted to disgraceful, dishonourable or unprofessional conduct.

(b) Patient C

Patient C testified that, at prior visits over a number of years, Dr. Phipps would quite often make inappropriate remarks and comments. She stated that she normally preferred her husband to accompany her. She said that 'the main reason why my husband was there was because there was a level of discomfort with me with Dr. Phipps.' With respect to her husband, her testimony at variance points suggests that Patient C's husband sought to exert considerable control over this aspect of her life.

Patient C's assertion of inappropriate comments was not consistent with her prior College interviews when she denied that Dr. Phipps had previously made such comments and stated that the photo incident was the 'first incident that was ever questionable.' Further, she had stated, 'I always trusted the fact that my doctor didn't look at me like a woman.'

Dr. Phipps denied that he would ever have said that he thought someone was sexy, although he may have commented about Patient C's general appearance, clothing and/or perfume. His evidence is not based on any specific recollection but rather his general practice.

Patient C has experienced considerable difficulties in her life and her explanation for the inconsistencies in her evidence – which she acknowledges – is understandable to some extent. The Committee is nonetheless concerned by inconsistencies in her evidence as described earlier in these reasons. In terms of whether the Committee should accept her testimony or earlier statements, Patient C stated that her husband's influence is no longer present and she is therefore now free to provide further details of her encounters with Dr. Phipps. On the other hand, she acknowledged that her memory of events would have been better at the time of the original investigation. The Committee finds that the inconsistencies in her statements undermine the reliability of her account on this issue.

The Committee finds that, on a balance of probabilities and considering all of the circumstances, the College has not proved that Dr. Phipps made comments to Patient C at prior visits that were inappropriate or of a sexual nature.

SUMMARY OF FINDINGS

The Committee finds the allegation that Dr. Phipps committed an act of professional misconduct in that he has engaged in the sexual abuse of patients to be proven.

First, during the period late August to early October 2014, Dr. Phipps showed one or more naked photographs of himself to eleven female patients during clinical visits. The women had been long-term patients of Dr. Phipps. They had trusted Dr. Phipps. In many instances, the women

were shown a photograph in which Dr. Phipps' penis was erect or semi-erect. Often, he used the pretext of an apparently innocuous story from a golf trip he had taken more than two years before. Some patients were shown naked photographs that had nothing to do with the golf trip and that Dr. Phipps took later at his home.

Second, Dr. Phipps was sexually aroused during the clinical visits of two patients (Patients B and A). Patient B observed that Dr. Phipps had an erection and Patient A felt his erect penis against her knee during a physical examination.

Third, Dr. Phipps made remarks of a sexual nature to four patients (Patients A, C, I and B) after showing each one of them a naked photograph of him.

Fourth, Dr. Phipps engaged in touching of a sexual nature when he touched Patient A with his erect penis during a physical examination.

Further, the Committee finds the allegation that Dr. Phipps committed an act of professional misconduct, in that he has engaged in conduct or an act that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional to be proven. Dr. Phipps has betrayed his patients' trust, the cornerstone of the doctor-patient relationship. He was in a position of power with respect to both his patients and his clinic staff, yet has breached in an egregious way the boundaries which are fundamental to proper and effective professional relationships. He also breached the trust of three of his clinic staff and engaged in disgraceful, dishonourable and or unprofessional conduct towards them.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

THE DISCIPLINE COMMITTEE OF
THE COLLEGEOF 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. NIGEL MARK PHIPPS

PANEL MEMBERS: **DR. C. CLAPPERTON (CHAIR)**
MAJOR A. H. KHALIFA
DR. J. WATTERS
MR. P. PIELSTICKER
DR. S-M YOUNG

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. E. WIDNER

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INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Hearing Date: **June 24 to 26, 2019**
Decision Date: **September 18, 2019**
Release of Reasons Date: **September 18, 2019**

PUBLICATION BAN

PENALTY DECISION AND REASONS FOR DECISION

On August 27, 2018, the Discipline Committee found that Dr. Nigel Phipps committed an act of professional misconduct, in that he engaged in the sexual abuse of patients and 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.

From June 24 to June 26, 2019, the Discipline Committee heard evidence and submissions on penalty and costs, and at the conclusion of the hearing, reserved its decision.

OVERVIEW OF FINDINGS OF PROFESSIONAL MISCONDUCT

The Committee's finding of sexual abuse of patients was based on the following actions by Dr. Phipps:

1. Showing one or more naked photographs of himself to eleven female patients during clinical visits;
2. Becoming sexually aroused during the clinical visits of two patients;
3. Making remarks of a sexual nature to four patients after showing each one of them a naked photograph of him.
4. Engaging in touching of a sexual nature when he touched one patient with his erect penis during a physical examination.

The Committee found that the above actions also amounted to disgraceful, dishonourable or unprofessional conduct, as was further found with respect to Dr. Phipps's actions towards three of his clinic staff, in that he also showed them naked photographs of himself.

AVAILABLE PENALTY ORDERS

Having made findings of sexual abuse and disgraceful, dishonourable or unprofessional conduct, the Committee may make an order under section 51(2) of the Code:

> **Orders**
>
> (2) If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:
>
> 1. Directing the Registrar to revoke the member's certificate of registration.
> 2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time.
> 3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.
> 4. Requiring the member to appear before the panel to be reprimanded.
> 5. Requiring the member to pay a fine of not more than $35,000 to the Minister of Finance.
>
> 5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.
>
> 5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1. 1991, c.18, Sched. 2, s. 51 (2); 1993, c. 37, s. 14 (2).

Orders relating to sexual abuse are dealt with further in section 51(5) of the Code.

> **Orders relating to sexual abuse**
>
> (5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Suspend the member's certificate of registration if the sexual abuse does not consist of or include conduct listed in paragraph 3 and the panel has not otherwise made an order revoking the member's certificate of registration under subsection (2).
3. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:
   i. Sexual intercourse.
   ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
   iii. Masturbation of the member by, or in the presence of, the patient.
   iv. Masturbation of the patient by the member.
   v. Encouraging the patient to masturbate in the presence of the member.
   vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.
   vii. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 19 (3).

In brief, having made a finding of sexual abuse of a patient, the Committee must order that Dr. Phipps be reprimanded. Further, the Committee must order a suspension of Dr. Phipps's certificate of registration, if it does not order revocation.

The type of sexual abuse committed by Dr. Phipps did not consist of acts listed under paragraph 51(5) 3. Consequently, while it is open to the Committee to revoke Dr. Phipps's certificate of registration, among other possible orders, revocation is not mandatory.

The Committee is aware that, before making an order under section 51(5), it shall consider any written statement that has been filed, and any oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient.

SUBMISSIONS ON PENALTY

The parties agreed that Dr. Phipps should be reprimanded and should reimburse the College fund for patient therapy and counselling in the amount of $176,660.00 and post security to guarantee the payment of that amount.

The College further submitted that Dr. Phipps's certificate of registration should be revoked, and that he should pay costs in the amount of $58, 610.00.

Counsel for Dr. Phipps submitted that:

- Dr. Phipps's certificate of registration should be suspended for a period of 14 to 18 months,
- Dr. Phipps should continue indefinitely with psychiatric treatment and monitoring, with quarterly reporting to the College;
- practice restrictions should be put in place, based on Dr. Phipps's existing undertaking; and
- any award of costs should be decided after the determination of penalty.

DECISION ON PENALTY

For the reasons below, the Committee determined that a fair and just penalty in the circumstances of this case is as follows:

- a 14-month suspension of Dr. Phipps's certificate of registration;
- requiring Dr. Phipps to reimburse and post security to guarantee payment to the fund for therapy in respect of patients for whom there was a finding of sexual abuse;
- a public reprimand;
- the imposition of terms, conditions and limitations on Dr. Phipps's certificate of registration including requirements for:

(i) ongoing monitoring of all professional encounters with patients and other practice restrictions as set out in the order, below; and

(ii) ongoing psychiatric treatment and monitoring, with quarterly reporting to the College, as set out in the order, below.

The Committee decided to consider written submissions with respect to costs following release of its penalty order.

SUMMARY OF EVIDENCE ON PENALTY

The College submitted a brief of victim impact statements which were read into the record. The College did not lead any additional evidence on penalty.

The Committee heard testimony from three witnesses who were called by Dr. Phipps, namely Dr. Phipps and two psychiatrists who testified on his behalf. Counsel for Dr. Phipps submitted letters of support of Dr. Phipps.

The victim impact statements, letters of support, and a number of other documents were entered as exhibits.

Victim Impact Statements

The Committee heard six victim impact statements. The Committee had regard to *R v Gabriel,* 1999 ONSC 15050, and took from the statements their descriptions of the harm done to and/or loss suffered by the victims, while disregarding any criticisms of Dr. Phipps, assertions as to the facts of his misconduct, or recommendations as to the severity of penalty.

The Committee found the statements to be poignant descriptions of the very real and ongoing harm suffered by Dr. Phipps's patients as a consequence of his misconduct. The patients spoke to their loss of trust in the medical profession, males and others, and to a pervasive sense of fear and vulnerability. One patient is greatly troubled in that she now questions the motives of almost

everyone she interacts with. Others mentioned their concerns with how their own reactions affect their children and what they teach them as parents. The sense of betrayed trust for several was made all the worse by the fact that they had felt a longstanding sense of safety and trust in Dr. Phipps after many years in his care, often for difficult problems.

Some patients reported worsening of their health. Several described difficulties in finding and establishing relationships with new health care providers, particularly those patients who have challenging, ongoing health problems. The negative impact of Dr. Phipps's actions on their personal relationships, at times profound, was highlighted by several patients. This, in conjunction with an inability or reduced ability to work, has led to financial hardship for some.

Dr. Phipps has continued to practise in a small community. The possibility of encountering Dr. Phipps in the medical building where his clinic is situated or in other public places is a source of considerable anxiety and discomfort for some patients. One patient wrote: "The anxiety we feel, in our own community where we live, work and play, never really goes away".

The themes of profound, unrelenting and inescapable impacts were echoed in a number of the statements. Patients wrote, for example: "I live with the fear of medical care, trusting any man, and the fear of a very uncertain future", "[I] will carry this with me indefinitely", "Dr. Phipps has turned my life upside down", "These visions will never disappear", and "To have something so horrific engraved in your mind and not be able to erase it no matter how hard you try is a terrible way to live".

Two patients described negative consequences of participating in the College process. One patient attributed the breakup of her marriage to her speaking out about Dr. Phipps's actions. Another wrote that she and her family had been subjected to rumours, innuendo and assumptions in their community.

One patient wrote that she was deeply disturbed by what she read in the August 2018 decision and was truly concerned for Dr. Phipps. She and family members remain his patients although she continues to review the events in her head repeatedly. In her view, Dr. Phipps's "…actions

do not speak to a lifetime of bad behaviour but a change in his behaviour that I am hopeful he is dealing with".

Dr. Phipps's Testimony

a) *Dr. Phipps's understanding of his misconduct and its effect on his patients, family, and practice*

Dr. Phipps testified that he accepted all of the findings made by the Committee. In particular, he accepted responsibility for the perceptions of the two patients at whose visits he was found to have had an erection. He acknowledged that it was his actions that had brought about these perceptions, whether or not he had in fact had an erection, which he acknowledged he may have, but could not remember.

Dr. Phipps stated that he has for some time felt guilt, overwhelming sadness, and shame for the harm that his actions had caused patients and their families. He has apologized to those who he remembered harming if he had an opportunity to do so. He described the guilt, shame and turmoil his actions have caused him as being much more severe than the death of their five-week old son some years ago, the diagnosis of a life-threatening allergy in one of his daughters, and the diagnosis of cystic fibrosis in their other daughter who spent a year in hospital in her early life as a result. Dr. Phipps doesn't expect that the feelings of shame, guilt and embarrassment will ever go away.

Dr. Phipps and his family live in a small town. He finds it difficult to go out as he feels embarrassed and has had people say hurtful things to him. His wife would often be asked about what happened and had no explanation until recently. Dr. Phipps said his family has had a very difficult time as a result of his actions but have also been very supportive of him. If his depression were to relapse, he believes they would make sure he received appropriate treatment if he hadn't already done so himself.

Dr. Phipps is certain that he would not allow himself to get into the situation he was in in 2014 again. Dr. Phipps testified that he has become much more comfortable talking about his mental health, he has an excellent therapist, and would not hesitate to make sure he receives what help he may need in the future.

Dr. Phipps sees his colleagues less often than previously as he has resigned his hospital privileges and is no longer on the board of the family health team. He recognizes that his actions have tarnished the reputation of other physicians in the community. His practice is smaller and many of his female patients elect to see the nurse practitioner instead of him. He no longer assists at surgery, provides neonatal care or palliative care, or does house calls.

Dr. Phipps was hopeful that he could deal with losing his certificate of registration, should that be the outcome of the hearing, and would understand the reasoning for it. He would be devastated but believes he would manage with the help of his family and therapist. Regardless, he is not able to foresee when he might be able to retire from a financial perspective. Dr. Phipps did not provide the Committee with any financial records.

b) Dr. Phipps's learnings from 'Understanding Boundaries' course

Dr. Phipps took the two-day Understanding Boundaries course at Western University in March 2015. The course is a group course, with no one-on-one interaction. There were about 20 participants. The Post-Workshop Appraisal was generally positive. Dr. Phipps's written plan for future change was described as good, thorough and practical. Dr. Phipps stated that he learned from the course, most importantly, that his relationship with his patients should be professional, by contrast with what it had been which was more intimate and friendly and with his having a feeling of familiarity with his patients. In his view, this inappropriate sense of familiarity with his patients contributed to his misconduct.

c) Dr. Phipps's marital issues

Dr. Phipps and his wife saw a marital counselor between July 2014 and June 2015. Dr. Phipps stated that he had discussed his inappropriate conduct with patients with the counselor, alone and with his wife present. The counselor's membership in his professional association was revoked and Dr. Phipps and his wife decided not to continue to see him.

Dr. Phipps agreed that there had been bad patches in his marriage followed by improvements. In the early 1990s, he and his wife saw a physician, possibly a psychiatrist, for six to nine months. In 2011 or 2012 they saw a therapist for about six months. Dr. Phipps and his wife saw another person for counseling for three or four sessions in 2017, but did not find that therapeutic relationship to be helpful.

Dr. Phipps characterized the issues in his marriage as being related to him acting in a manner that was disrespectful of his wife. Dr. Phipps acknowledged that his boundary transgressions led to conflict with his wife. On one occasion, there was flirtatious texting with an individual who worked in Dr. Phipps's office. Around the same time, perhaps 2013, Dr. Phipps's wife discovered that he had paid for a lap dance or a stripper on a golfing trip. As well, Dr. Phipps's inappropriate actions with patients were a source of conflict with his wife.

Dr. Phipps described the effect of his actions on his marriage as ongoing, but that he and his wife see their marriage as being in a 'very good place' now.

d) Dr. Phipps's alcohol use

Dr. Phipps acknowledged that drinking too much at social occasions had been an issue for perhaps a decade before his misconduct in 2014. He is not currently in any alcohol addiction program and has not been in the past.

e) Dr. Phipps's letter of apology to his wife

Dr. Phipps wrote a letter of apology to his wife after an episode of irritability, yelling and bad behaviour towards her in the summer of 2014. Dr. Phipps's wife gave the letter to their marriage counselor. In the letter, Dr. Phipps states that he feels he has been in denial about his mental state for a long time; tries to hide his mood and feelings; doesn't look forward to things that he used to; and doesn't do things he used to enjoy. Further, in the letter of apology, Dr. Phipps states that he doesn't look forward to going to work; he's drinking too much; he has no close friends; and he doesn't feel like socializing which makes him feel guilty because he knows his wife does. Dr. Phipps also writes that he needs to see a therapist on his own to deal with these issues. Dr. Phipps testified that the letter is an accurate depiction of how he felt in the summer of 2014. Dr. Phipps did not discuss the apology letter with their marriage counselor, but he did discuss it with Dr. Book, his psychiatrist.

f) Dr. Phipps's mental health, care providers, and treatment

Dr. Bloom (2016-17)

Dr. Phipps saw Dr. Bloom for several sessions at the end of 2016 and beginning of 2017. Dr. Phipps had no recollection of the sessions but accepted that he had said to Dr. Bloom that dysthymia had stopped being a problem for him when he started Wellbutrin. He testified that he was not really aware of his mental state at that time and was still not discussing it with anyone at that time.

Dr. Mamak (May 2017)

Dr. Phipps saw Dr. Mamak, a psychologist, in about May 2017. Dr. Phipps acknowledged that a statement that his mood symptoms were well controlled on medication sounded like a discussion he had with her.

Dr. Book (May 2017 - October 2018)

In May 2017, Dr. Phipps saw Dr. Howard Book, a psychiatrist in Toronto with experience in boundary issues and violations. Dr. Phipps also began radiation therapy in May 2017 for cancer but continued to see Dr. Book on a limited basis until the effects of the radiation made it difficult for Dr. Phipps to travel and have useful discussions.

Dr. Phipps resumed seeing Dr. Book in the fall of 2017 and saw him twice a week or for double sessions in order to catch up for the time missed. He continued to see Dr. Book until October 2018. The Committee heard that Dr. Book could not participate in this hearing because of serious family and personal health issues and that there is no report from him as he would not be available for cross-examination. As a result, counsel for Dr. Phipps sought and was granted an adjournment of this hearing so that Dr. Phipps could see a psychiatrist who would be available to testify.

Dr. Phipps stated that the reason he went to see Dr. Book was to try and understand why he transgressed as he had, showing photographs to patients and violating boundaries. He viewed these actions as very much out of character. He testified that he had no understanding of why he had acted in these ways and wanted to be sure he didn't do so again in the future.

Dr. Phipps testified that he learned a great deal about his mental health as a result of his work with Dr. Book. He stated that he had always been in denial and had been uncomfortable talking about his mental health. He would occasionally raise it with his wife but not with his family, friends or family physician, Dr. Carson. He had always thought that he had been mildly depressed at most, down and a bit despondent but able to function essentially normally. However, during the summer of 2014, his symptoms intensified and significantly affected everything in his life.

As he worked with Dr. Book, Dr. Phipps began to realize that he had been feeling down, or dysthymic, during much of his adult life. He came to understand that he had been suffering from a major depression in 2014 that was affecting his mood, behaviour and actions. During the

summer of 2014, Dr. Phipps felt extremely lacking in motivation, tired all the time and sleeping excessively. He was over-eating, drinking alcohol to excess, and was having trouble remembering things. He did not enjoy previously pleasurable activities such as going to the gym and playing golf and he stopped doing them. He was extremely irritable, and his wife was often "on the receiving end". Dr. Phipps would frequently lose his temper over minor things and begin yelling and arguing with his wife. It was at her suggestion that they began to see the marriage counselor that summer.

Dr. Phipps stated that the symptoms he described in his letter to his wife began to improve as his therapy with Dr. Book progressed and as he began to feel better after his cancer therapy.

Dr. Siotis (December 2018 – present)

Once Dr. Phipps knew that Dr. Book would not be able to continue treating him, Dr. Phipps was able to identify a psychiatrist, Dr. Siotis, with whom he could continue. He first saw her in December 2018 and has since seen her on a more or less weekly basis. Dr. Phipps testified that, as with Dr. Book, he wanted to understand what had caused his inappropriate behaviour and how to ensure it would not happen again. In particular, as he had come to realize the severity of his depression, Dr. Phipps wanted to ensure that it was adequately treated.

Dr. Phipps testified that he came to understand that he began to engage in self-destructive behaviour as a result of his depression, without realizing it. As examples of this self-destructive behaviour, Dr. Phipps cited showing photographs to his patients; drinking in excess; his behaviour in his marriage; and not eating properly or exercising.

Dr. Phipps described his alcohol consumption as being related to social occasions. Dr. Phipps stated that he had been consuming two to three times more alcohol than he had in the past. Following the College's visit to Dr. Phipps's office in October 2014 and as agreed to with his wife, Dr. Phipps stopped drinking in excess and testified that he has been able to sustain this easily.

g) Medications prescribed by Dr. Phipps's family physician.

Dr. Phipps described his relationship with his family physician, Dr. Carson. Dr. Phipps and Dr. Carson have been colleagues in the same practice group since about 2000. If Dr. Phipps felt depressed, he would request medication from Dr. Carson. Dr. Carson continues to be Dr. Phipps's family physician.

Around 2004, prior to the introduction of an EMR in their office, Dr. Phipps complained to Dr. Carson about his mood, which seemed worse in the winter months. Dr. Phipps thought he had seasonal affective disorder and spoke with Dr. Carson about his mood and feelings. Dr. Phipps's medical chart cites the diagnosis as seasonal affective disorder in November 2005. Dr. Phipps testified that Dr. Carson recommended an antidepressant, Cipralex, which Dr. Phipps took with some improvement until about 2012.

Dr. Phipps was unhappy with his mood at that point and asked to try a medication with a different mode of action. In place of Cipralex, at Dr. Phipps's request, Dr. Carson prescribed Pristiq 50 mg. Dr. Phipps testified that he felt better. Although he could not recall any specifics, Dr. Phipps acknowledged that he and Dr. Carson would have discussed whether the medications and doses were effective. When the Pristiq dose was increased to 100 mg on June 11, 2012, again at Dr. Phipps's request, there was no further improvement. He remained on this dose until March 4, 2013 when the dose was decreased back to 50 mg.

Dr. Phipps also began on Wellbutrin in 2013, initially at 150 mg and then titrated up to 300 mg. He described the combination of Pristiq 50 mg and Wellbutrin 300 mg as being the most effective in terms of improving his mood. Dr. Phipps remains on this combination of medications. Dr. Phipps's testimony in respect of his antidepressant medications is consistent with a summary letter provided by Dr. Carson.

Dr. Phipps testified that he did not see Dr. Carson regularly as a patient, nor did he see him in the summer of 2014. Dr. Phipps stated that he was in denial about his depression, felt embarrassed

talking about it with anyone, and incorrectly assumed that he was able to manage the non-medication aspects of treatment himself.

h) Dr. Phipps's practice restrictions

Dr. Phipps has remained in practice since the College's visit to his office in October 2014, other than during his cancer treatment. Since May 2015, Dr. Phipps has had a practice monitor for all professional encounters with female patients of any age. Dr. Phipps testified that he had never had a complaint to the College prior to 2014 and has had none since.

Testimony of Dr. Siotis

Dr. Siotis is a psychiatrist who has been treating Dr. Phipps since December 2018. She obtained her MD at the University of Geneva, completed an internship and residency at McMaster University, and was certified as a specialist in psychiatry in 1989. She did further training in psychotherapy. Dr. Siotis has had a focus on treating patients with mood and anxiety disorders for thirty years, using both pharmacologic therapy and psychotherapy.

Until 2014, Dr. Siotis held an academic appointment at McMaster University where, early in her career, she developed the cognitive behavioural program for patients with mood disorders and, later, a program of psychosocial treatment for patients with treatment-resistant mood disorders. She has also worked with the Department of National Defence to train mental health workers to use cognitive behavioural therapy in a consistent way for the treatment of depression in military personnel.

Dr. Siotis has a part-time office practice and continues on the active staff of the mood disorders program for inpatients at the Juravinski Centre in Hamilton. Dr. Siotis has treated physicians throughout her career. Most of her office patients now are physicians in practice, residents, or medical students referred from McMaster University programs. She also sees physicians with complex mood disorders referred by the Physician Health Program.

a) Dr. Siotis's qualification as a participant expert witness

Counsel for Dr. Phipps requested that the Committee qualify Dr. Siotis as a participant expert witness in the area of psychiatry, to give opinion evidence pertaining to the assessment and treatment of mood disorders, including depression as it pertains to Dr. Phipps and her treatment of him.

The Committee had regard to *Imeson v Maryvale*, 2018 ONCA 888 (para.62), where the Court cites *Westerhof* (para.60) on the proper role of a participant expert witness:

> [A] witness with special skill, knowledge, training or experience who has not been engaged by or on behalf of a party to the litigation may give opinion evidence for the truth of its contents without complying with rule 53.03 where:
>
> - the opinion to be given is based on the witness's observation of or participation in the events at issue; and
> - the witness formed the opinion to be given as part of the ordinary exercise of his or her skill, knowledge, training and experience while observing or participating in such events.

Further, the Court held that participant expert witnesses are subject to the two-step *Mohan/White Burgess* test for the admissibility of expert evidence (as are litigation expert witnesses).

The first step is to assess whether the proposed evidence meets the threshold requirements that it is logically relevant, necessary to assist the trier of fact, not subject to any other exclusionary rule, and proffered by a properly qualified expert who is willing and able to provide evidence that is impartial, independent, and unbiased. The second, gatekeeping, step is a determination of whether the potential benefits of admitting the evidence outweigh its potential risks to the trial process.

College counsel was content with Dr. Phipps's counsel's request to qualify Dr. Siotis as a participant expert witness. The Committee did so, consistent with *Westerhof* and the *Mohan/White Burgess* framework in accordance with the limits as set out above. As a participant expert, Dr. Siotis was permitted to testify and provide opinion evidence without serving a report.

b) Dr. Siotis's approach to new patients

Dr. Siotis described her approach to seeing a new patient for the first time. Her goal is to reach a diagnosis or differential diagnosis, which often takes two or three sessions. She described diagnosis as being purely descriptive, essentially symptoms, and derived from a standardized manual, the DSM-5. Diagnoses are organized in terms of Axis 1, which is major mental illness, and Axis 2, which are personality traits that have a role in how individuals behave and act in their lives.

In addition to diagnosis, Dr. Siotis develops a formulation which takes account of biological, psychological and social factors that may have predisposed the individual to develop an illness, factors that may have precipitated the illness, and factors that may protect the individual against the illness.

c) Sources of Dr. Siotis's information in respect of Dr. Phipps

Dr. Siotis acknowledged that, as would be usual in a treating relationship, much of the information on which her diagnoses and formulation were based came from Dr. Phipps, with some information from her two sessions with Dr. Phipps's wife. In general, her approach is to keep an open mind, remain objective, and not seek information from sources such as other physicians until she has completed her own assessment. In the week before the hearing, Dr. Siotis had received and read Dr. Bradford's report, the decision and reasons from the hearing of allegations and a copy of the letter Dr. Phipps wrote to his wife in the summer of 2014, and she saw the photographs.

Dr. Siotis assessed Dr. Phipps twice in December 2018 and wrote her consultation report in early January 2019 based on those encounters. Dr. Siotis had continued to see Dr. Phipps more or less on a weekly basis for a total of fourteen sessions at the time of the hearing. She contacted Dr. Book but never spoke with him in a meaningful way as she did not receive a release of information form from him that he wanted her to complete. Dr. Siotis did not speak with Dr. Bradford until the week prior to the hearing.

Dr. Siotis pointed out that psychiatrists recognize that there are patients who they feel are not being truthful or whose story they don't fully understand, in which case they pursue as much information from other sources as possible. This was not the case with Dr. Phipps who she believed to be truthful. Dr. Siotis rejected the suggestion of College counsel that a treating psychiatrist doesn't question a patient unless there are unusual features that raise concern about truthfulness. Dr. Siotis's approach is always to question the validity of what she hears from patients and not to accept what she's told at face value. This questioning may be very brief, as it was with Dr. Phipps, because it was obvious to her that he was truthful.

Dr. Siotis testified that she had always been aware of the details of Dr. Phipps's misconduct other than his having a semi-erection in one of the photographs. Dr. Siotis was specifically aware of the finding that Dr. Phipps had had an erection at two patient visits because Dr. Phipps had told her.

d) Dr. Siotis's assessment of Dr. Phipps

Dr. Phipps explained to Dr. Siotis that he needed further treatment and did not have a psychiatrist. They reviewed the events of July and August 2014, the story of the golf trip two years earlier and the photograph Dr. Phipps had taken. Dr. Siotis testified that Dr. Phipps told her he had shown the photograph to 12 patients and three staff in his office over a period of about four weeks. He did not understand why he had done so and was unaware that it was inappropriate. Further, he stated to her that he did not care, which Dr. Siotis described as very typical of the lack of care of oneself in depression, and a form of self-destruction.

Dr. Phipps described his behaviour to Dr. Siotis as very uncharacteristic of himself. He acknowledged that his wife and daughters were angry and troubled but told her also that things had really improved, and he has a very good relationship with his family. Dr. Phipps and Dr. Siotis discussed his past diagnosis of depression and anti-depressant medication. They discussed prior traumatic events that included the death of Dr. Phipps's son and illnesses of his daughters.

With her initial assessment, Dr. Siotis concluded that, in terms of Axis 1, major psychiatric disorder, Dr. Phipps had had persistent depressive disorder, mild, for many years, likely since the events with his children. Dr. Phipps also experienced recurrent major depressive episodes, although by the time he saw Dr. Siotis, his mood was normal, and he had returned to a mild depression. The focus of her treatment was the episode of major depressive disorder that occurred around 2014. There may well have been other episodes, but Dr. Siotis opined that it is common for patients to have difficulty remembering when they were depressed, and this would have been particularly so for Dr. Phipps who had no idea what depression was.

Dr. Siotis also considered whether Dr. Phipps had generalized anxiety disorder and/or alcohol use disorder in addition to depression.

In terms of Axis 2, personality traits, Dr. Siotis concluded that Dr. Phipps had obsessive-compulsive personality traits, which she described as extremely common and in fact desirable in physicians.

College counsel suggested to Dr. Siotis that there must be something unusual about Dr. Phipps, perhaps sexual interest and sexual motivation, to account for his actions. Dr. Siotis responded that depression and alcohol were clearly significant factors, in her view. Further, although she stated that she is not an expert in sexual deviance, she had discussed these issues and identified no other factors, particularly in the sexual domain.

e) Dr. Siotis's ongoing treatment of Dr. Phipps

Dr. Siotis testified that Dr. Phipps described having various symptoms between the spring of 2014 and October 2014: anger, lack of pleasure, lack of motivation, drinking a lot, difficulties in his marriage which were quite significant in 2014, his temper, and over-sleeping. Dr. Siotis observed that these were the symptoms of depression. Based on information about his upbringing, she opined that Dr. Phipps had issues with self-worth, as well.

Dr. Siotis said she had questioned whether Dr. Phipps's depression and low self-esteem were also accompanied by self-destructive behaviour, which would be common. She described Dr. Phipps as having an excellent career and confidence about his work. However, in the social-interpersonal domain he felt inadequate, more socially conscious, and to a degree, he experienced social anxiety. When Dr. Phipps became depressed, he would drink more, which would numb painful feelings and stop him thinking about what was going on.

Dr. Siotis identified an incident at a strip club as self-destructive behaviour by Dr. Phipps, "setting himself up for trouble." Away with friends on a golf trip, he used a credit card to pay the bill despite being warned not to by a friend because his wife would find out. She gave as a second example, Dr. Phipps's exchanging texts with a nurse practitioner who worked in his office and who had had surgery. Dr. Phipps told Dr. Siotis that his wife was aware of the texts and it would create problems if he deleted them. Regardless, he did so and his wife was very angry when she found out.

Dr. Siotis acknowledged that it is not unusual for physicians to be depressed, nor is it unusual for a physician with depression to continue to work adequately. Dr. Siotis had asked Dr. Phipps on a couple of occasions about any suicidal thoughts and concluded that this was not a concern.

f) Dr. Phipps's marital issues

Dr. Siotis opined that there have been significant periods of strife in Dr. Phipps's marriage on and off for many years. She agreed that these were significant stressors and could worsen or

trigger depression. Dr. Siotis also acknowledged that marital conflict played a role in triggering Dr. Phipps's boundary crossings, not just within his marriage, but with patients as well.

Dr. Siotis is not providing marital counselling but noted that Dr. Phipps and his wife had started therapy as a couple in 2014. There are no significant issues in the marriage at this point and Dr. Siotis testified that things are going very well for them. In her view, the fact that they have dealt with significant adversity, in respect of their children and now Dr. Phipps's misconduct, and are still together is a very good prognostic factor for their marriage.

g) Overall formulation

Dr. Siotis opined that Dr. Phipps had not been very good historically at recognizing his depressive symptoms, as is common. Sometime in 2014 or perhaps earlier, two major stressors in his life led to a worsening of his depressive symptoms and increased alcohol consumption: his father's decline with Alzheimer's disease and his marital issues. In this context, he engaged in self-destructive behaviours as exemplified by his showing photographs of himself to patients and office staff.

Individuals with depression, with or without excessive alcohol intake, have difficulties with insight which, in her opinion, explained why Dr. Phipps did not understand the gravity of his actions. She opined that Dr. Phipps has some avoidant personality features and difficulties facing challenging emotional situations. In that circumstance, alcohol helps one to forget or deny. In the previous two years, Dr. Phipps had had mostly positive reactions to the photograph in that people had found it funny. With the impairment of insight and judgement that occur with depression, Dr. Phipps did not appreciate the difference between showing the photograph to friends and others and showing it to patients.

With respect to major depression and self-destructive behaviours, Dr. Siotis opined that when an individual doesn't like themselves or doesn't think that they're good or worthy enough, they will become involved in maladaptive behaviours that confirm what they think of themselves. In her view, Dr. Phipps had had an exemplary career as a physician, and this has been crucial in his

maintaining a sense of self-worth. In the personal domain, he has not had the same ability to push away his core belief that he is inadequate, and he doesn't feel good about himself.

Dr. Siotis opined that a lack of insight and/or judgement is common in patients with depression. Physicians are generally high functioning individuals and have the ability to continue working despite experiencing depression. Often, they don't recognize depression in themselves or minimize or hide it, which in turn shows a lack of insight into the fact that they are not functioning well. Dr. Siotis opined further that in August and September of 2014, Dr. Phipps lacked proper inhibition as a result of both his depression and alcohol use.

Dr. Phipps has expressed a great deal of shame, disappointment in himself, and fear to Dr. Siotis. This differs from his initial reaction to what he had done, when it would have been expected that he'd be more upset about his behaviour. In Dr. Siotis's view, Dr. Phipps is now able to experience some of the horror of what he has done, and now fully appreciates how inappropriate his behaviour was.

h) Dr. Phipps's prognosis

Dr. Siotis testified that major depression can relapse under stress even while the patient is on medication. Dr. Siotis opined that the gold standard treatment is the combination of medication and psychotherapy, which Dr. Phipps had never received until he began seeing Dr. Book in October 2017. Dr. Phipps has since learned to recognize and express emotions. Dr. Siotis described Dr. Phipps as progressing quickly and well in his sessions with her. He was very receptive to the issue of his having a low sense of self-worth, and she continues to work with him on it.

Dr. Siotis opined that Dr. Phipps is receiving appropriate treatment, is compliant and is learning. Accordingly, the prognosis for his major depression and alcohol use disorder is very good. His depression is stable, and his mood is probably the best it has been in a long time. His drinking is no longer what it was. Dr. Phipps's wife is supportive, and their marriage is going well.

The addition of psychotherapy to medication reduces the chances of relapse of major depression. Dr. Siotis cannot predict the chances of relapse but said that Dr. Phipps has done and continues to do everything that needs to be done to minimize that chance. Traumatic events or changes in an individual's life may make them vulnerable to relapses. Dr. Phipps is vulnerable in the relationship domain, so he may be affected by a death or serious illness, conflict in his marriage, loss of ability to work, or even loss of a child moving away.

In Dr. Siotis's view, Dr. Phipps has more psychotherapy work to do, particularly on strategies to strengthen his self-esteem and not to be as vulnerable as he has been. He needs to continue his medication, minimize alcohol consumption, and continue monitoring with a psychiatrist.

Testimony of Dr. Bradford

Dr. Bradford was asked to assess Dr. Phipps in terms of psychiatric issues and whether they may have contributed to the sexual behaviour, which is central to his misconduct, and to opine on the risk for future problematic sexual behaviour.

Dr. Bradford is a forensic psychiatrist. He has achieved numerous educational qualifications in South Africa, England, Canada and the US. He has published numerous academic papers and authored numerous textbook chapters and textbooks. He has extensive teaching and administrative experience and has served as a consultant or expert witness to provincial, national and international bodies on many occasions. Dr. Bradford was director of the Sexual Behaviours Clinic at the Royal Ottawa Health Care Group from 1980 to 2000. Current appointments include emeritus professor and scientist at the Institute of Mental Health Research, University of Ottawa, full professor at McMaster University, and staff psychiatrist at St. Joseph's Healthcare, Hamilton.

Dr. Bradford's research has centred on the assessment, diagnosis, and treatment of paraphilic disorders and sexual behaviours and he has expertise in the area of recidivism as it relates to sexual behaviours. About 60% of Dr. Bradford's outpatient clinical work is with sexual offenders and about 40% with individuals with chronic mental illness, e.g. schizophrenia and

bipolar disorder. The bulk of the patients Dr. Bradford sees in the Sexual Behaviours Clinic have been involved in the criminal justice system, while others are referred by family physicians or are self-referred.

Counsel for Dr. Phipps requested that the Committee qualify Dr. Bradford as a litigation expert witness to give opinion evidence in the area of forensic psychiatry, including the assessment and treatment of sexual behaviours and assessment of the risk of recidivism. With College consent, the Committee did so. Dr. Bradford has served two reports.

a) Dr. Bradford's information sources pertaining to Dr. Phipps

Dr. Bradford reviewed the Committee's decision and reasons on liability. He was aware that Dr. Phipps had shown photographs of himself naked to female patients and office staff, made sexualized comments, and was found to have had an erection at two patient visits. Dr. Bradford saw the photographs. He was also aware that the Committee had had some concerns with Dr. Phipps's credibility.

As well, Dr. Bradford:

- reviewed a psychological evaluation by Dr. Mamak;
- reviewed the letter that Dr. Phipps wrote to his wife in the summer of 2014;
- reviewed the Post-Workshop Appraisal related to Dr. Phipps's attendance at the Understanding Boundaries course; and
- spoke by telephone with Dr. Book about Dr. Book's diagnostic impression of and therapeutic contact with Dr. Phipps.

Dr. Bradford first saw Dr. Phipps on November 20, 2018 and saw him again on several occasions, for a total of about four hours of initial evaluation. Dr. Phipps returned to complete several sexual questionnaires in December 2018, requiring approximately three hours. Dr. Bradford interviewed Dr. Phipps's wife on her own for an hour or two on the same day. Dr. Phipps returned again for about three hours to complete a risk assessment. Dr. Bradford made

Dr. Phipps aware that he might recommend hormonal tests, additional questionnaires and sexual arousal testing depending on whether there were concerns about sexual deviation or paraphilic disorder in the initial assessment.

b) Dr. Bradford's assessment of Dr. Phipps

Dr. Bradford opined that Dr. Phipps had been drinking more than previously around the time he showed the photographs and that this was a factor in his behaviour. As well, there were difficulties in his relationship with his wife, and they were going to a marital counselor for the second or third time. In Dr. Bradford's view, Dr. Phipps did not realize at the time he showed the photographs that he had breached boundaries with his patients. His re-telling the golf story and showing the photograph at his golf club had been well received previously and Dr. Phipps had seemed to see his actions with his patients as a joke. In discussing with Dr. Bradford what he had done, Dr. Phipps felt very badly about his conduct and realized how inappropriate it was.

Dr. Bradford testified that he continued to try and understand why Dr. Phipps, at age 57 or 58 and having had no difficulties before, would engage in such inappropriate sexual behaviour, and particularly whether his actions reflected a 'trait' or a 'state'. He described a trait as resulting in abnormal behaviour, exhibitionism for example, that becomes manifest in young adulthood, recurs if not treated, and is very difficult to treat. Dr. Bradford testified that he has had considerable experience with such individuals and opined that this was not the issue with Dr. Phipps. It would be very unlikely for a trait not to have manifested before age 58.

When aberrant sexual behaviour occurs in the absence of a trait, then it reflects a 'state', for which there are causes. Dr. Bradford opined that Dr. Phipps's behaviour occurring relatively late in life, and within a fairly circumscribed period of a few weeks, point to it being a state. Dr. Phipps had been depressed for a number of years and appeared to be more depressed in the summer of 2014. Dr. Bradford questioned whether that was why Dr. Phipps was drinking more, was irritable, was having more marital problems, which in turn caused him more distress. He opined that depression can lead to poor impulse control, poor judgment and/or self-destructive

behaviour. He also noted that individuals who are depressed can drink more and that this in turn tends to worsen their depression.

Dr. Bradford described the doses of anti-depressants that Dr. Phipps was taking as substantial. As well, Dr. Phipps felt much worse when he tried to reduce the dose of Wellbutrin. Dr. Bradford viewed this as an indicator that Dr. Phipps was quite depressed. Dr. Bradford found Dr. Phipps to be somewhat depressed still when he saw him, suggesting that his current medication, on its own, was not completely effective treatment.

Dr. Bradford's impression was that, while Dr. Phipps acknowledged his depression, he tended to minimize his symptoms. Dr. Bradford sought information from Dr. Book, who thought Dr. Phipps was suffering from major depression, and from Dr. Phipps's wife, who described behavioural changes indicative of a relapse of Dr. Phipps's depression around this time. She described Dr. Phipps as drinking more, coming home drunk, being angry all the time, not speaking much and barely able to carry on a conversation. These were the worst symptoms she had ever seen in him and very much out of character for him. Dr. Bradford noted that Dr. Phipps talked about his denial of his depression and his description of symptoms that are typical of major depression in the letter he wrote to his wife in the summer of 2014.

The natural history of depression is characterized by episodes of major depression that tend to recur every three to nine years. Treatment, such as medication, has a protective effect but doesn't always work completely. Even when adequately treated for depression, the success rate is probably about 60%.

c) Psychological testing and questionnaires

Dr. Bradford summarized Dr. Mamak's report as indicating that Dr. Phipps was shy and introverted, and struggled with anxiety and mood problems. His scores on a substance abuse screening inventory indicate that he may have an alcohol abuse problem, which Dr. Phipps acknowledges.

Dr. Bradford found no evidence of hypersexuality, sexual deviation or paraphilic disorder.

Dr. Phipps showed no psychopathic traits on the psychopathy checklist. Dr. Bradford noted that personality disorders are associated with sexual deviation and are a factor in respect of risk.

On the Risk for Sexual Violence Protocol, Dr. Phipps had none of the risk factors such as chronicity, diversity of sexual violence, escalation, or physical or psychological coercion.

Dr. Bradford acknowledged that, up to a point, the risk assessment tools used were developed primarily to evaluate individuals involved in sexual offences in the criminal justice system. He described the Risk for Sexual Violence Protocol as a more dynamic, interview-based tool than many of the others, used in various settings including professional regulation.

In terms of psychological adjustment, Dr. Bradford opined that Dr. Phipps had had some problems with self-awareness around the summer of 2014 related to mood disturbance, and problems with stress and coping. Drinking excessively may have been a form of self-treatment.

In terms of major mental illness, Dr. Bradford's view is that Dr. Phipps was suffering from major depression in the summer of 2014 and had probably had another episode in the past. He opined that, with appropriate treatment and monitoring, the risk of recurrence is very low.

d) Risk of future aberrant sexual behaviour

Dr. Bradford opined that risk is a hazard that is not completely understood and can be forecast only with some level of uncertainty. Risk is a multifaceted construct and must be considered in a specific context. The margins of error around a numerical estimate are quite wide, perhaps 30%.

In respect of risk management, i.e., addressing risk factors such as alcohol use and marital discord, Dr. Bradford opined that Dr. Phipps has done well, has shown willingness to make changes, and presents no problems in manageability. He had sought treatment for mental health issues and has remained in treatment consistently for 15 years. He was cooperative with the

College. He has not denied marital issues and has attended counseling on more than one occasion. He attended the Understanding Boundaries course on his own initiative, and it appeared that he did well.

Dr. Bradford described Dr. Phipps's misconduct in 2014 as brief and wholly out of character. He had practised since 1985 without any known difficulties. He had been conscientious, respectful to patients, and was well-regarded as a family physician. Dr. Phipps had managed well in the face of considerable personal stress from his own health issues and those in his family. Dr. Bradford identified no trait suggesting sexual deviance or risk factors for future problems with sexual behaviour.

While he opined that sexual deviation was not an issue, Dr. Bradford acknowledged that sexual arousal at two patient visits, as found by the Committee, suggests a sexual motivation for Dr. Phipps's actions or at least that a sexual motivation cannot be ruled out. He went on to opine that sexual arousal in this instance would have been a 'state' rather than a trait, i.e., a condition for which there are contributing factors, or which occurred in particular circumstances, rather than a recurrent, lifelong, difficult-to-treat predisposition.

In his discussions with Dr. Bradford, Dr. Phipps had denied a sexual motivation or having been aroused during the patient visits. Dr. Bradford accepted that such a denial shows a potential lack of insight, but also cautioned that extensive studies have shown that denial does not correlate with risk and does not adversely affect treatment. He opined that insight is dynamic, developing insight is part of treatment, and that Dr. Siotis's role with Dr. Phipps presumably would be to treat his depression and work on insight.

About 20% of the general population will suffer a major depressive disorder at some time in their life and that the proportion may be higher in physicians. Dr. Bradford agreed that ongoing marital problems and drinking to excess are also not uncommon in the general population.

Dr. Bradford opined that Dr. Phipps needs to remain in treatment with a psychiatrist for major depression. Dr. Phipps was struggling with psychological distress and a relapse of major

depression at the time, which affected his judgment, self-awareness and insight and contributed to his misconduct. Dr. Phipps has accepted responsibility for his poor judgment and misconduct. Dr. Bradford found him to now have better insight and self-awareness, to be genuinely remorseful, to feel guilty and ashamed for his actions, to be empathic towards the women harmed by his actions, and to have come to understand how inappropriate they were. Dr. Bradford acknowledged that Dr. Phipps's present concerns include both remorse for his actions and stress arising from these proceedings which may have an impact on his ability to practice medicine.

In Dr. Bradford's opinion, with proper treatment, Dr. Phipps will do well and the risk of him engaging in aberrant behaviour in the future is low.

Letters of Support for Dr. Phipps

Counsel for Dr. Phipps submitted a brief of 21 letters of support for Dr. Phipps, written between September 2018 and May 2019. The writers had all been provided with a copy of the August 2018 Decision and Reasons and almost all indicated in their letters that they had read it. Many of the writers are patients of Dr. Phipps or family members of patients. Some know Dr. Phipps from their roles in the community and a few had interacted with him in health care work-related roles. Dr. Phipps's practice monitor for the past three years wrote on his behalf.

All of the writers spoke of Dr. Phipps's qualities as a physician in very positive terms including that he acts with compassion, respect for patients and professionalism. Many of the writers said that Dr. Phipps is knowledgeable and makes himself available to patients, exceeding their expectations. Many commented about the high quality of Dr. Phipps's care. Three of the letters describe his misconduct with patients as not in keeping with their own experience of him and/or that of others they had spoken with. Dr. Phipps's contributions to and respect within the community were common themes as well. Virtually all noted that it would be a considerable loss for Dr. Phipps's patients and the larger community should he no longer be able to practice.

REASONS FOR DECISION ON PENALTY

In arriving at its penalty decision, the Committee considered the decision and reasons released in August 2018, the testimony and documentary evidence admitted at this hearing, the submissions of the parties, and prior decisions of the Committee. Both counsel provided books of authorities.

Principles of Penalty

The principles guiding the imposition of penalty are well-established. The protection of the public is paramount in determining an appropriate penalty. Other key principles include: maintenance of the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest; denunciation of wrongful conduct; specific deterrence as it applies to the member; general deterrence in relation to the membership as a whole; and, where appropriate, the member's potential for remediation. The penalty should also be proportionate to the misconduct.

The task for the Committee is to carefully consider the facts and circumstances and, by weighing the need for public protection and other penalty principles, to arrive at a penalty which is fair, reasonable and appropriate. The nature of the misconduct and aggravating and mitigating factors need to be considered. Like cases should be treated alike and the Committee should have regard to penalties imposed in similar cases, although the Committee is not bound by its prior decisions.

The Committee heard submissions about the weight that denunciation, deterrence, and rehabilitation should be given as guiding principles on penalty in light of the fact that Dr. Phipps engaged in sexual abuse, and in respect of whether the penalty should be altered if a mental condition was a significant factor in the misconduct.

The College submitted that penalty ranges can be increased where justified by the facts of a case, changing societal values, and a need for greater denunciation, citing *R. v. Lacasse*, 2015 SCC 64 and *CPSO v Peirovy*, 2018 ONCA 420. In the latter, the Court of Appeal wrote at para. 83:

> The Discipline Committee was in the best position to assess whether a deviation from the range of penalties previously imposed for similar misconduct or a wholesale change was required.

The College submitted, further, that the need for general deterrence is heightened in cases of physician misconduct involving sexual abuse. Societal tolerance for such misconduct has diminished, as recognized in *Peirovy*, 2018, and elsewhere. It is thus essential that penalties reflect this, to maintain public confidence in professional regulation and to send a clear message of general deterrence to the profession.

Counsel for Dr. Phipps submitted that deterrence deserves lesser weight and rehabilitation greater weight when mental illness has played a central role in an offence, citing four criminal cases: *R v Batisse*, 2009 ONCA 114, *R v Ellis*, 2013 ONCA 739, *R v Brown*, 2016 ONCJ 646, and *R v Haslett*, 2015 ONSC 5569.

In *Batisse*, the Court of Appeal wrote that specific deterrence and denunciation have limited meaning for the offender who was out of touch with reality due to mental illness. Accordingly, the primary concern in sentencing shifts from specific deterrence - which is likely to be ineffective if the mental illness relapses - to treatment as the better means of ensuring public protection.

College counsel submitted that the considerations around public protection are significantly different in criminal sentencing by comparison with professional regulation. In the latter, public protection is invariably the foremost penalty principle, achieved by revocation if necessary. Consequently, the altered weighting of sentencing principles relating to mental illness should not be imported from criminal sentencing to penalty determination in a discipline context.

In brief, and as detailed below, the Committee viewed public protection as paramount in respect of the appropriate penalty for Dr. Phipps's misconduct, and determined that the need for denunciation and specific and general deterrence were not diminished. The Committee found that rehabilitation is an appropriate, achievable and desirable goal for Dr. Phipps and that this is

in the public interest. Thus, the Committee did not rely on the sentencing principles relating to mental illness articulated in *Batisse* and elsewhere.

Credibility, Reliability and Weight given to Expert Opinions

a) Dr. Phipps

The Committee found that Dr. Phipps's testimony at the liability hearing in October 2017 was not credible on a number of points, including:

- His motivation for showing naked photographs of himself and the reason he showed them only to female patients;
- His assertion that what was inappropriate about showing the photographs to Patient B, and why he thought she would be upset, was that two of the photographs were not taken on the golf trip
- His assertion that he only realized that his conduct was inappropriate at the October 3, 2014 visit by College investigators.

At this hearing, Dr. Phipps testified about: his symptoms and history of depression; his use of antidepressant medication; his recollection of how he felt in 2014; the marital counselling, psychiatric treatment, and other care he has received; what he believes he has gained from such care; his present understanding of his misconduct; and how he views the risk of major depressive episodes and misconduct in the future.

The Committee found Dr. Phipps's testimony at the penalty hearing to be credible. There were not the internal inconsistencies and inherent improbabilities that marked parts of his testimony previously and, recognizing that his testimony involved relatively few verifiable facts, it accorded with other evidence where available. The letter that Dr. Phipps wrote to his wife in the summer of 2014 provides direct evidence of his symptoms and feelings at that time.

The Committee is persuaded that Dr. Phipps recognizes the severity of his misconduct and is genuinely remorseful about his actions and the harm caused to his patients, his family, and his colleagues in his community. Dr. Phipps described the guilt, shame and turmoil his actions have caused as much more severe than any of the difficult personal events he and his family have dealt with over the years.

As well, Dr. Phipps accepted all findings made against him in this matter, and that his actions were the cause of the harm experienced by his patients. With respect to the finding that he had an erection at the time of two patient visits, the Committee accepts Dr. Phipps's evidence that he does not have a recollection of those events.

In respect of the credibility findings against Dr. Phipps in the liability hearing, College counsel submitted that there is no basis on which to revisit those findings and cautioned against doing so. The Committee has no intention of revising the credibility findings it has already made. Counsel for Dr. Phipps submitted that Dr. Phipps now has better insight than he did at the time of the liability hearing. He had had relatively little treatment for depression at that point, didn't appreciate how severe his depression was and how it was affecting him, lacked self-awareness, and had impaired judgement. Further, he had difficulty with memory, which Dr. Siotis opined is common in individuals who are depressed.

That problems with insight, judgement, self-awareness and memory are associated with depression is consistent with the expert evidence, which the Committee accepts. In brief, the Committee accepts that Dr. Phipps may have better insight at this point into his depression and its effects due in part to the treatment he has received.

b) Dr. Siotis

Dr. Siotis was qualified as a participant expert witness, on consent, to give opinion evidence pertaining to the assessment and treatment of mood disorders, including depression as it pertains to Dr. Phipps and her treatment of him. She has been Dr. Phipps's treating psychiatrist since December 2018.

The Committee found that Dr. Siotis's testimony fell within the proper scope of evidence of a participating expert as set out in *Westerhof* and within the specific limits of her qualification, as above.

The Committee looked to *CPSO v Doyle*, 2018 ONCPSD 41 in regard to the proper weighing of the evidence of a treating physician. In *Doyle*, the physician did not testify but sought to establish his insight through the evidence of his treating psychotherapist. Although the Committee found the therapist to be a credible witness and his evidence informative, it put limited weight on his evidence in respect of determining an appropriate penalty for three reasons. First, as a treating therapist, his opinion was not independent and impartial. Second, the therapist opined on the physician's current state of mental health and did not consider the numerous and serious deficiencies in the physician's practice and professionalism. Third, the therapist relied on the physician's self-reporting in arriving at his conclusions, and there was evidence that the physician minimized the seriousness of his deficiencies when relaying them to the therapist.

In dismissing an appeal by the physician (*CPSO v Doyle*, 2019 ONSC 3905), in respect of independence and impartiality, the Court wrote that, as the psychotherapist had formed a positive therapeutic alliance with the physician, the psychotherapist's hopes for the physician would have been tinged with a natural bias and optimism in favour of his patient.

The Committee finds that the facts in Dr. Phipps's case differ significantly from *Doyle*, and that two of the three grounds on which the treating therapist's evidence was given limited weight do not apply here.

First, the focus of Dr. Siotis's work with Dr. Phipps was his mental health at the time of his misconduct in 2014, and on the extent to which his mental health may have given rise to that misconduct. Thus, Dr. Phipps's deficiencies, i.e., the actions which constitute his misconduct and any explanation of them, have been central to her assessment and treatment. Second, while Dr. Siotis's opinions rely on self-reporting to a large extent, there is good evidence that Dr. Phipps did not minimize his actions. Dr. Phipps had made Dr. Siotis aware of essentially all the findings before she read the decision on liability and viewed the photographs just before this hearing. As

well, Dr. Siotis's understanding of how Dr. Phipps felt in the summer of 2014 is well supported by the detailed letter he wrote to his wife at the time. That Dr. Phipps may not have recognized or minimized his symptoms of depression has been quite apparent to Dr. Siotis and is a common feature of the illness toward which treatment is addressed. Further, the Committee accepts that Dr. Siotis routinely considers, as a necessary component of her evaluations, the truthfulness of what a patient may tell her and that, with her experience and expertise, she is a reasonable judge of it. Lastly, the Committee heard directly from Dr. Phipps about matters that were the subject of his clinical encounters with Dr. Siotis and we have found him to be credible.

The Committee notes that, by the *Mohan/White Burgess* test, for the evidence of expert witnesses to be admissible, it must be proffered by a properly qualified expert who is willing and able to provide evidence that is impartial, independent, and unbiased.

The Committee recognizes that a treating physician and participating expert would want her patient to be successful in addressing his illness but is nonetheless of the view that Dr. Siotis is properly qualified to give opinion evidence as a participating expert in this hearing. Her expertise and experience are particularly germane to Dr. Phipps's circumstances. Dr. Siotis's evidence was objective, balanced, grounded in her clinical records, consistent with other documentary evidence and Dr. Phipps's testimony, respectful of the limits of her expertise, and deserving of significant weight.

c) Dr. Bradford

Dr. Bradford was qualified, on consent, as a litigation expert witness to give opinion evidence in the area of forensic psychiatry, including the assessment and treatment of sexual behaviours and assessment of the risk of aberrant sexual behaviour in the future.

The Committee considered the sources of information on which Dr. Bradford's opinions were based and had regard to *R v Abbey*, [1982] 2 SCR 24, 1982 CanLII 25 (SCC):

> While it is not questioned that medical experts are entitled to take into consideration all possible information in forming their opinions, this in no way removes from the party tendering such evidence the obligation of establishing, through properly admissible evidence, the factual basis on which such opinions are based. Before any weight can be given to an expert's opinion, the facts upon which the opinion is based must be found to exist.

College counsel urged caution in giving weight to Dr. Bradford's opinion on two grounds: first, that it relied on self-reporting by Dr. Phipps against whom negative credibility findings had been made, citing *R. v. Veysey*, 2010 ONSC 3704, and second, that Dr. Bradford may not have fully appreciated the extent of Dr. Phipps's misconduct.

In *Veysey*, the issue was whether a sexual offender with an extensive criminal history and documented sexual deviances should be designated a long-term offender or a dangerous offender. Dr. Bradford, as a litigation expert, had completed a detailed sexual behaviour assessment including sex hormone profile, various questionnaires, and objective measures of sexual preference. The Court expressed concern that he had not sufficiently reviewed prior reports and had relied on self-reporting by the offender, concluding that, if that were so, then his opinion on future risk was 'on shaky grounds'.

The present facts are very different. There is no evidence of misconduct by Dr. Phipps outside the several weeks in 2014 and no evidence of deceit or manipulation. As well, Dr. Bradford relied on more than self-reporting by Dr. Phipps, as set out above. In brief, he reviewed a psychological evaluation, Dr. Phipps's 2014 letter to his wife, Dr. Carson's letter, among other documents admitted in evidence. Dr. Bradford also spoke with Dr. Book. In addition, the Committee heard directly from Dr. Phipps.

In respect of his understanding of Dr. Phipps's misconduct, Dr. Bradford had the Committee's written decision and reviewed the findings in detail with Dr. Phipps. Dr. Bradford was aware of the specifics of Dr. Phipps's misconduct and had seen the photographs. He was aware that the Committee had had concerns with Dr. Phipps's credibility.

The Committee concludes that Dr. Bradford's opinion evidence has a reasonable factual basis and is prepared to put significant weight on it. Dr. Bradford's expertise is relevant to key issues and the Committee found his evidence informative, reasonable and consistent. Dr. Bradford acknowledged the limitations of the assessment tools he used and made clear the uncertainties related to risk assessment in his report and his testimony. He acknowledged that the finding that Dr. Phipps was sexually aroused at two patient visits suggested a sexual motivation and provided useful context for that observation.

Nature of the Misconduct

The findings against Dr. Phipps are very serious. Dr. Phipps's sexual abuse took multiple forms and involved multiple patients. Dr. Phipps showed various naked photographs of himself to 11 patients, was sexually aroused during clinical visits with two patients, made remarks of a sexual nature to four patients, and engaged in touching of a sexual nature of one patient. Dr. Phipps showed one of the photographs to three of his office staff.

Dr. Phipps betrayed the trust of his patients and of his staff and breached in an egregious way the boundaries that are fundamental to proper and effective professional relationships. By sexualizing his clinical encounters with these patients, Dr. Phipps damaged the core of his treating relationship with them.

Aggravating Factors

a) Vulnerability of the patients

Dr. Phipps chose to show photographs and engage in other forms of sexual abuse only with longstanding female patients with whom he had an established relationship of trust. They respected Dr. Phipps's professionalism and valued his care. Some of the patients had complex, chronic physical and/or mental illnesses and had come to depend on the care that Dr. Phipps had provided for years. For these individuals, the power imbalance inherent in the physician-patient relationship was particularly pronounced. This is an aggravating factor.

b) Severity of the harm to patients

In their testimony at the liability hearing and in their victim impact statements, several of Dr. Phipps's patients made clear the breadth, severity, and unrelenting nature of the harms his misconduct has caused them and their families. A number have suffered profound negative impacts on their personal relationships, ability to work, financial circumstances, and simply feeling safe and able to function comfortably in their routine daily lives.

The consequences of Dr. Phipps's misconduct have reflected on the profession generally and caused important difficulties for several patients in establishing appropriate trust-based relationships with new physicians and others in positions of authority.

Dr. Phipps's misconduct did not result from a single or momentary lapse of judgement, but rather took place with multiple patients over a period of five to six weeks. Both the severity of the harm and the fact there were multiple individuals impacted are aggravating factors.

Mitigating Factors

a) College history and cooperation with investigation

Dr. Phipps has no prior history of College concerns or misconduct. Dr. Phipps acknowledged his misconduct, in part; specifically, that he had shown photographs to a number of patients and staff. Dr. Phipps cooperated with the investigation. He provided to the College three photographs, information about a fourth photograph, and the names of patients he recalled having shown the photographs to. He encouraged patients to cooperate with the College. He acknowledged that his conduct was disgraceful, dishonourable and unprofessional, although he denied that he had engaged in sexual abuse.

Dr. Phipps has cooperated with the practice restrictions set out in his undertaking of May 2015 and has practised without incident during this time.

b) Dr. Phipps's actions were not in keeping with his prior behaviour

The Committee heard consistent evidence that, throughout his career, prior to his misconduct in the late summer of 2014, Dr. Phipps was very well regarded by his patients. He was professional, respectful, considerate, and made time for his patients. He had offered to have a chaperone present during intimate exams. Patients were comfortable with him and felt that he provided very good care.

By all accounts, Dr. Phipps's actions in the summer of 2014 were uncharacteristic. Patients overwhelmingly were surprised or shocked by his actions, whether they were the subjects of his misconduct and suffered serious harm or later, wrote letters on his behalf. His office staff likewise found Dr. Phipps's actions very much out of character.

Counsel for Dr. Phipps submits that Dr. Phipps's misconduct occurred during a circumscribed period of several weeks and should be considered in the context of a thirty-year career that had been unblemished before that point. Moreover, there have been no concerns in the almost five years since the College investigators attended at his office in October 2014.

c) Dr. Phipps took remedial steps

Dr. Phipps completed the Understanding Boundaries course at Western University at the first opportunity, in March 2015.

Dr. Phipps has been diligent in seeking out and participating in appropriate psychiatric care. He was limited in this in 2017 by his cancer treatment and, more recently, by Dr. Book's inability to continue to provide care for personal reasons.

With respect to marital issues, Dr. Phipps and his wife undertook counseling in mid-2014 and on other occasions since. Dr. Phipps reports that he has, without difficulty, reduced his alcohol consumption.

d) Letters of support

The views expressed in the letters of support of Dr. Phipps are consistent with other evidence that Dr. Phipps had been a respected and capable physician apart from his misconduct. The Committee is aware of the limitations of character evidence. As other panels of this Committee have noted, character references are of limited utility in a case involving sexual abuse of a patient, where the conduct takes place in private and has little connection to the external persona of the perpetrator. That said, the Committee noted the pervasive positive comments, which illustrate how Dr. Phipps is perceived by his community. Many of the characteristics attributed to him are among those recognized by the profession as desirable in a family doctor. The Committee concluded that this was a mitigating factor, albeit a limited one.

Collateral Consequences

The Committee considered the question of potential collateral consequences of its findings and penalty on Dr. Phipps and his family, i.e., the stress and impact on his personal and family life, his standing in the community and profession, and his financial circumstances. Three criminal cases, in which collateral consequences were taken into account in sentencing, were considered, *R v Pham*, 2013 SCC 15, *R v Zhou*, 2016 ONSC 3233, and *R v Ellis* 2013 ONCA 739.

The Supreme Court wrote in *Pham*:

> [8] …in determining what a fit sentence is, the sentencing judge should take into account any relevant aggravating or mitigating circumstances, as well as objective and subjective factors related to the offender's personal circumstances,

And further:

> [14] …a sentencing judge may exercise his or her discretion to take collateral…consequences into account, provided that the sentence that is ultimately

> imposed is proportionate to the gravity of the offense and the degree of responsibility of the offender.

The Committee did not find the consideration of collateral consequences for Dr. Phipps to be useful in determining the penalty in this matter. No doubt these proceedings have resulted in very significant adverse consequences for Dr. Phipps. The principles in determining an appropriate penalty order in a discipline case, however, are significantly different than those at play in a criminal trial. In particular, the Committee must consider maintaining the integrity of the profession and public confidence in the College's ability to regulate in the public interest.

Depression as a Contributing Factor for Dr. Phipps's Misconduct

A critical question for the Committee is whether symptoms or effects of depression contributed to the actions that constitute Dr. Phipps's misconduct in late summer of 2014.

The position of the College is that the evidence has not established that depression caused Dr. Phipps's misconduct and that, in any event, it should not be a mitigating factor in the regulatory context where public protection is paramount. The College takes the position that revocation is the only penalty that will adequately protect the public and maintain public confidence.

The position of counsel for Dr. Phipps is that the evidence of Dr. Siotis, his treating physician, and of Dr. Bradford establishes that Dr. Phipps was suffering from a major depressive episode at the time of his misconduct and that that episode and his misconduct were causally related. Treatment and rehabilitation should therefore be emphasized, while public protection can be properly ensured by continued practice restrictions.

There is considerable evidence that Dr. Phipps suffered from depression; his family doctor made (or accepted) the diagnosis many years ago, Dr. Phipps responded to a combination of anti-depressant medication and had worse mood symptoms at lower doses. Both experts concluded that Dr. Phipps has had depression. As well, Dr. Bradford found Dr. Phipps to be still somewhat

depressed when he saw him in December 2018. Dr. Siotis felt that Dr. Phipps had returned to a state of mild depression when she first saw him, also in December 2018.

Both Dr. Siotis and Dr. Bradford opined that Dr. Phipps had had a major depressive episode around the time of his misconduct in 2014. They also concluded that he had had one or more other such episodes in the past, possibly following the death of his newborn son and when he had first sought medication for depression. Their ability to judge other episodes is limited by Dr. Phipps not recognizing, not acknowledging, and/or not having been willing in the past to discuss his symptoms. In Dr. Siotis's view, this is a common feature of depression in high-functioning individuals. In addition, both Dr. Siotis and Dr. Bradford have focused primarily on the period of his misconduct and events since, rather than possible past episodes.

The evidence supports that the interplay of excess alcohol use, marital discord, and stress related to the illness of Dr. Phipps's father contributed to a major depressive episode in the summer of 2014.

Dr. Siotis opined that, at some point in 2014 or perhaps earlier, two major stressors led to a worsening of his depressive symptoms and increased alcohol consumption: his father's decline with Alzheimer's disease and his marital issues. She also noted that Dr. Phipps has some avoidant personality features and difficulties facing challenging emotional situations. In that circumstance, alcohol helps one to forget or to deny how one feels.

Dr. Bradford identified Dr. Phipps's drinking to excess and difficulties in his relationship with his wife as contributing to his major depressive episode at that time. He noted that individuals who are depressed may tend to drink more, which in turn has the effect of worsening their depression.

Dr. Siotis opined that a lack of insight and/or judgement is common in patients with depression. In her view, Dr. Phipps lacked proper inhibition as a result of both his depression and excess alcohol use in August and September of 2014.

Dr. Bradford expressed a similar opinion: depression can lead to poor impulse control, poor judgment and/or self-destructive behaviour. He also felt that Dr. Phipps had had problems with self-awareness around the summer of 2014 related to his mood disturbance, stress and difficulties coping.

On the golf trip and at his golf club, Dr. Phipps had had positive reactions to the photograph in that people had found it funny. In Dr. Siotis's opinion, with the impairment of insight and judgement that occur with depression, Dr. Phipps did not appreciate the difference between showing the photograph to friends and others and showing it to patients and did not appreciate the gravity of his actions.

In Dr. Bradford's view, with his diminished self-awareness and insight, Dr. Phipps did not realize that he had breached boundaries with his patients when he showed the photographs, expecting that they would see it as a joke as his friends had.

Dr. Siotis characterized a lack of caring about oneself as very typical of depression and a form of self-destruction. She opined that when an individual doesn't like themselves or doesn't think that they're good or worthy enough, they will engage in maladaptive behaviours that confirm their negative self-view. In this context, Dr. Phipps engaged in self-destructive behaviours as exemplified by his showing a naked photograph of himself to patients and office staff. At the same time, Dr. Phipps lacked proper insight and did not understand the gravity of his actions. Dr. Siotis identified as other examples the incident at the strip club and the text message exchange with the nurse practitioner. In both instances, Dr. Phipps was aware that these actions would anger his wife.

Both Dr. Siotis and Dr. Bradford opined that Dr. Phipps's insight into his misconduct is now much different.

Dr. Siotis testified that Dr. Phipps had expressed a great deal of shame and disappointment in himself. In her estimation, this is very different from his reaction at the time of his misconduct when she would have expected him to be much more upset than he apparently was. In her view,

he is now at a point where he is able to experience the expected emotions even though they're confirming his negative self-image.

Similarly, Dr. Bradford found Dr. Phipps now to have better insight and self-awareness, to be genuinely remorseful for his actions, and to have come to understand how inappropriate his actions were.

The Committee accepts Dr. Phipps's testimony about his history of depression, the worsening of his symptoms in 2014, his alcohol use, marital issues, and the symptoms he was experiencing in 2014. His evidence was consistent with the letter that he wrote at the time to his wife as well as Dr. Carson's summary letter and clinical notes. Dr. Phipps's evidence was that he felt that he had always denied anything more than mild depression and had tried to hide his mood and feelings. He had been drinking excessively, not managing his diet and exercise well, no longer enjoyed or participated in previously pleasurable activities, no longer looked forward to his work or to socializing, and needed to see a therapist to help him. Both experts opined that these symptoms were characteristic of depression.

The severity of Dr. Phipps's symptoms in 2014 is also apparent by comparison with his current condition. The Committee accepts Dr. Phipps's testimony that he now has a more clear understanding of the severity of his depressive episode and its symptoms, is much more open about discussing them with his family and his physicians, and is committed to continuing treatment. This is consistent with, for example, Dr. Siotis's evidence that Dr. Phipps seemed to have been well prepared by his work with Dr. Book when he started with her. Further, he has been diligent in his work with her and has made good and rapid progress under her care.

Dr. Siotis and Dr. Bradford opined that depression is not uncommon amongst physicians, nor are excess alcohol use or marital strife. The Committee heard from Dr. Siotis that physicians are generally high functioning individuals who have the ability to continue working at an adequate level despite their depression. Often, they don't recognize depression in themselves or they minimize or hide it, and they typically lack insight into the fact that they are not functioning

well. The Committee heard no evidence about the frequency of misconduct in depressed physicians in general.

The Committee accepts the expert evidence that Dr. Phipps had experienced one and possibly more severe depressive episodes prior to 2014. The Committee did not hear any evidence as to why the 2014 episode was different such that it was associated with misconduct. How prior episodes of depression may have affected Dr. Phipps is unknown, but it appears that Dr. Phipps maintained a safe and effective clinical practice for many years despite stressful events in his life and depression that was at times severe.

The Committee recognizes that it is not bound to find an explanation for Dr. Phipps's misconduct. His misconduct could simply have been the actions of a previously well-regarded and competent physician who engaged in misconduct without any reasonable explanation.

In this case, however, as outlined above, the Committee accepts:

- the expert opinions that diminished self-awareness, insight, judgement, memory, and impulse control, and self-destructive behaviour are reasonably common in severe depressive episodes;
- that Dr. Phipps has had depression for many years and had a severe depressive episode in the late summer of 2014; and
- that Dr. Phipps experienced the above symptoms or a worsening of these symptoms as a result.

The Committee concludes that the severe depressive episode in the late summer of 2014 contributed to the actions that constitute Dr. Phipps's misconduct and finds that this should be considered in determining the appropriate penalty.

The Committee accepts that, while Dr. Phipps had been on anti-depressant medication for many years, he had had little or no psychotherapy at the time of the liability hearing and consequently his depression was not optimally managed.

Risk of Future Misconduct by Dr. Phipps

The Committee considered the critical question of the risk of future misconduct by Dr. Phipps in terms of the finding of sexual arousal and potential sexual motivation, and in relation to his depression.

a. Sexual motivation

College counsel proposed that the motivation for Dr. Phipps's misconduct was sexual in nature and not related to depression and, further, that Dr. Phipps's denial of sexual interest or motivation was evidence of a persistent lack of insight that would impact any rehabilitation.

Dr. Bradford acknowledged that such a denial shows a potential lack of insight given the finding that Dr. Phipps had had an erection at two patient visits. He opined that insight occurs at an intellectual level, i.e., acknowledging (or denying) conduct, and at an emotional level, e.g. acknowledging wrong and feeling guilt and empathy. Moreover, insight is dynamic and developing insight is one of the goals of treatment. Last, denial does not impair treatment or predict long term outcome. In any event, in Dr. Bradford's view, the finding of sexual arousal reflects a 'state' rather than a trait, that is, it occurred in specific circumstances and related to specific factors, rather than being a lifelong, difficult-to-treat predisposition. Dr. Bradford found no evidence of hypersexuality, sexual deviance, psychopathy or risk factors for sexual violence on formal testing.

Dr. Siotis testified that, although she is not an expert in sexual deviance, she had discussed issues of sexual interest and sexual motivation with Dr. Phipps. She identified no factors in the sexual domain relevant to his misconduct, whereas she had identified depression and excess alcohol use as very relevant factors.

The Committee accepts the opinions of Dr. Siotis and Dr. Bradford and concludes that the finding that Dr. Phipps was sexually aroused, and his potential lack of insight in this regard, do not significantly affect the risk that he will engage in misconduct in the future.

b. Depression

The question for the Committee was the extent to which severe depressive episodes can be avoided by proper treatment and, insofar as Dr. Phipps's misconduct was related to depression, what is the likelihood of future similar misconduct by Dr. Phipps.

Dr. Bradford described the natural history of depression, in general, as including recurrent episodes of severe depression every three to nine years.

Dr. Siotis opined that the combination of psychotherapy and anti-depressant medication is the gold standard therapy and reduces the chances of relapse of major depression. Traumatic events, changes in an individual's life and other stressors may make them vulnerable or trigger relapses and need to be addressed in treatment.

Dr. Bradford cited a 60% 'success rate' in patients who are adequately treated for depression.

Dr. Bradford opined that Dr. Phipps has, with appropriate treatment and monitoring, a very low risk for recurrence of severe depression.

Dr. Siotis described the prognosis for Dr. Phipps's depression and alcohol use disorder as very good. She opined that Dr. Phipps is receiving appropriate treatment, has progressed well, and is diligent in doing everything to minimize the risk of relapse. Continued therapy is an opportunity for Dr. Phipps to make himself less vulnerable to relapse by strengthening his self-esteem and personal relationships.

In respect of managing Dr. Phipps's risk of relapse, both psychiatrists identified the need to address his alcohol use and family relationships in ongoing treatment and monitoring. Dr. Siotis recommended that Dr. Phipps minimize his use of alcohol. Dr. Phipps has acknowledged both issues. He and his wife have undertaken marital counseling on several occasions, and he has reduced his alcohol use well below what it was in 2014, apparently without difficulty. Dr. Siotis

opined that the prognosis for Dr. Phipps's alcohol use disorder is very good. He is not now and has not been in a formal treatment program.

In respect of Dr. Phipps's marriage, Dr. Siotis opined that he and his wife have dealt with significant adversity, and that they remain together is a very good prognostic factor. In her view, Dr. Phipps's wife is supportive, there are no significant issues at this point and things are going very well in their marriage. Dr. Phipps's testimony echoed this. Dr. Siotis is not providing marital counselling but Dr. Phipps and his wife have sought counseling on their own at various times.

The outlook of the experts seems more positive for Dr. Phipps than their more general observations about depression might suggest. This view presumably reflects their specific, detailed knowledge of Dr. Phipps's history, modifiable factors, the treatment he is now receiving, the improvements that have occurred, and the expectation that he will continue treatment and monitoring indefinitely.

c. Risk of aberrant sexual behaviour in the future

The Committee relied on Dr. Bradford's evidence on estimating this risk. In general, risk is a multifaceted construct, needs to be considered in a specific context, and is associated with significant uncertainty. Dr. Bradford cited a margin of error of up to or about 30% in general, depending on the tool being used. As well, the risk assessment tools available were not originally developed for circumstances such as Dr. Phipps's but rather, for the most part, in persons involved in sexual offences in the criminal justice system. The assessment of the risk for sexual violence, however, is a more dynamic, interview-based tool and thus more clearly applicable in regulatory and other settings.

In respect of Dr. Phipps, Dr. Bradford testified that, with proper treatment, the risk of him engaging in aberrant sexual behaviour in the future is low. Indeed, in his report, Dr. Bradford states that Dr. Phipps is not at risk for future aberrant behaviour with patients.

Dr. Bradford based this conclusion on his view that Dr. Phipps's misconduct was brief (in relation to his years in practice), out of character, and occurred when he was struggling with psychological stress and a relapse of major depression, which affected his judgement, self-awareness and insight. Further, Dr. Phipps is receiving comprehensive treatment, has been successful in addressing his depression, has developed a much clearer understanding of the impact of his actions and is genuinely remorseful.

The Committee accepts Dr. Bradford's opinion in respect of Dr. Phipps's depression, the role its effects are likely to have played in his misconduct and that with proper treatment and monitoring, the risks of future severe depressive episodes and of future aberrant sexual behaviour are low.

By all accounts, until the period of several weeks in the late summer of 2014, Dr. Phipps had behaved in a respectful and professional manner towards his patients. Since then, Dr. Phipps has sought out and participated actively in treatment for his depression, has engaged in marital counseling, and has reduced his alcohol intake. At this point, he has had significant success in managing each of these issues.

The Committee concludes that the risk of future similar misconduct by Dr. Phipps is low, as long as he continues appropriate treatment and monitoring of his depression, including managing the risk factors of excess alcohol use and marital discord.

Prior Cases

The Committee recognizes that no prior case comes close to the facts and circumstances of this case, most notably, the finding of sexual abuse by Dr. Phipps on the basis of showing naked photographs of himself to 11 patients, making remarks of a sexual nature to four patients, and engaging in touching of a sexual nature in respect of one patient. Both counsel identified cases to illustrate principles and/or previous penalty ranges that they viewed as informative.

College counsel drew attention to three cases of sexual abuse by physicians, relatively recent, in which revocation or its equivalent was the outcome.

In *CPSO v Minnes*, 2015 ONCPSD 3, the physician was found to have engaged in disgraceful, dishonourable, or unprofessional conduct. This consisted of intrusive and coercive sexual behaviour with a teen-aged female at a summer camp, who was not his patient but with whom he was in a position of trust. The physician had also engaged in intrusive and unwanted touching of female staff at a hospital over a number of years. The Committee ordered revocation and stated that it would have done so for the misconduct with the teen-aged female on its own. The facts are very different than Dr. Phipps's case, given that it included misconduct in the nature of a sexual assault towards a vulnerable teenager who was a camp counsellor. Dr. Minnes was the camp physician. Further. Dr. Minnes offered no explanation for his misconduct, took no responsibility, and undertook no assessments or remedial steps. The Committee does not find this case to be of assistance in determining the appropriate penalty, as the facts were very different.

In *CPSO v Dubins,* 2016 ONCPSD 34, the physician admitted to disgraceful, dishonourable or unprofessional conduct in respect of a single patient in that he asked unnecessary and inappropriate questions of a sexual nature, used graphic and offensive sexual imagery in hypnotherapy, and told the patient to unbutton and lower his pants. The aggravating factors identified by the Committee included the fact he had been cautioned previously by the Inquiries, Complaints and Reports Committee (the ICRC) for engaging in similar conduct. The context of the treatment in this case was hypnotherapy, where patients relinquish control and are in a very vulnerable state. Further, Dr. Dubins exposed his patients to unnecessary harm. The College expert concluded that the reliance upon sexually-themed aversive imagery was excessive, not specifically required for positive clinical effect, and, in some cases, could render the treatment ineffective. Most importantly, the treatment could be harmful. Patients with a history of anxiety and depression who are known to have difficulty in stopping smoking would be at highest risk for an adverse effect from Dr. Dubins's approach to treatment. The only mitigating factor was the fact the physician had admitted the conduct. The Committee stated that it would have imposed revocation, but the physician had already resigned and undertaken never to reapply to practise medicine. The hypnotherapy context, the prior caution and the absence of mitigating

factors, such as insight and or any prospect for rehabilitation, distinguish the case from that of Dr. Phipps.

In *CPSO v Beairsto*, 2017 ONCPSD 43, the physician engaged in misconduct that included sexual abuse. He had committed repeated boundary violations with a single female patient over an extended period of time. He had little insight as to the effect of his behaviour and had a history of a prior College matter also in respect of boundary violations. There was no evidence of psychiatric illness. His certificate of registration was revoked as the Committee was not sufficiently persuaded that remedial measures would alter his conduct. The Committee in *Beairsto* was also of the view that revisions to the RHPA that made revocation mandatory for touching the buttocks for non-clinical reasons should be applied retrospectively. (This Committee notes that the Divisional Court has subsequently found that revisions to the RHPA making revocation mandatory should not be applied retrospectively.)

Counsel for Dr. Phipps also provided a series of cases to illustrate a range of penalties for sexual misconduct, including suspensions in many instances.

In *CPSO v Wesley*, 2002 ONCPSD 36, the physician was a psychiatry resident who made inappropriate and unacceptable disclosures of personal information to the patient and engaged in joking of a sexual nature with the patient. Dr. Wesley also told the patient that he had a "romantic interest" in her. The Committee found that he had committed an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and that he had engaged in sexual abuse. The case proceeded on the basis of an agreed statement of facts and admission. The parties presented a "consent disposition" which the Committee rejected. The Committee ordered a reprimand, and that terms, conditions and limitations be placed on his certificate of registration, including a provision that he not see female patients without a third party in attendance. He was also ordered to post a letter of credit for the fund for patient therapy and to pay costs to the College. The Committee finds that the misconduct in Dr. Wesley's case was not as serious as in Dr. Phipps's case as it only involved one patient and Dr. Wesley did not

show photographs of his genitalia to the patient. The Committee found this case to be of little assistance because the facts were significantly different, and it was decided 17 years ago.

In *CPSO v Noriega*, 2004 ONCPSD 5, the physician admitted to sexual abuse consisting of very intrusive sexual touching of a teen-aged female patient's breasts and genitalia. The Committee directed a nine-month suspension, reprimand and practice restrictions. Again, this case was of no assistance as it was decided 15 years ago and the legislation was quite different at that time. Today, the facts in this case would have resulted in mandatory revocation due to the nature of the sexual abuse.

In *CPSO v Lee*, 2009 ONCPSD 14, the physician engaged in sexual abuse of a patient by making remarks and engaging in touching of a sexual nature, including touching her breast with his mouth and bringing his face close to her vagina. The Committee ordered a reprimand, a six-month suspension of his certificate of registration, and imposed terms, conditions and limitations on his certificate of registration restricting his practice and providing for the completion of remedial courses. Dr. Lee was also ordered to reimburse the College fund for patient therapy in relation to the patient. He was also ordered to pay costs. Again, under the current legislation, the facts in this case would result in mandatory revocation if decided today due to the nature of the sexual abuse.

In *CPSO v Marks*, 2012 ONCPSD 13, the physician pled no contest to the allegation that he had engaged in sexual abuse by hugging and kissing three patients. Dr. Marks practised exclusively psychotherapy and hypnotherapy at an office in his home. The Committee accepted the parties' joint proposal on penalty and ordered that the physician be reprimanded and suspended for four months. They also imposed terms, conditions and limitations on his certificate of registration, including that all encounters with female patients be video monitored, and ordered that he complete programs in medical ethics and boundaries. He was also ordered to pay costs the College.

In *CPSO v Muhammad*, 2013 ONCPSD 23, the physician made sexual comments to a young woman, who was both his employee and a patient, and hugged and kissed her. The Committee

made a finding of professional misconduct: in that he had engaged in the sexual abuse of a patient; and, in that he had engaged in disgraceful, dishonourable or unprofessional conduct. The Committee accepted a joint submission on penalty and ordered a reprimand; a two-month suspension, instruction in communications as set out in an individualized education plan, reimbursement of the fund for patient therapy, and the payment of costs to the College.

In *CPSO v Maharajh*, 2013 ONCPSD 37, on the basis of an Agreed Statement of Facts and Admission, the Committee found the member committed an act of professional misconduct in that he had sexually abused a patient and engaged in disgraceful, dishonourable or unprofessional conduct. In the penalty phase of the hearing, the physician admitted to putting his mouth close to or on to the breasts of 10 to 12 other patients. The Committee found no evidence of a mental illness that would diminish or relieve the physician's responsibility for his actions and was concerned about his lack of insight and failure to take responsibility. The Committee ordered a reprimand, an eight-month suspension of his certificate of registration, terms, conditions and limitations on his certificate of registration including that his practice be restricted to male patients only (which is no longer permitted under the current legislation) and that he continue individual psychodynamic psychotherapy. It also ordered reimbursement of the College fund for patient therapy for Patient A and up to six other patients. If decided under the current legislation, this case would have resulted in an order of mandatory revocation due to the nature of the sexual abuse.

In *CPSO v Rakem*, 2014 ONCPSD 25, the physician admitted that he had committed an act of professional misconduct in that he sexually abused a teen-aged female patient and engaged in disgraceful, dishonourable or unprofessional conduct in the form of sexual remarks and sexual touching of her buttocks and other areas. The physician had taken advantage of her interest in studying health sciences and purported to demonstrate examination technique. The Committee accepted the joint proposal on penalty and ordered a reprimand, a six-month suspension, the imposition of terms, conditions and limitations on his certificate of registration including supervision, the completion of the College boundaries course and reimbursement and security for payment to the College fund for patient therapy. If this case were decided today, changes in the legislation would result in mandatory revocation due to the touching of the buttocks.

In *CPSO v Peirovy*, 2015 ONCPSD 30, the Committee found after a contested hearing that the physician engaged in sexual abuse and an act or omission that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to four patients, by touching their breasts with his fingers or stethoscope during examinations. He was also found to have committed professional misconduct in that he was guilty of an offence relevant to suitability to practice in relation to two of the patients. After a contested penalty hearing, the Committee ordered a reprimand, a six-month suspension of his certificate of registration, and terms., conditions and limitations on his certificate of registration, including a practice monitor and that he complete individualised instruction and a clinical education program. The Committee ordered that he reimburse and guarantee payment to the College fund for patient therapy. It also ordered that he pay costs to the College. The decision was upheld by the Court of Appeal, which described it as a serious penalty (2018 ONCA 420). Again, if this case had been decided under the current legislation, it would have resulted in mandatory revocation due to the nature of the sexual abuse.

In *CPSO v Baird*, 2017 ONCSPD 45, the physician made comments of a sexual nature to a patient and inappropriate comments to a nurse. Dr. Baird entered a plea of no contest to the allegations in the Notice of Hearing. The Committee made a finding of sexual abuse and disgraceful, dishonourable or unprofessional conduct. The parties' jointly proposed penalty and costs order included a reprimand and payment of costs to the College but they disagreed regarding the length of suspension, reimbursement of the College fund for patient therapy and the type of remedial courses. After a contested penalty hearing, the Committee ordered a reprimand, a two-month suspension, and a term, condition and limitation on his certificate of registration that he complete individualised instruction in medical ethics. The Committee also ordered that Dr. Baird reimburse the College fund for patient therapy and post security to guarantee that payment. He was also ordered to pay costs to the College.

In *CPSO v Yaghini*, 2017 ONCPSD 29, the physician made inappropriate comments to a teen-aged female patient, kissed her on the cheek and attempted to kiss her on her lips. The Committee found that he had committed an act of professional misconduct in that he engaged in the sexual abuse of a patient and has engaged in disgraceful, dishonourable, or unprofessional

conduct. After a contested penalty hearing, the Committee ordered that the physician be reprimanded, that his certificate of registration be suspended for nine months, that terms, conditions and limitations be placed on his certificate of registration and that he complete a boundaries course and counselling program. The Committee also ordered that he reimburse the College fund for patient therapy. The Committee found the age of the complainant to be an aggravating factor but also found that the physician had gained some insight and should be further assisted by the remediation it ordered. It also relied on the expert evidence of risk assessment, indicating that, "The Committee accepts Dr. Glancy's conclusions that Dr. Yaghini exhibits a number of favourable factors, which suggest that he poses little risk to patients and the public and that the risk of his re-offending cannot be demonstrated to be measurably above that of the general population. This conclusion leads the Committee to believe that protection of the public can be achieved by measures short of revocation."

In *CPSO v Lee*, 2017 ONCPSD 46, the physician was found to have engaged in sexual abuse of two patients for making remarks of a sexual nature to each and engaging in touching of a sexual nature of one of the patients. He also asked a patient to pay cash for a prescription, to fill a prescription for him and to photograph another patient, conduct found to be disgraceful, dishonourable or unprofessional. The misconduct occurred over an extended period. The view of the Committee was that the physician lacked insight and had made no attempt at remediation of the issues in question. The order by the Committee included revocation of his certificate of registration. The Divisional Court upheld the findings of the Committee but granted the physician's appeal of the penalty of revocation (*CPSO v Lee*, 2019 ONSC 4294) and returned the matter to the Committee for re-hearing on penalty. The Divisional Court found that revocation was an unfit penalty that was not carefully tailored to the circumstances of the case, not consistent with prior decisions, and not proportionate. The Court wrote that the Committee had focused on the physician's conduct and the need for specific deterrence. It had dismissed as not relevant the physician's prolonged compliance with practice restrictions which had been without incident. It rejected the option of ongoing supervision by a practice monitor despite acknowledging that this might protect the public. As well, while the Committee held that revocation would encourage other victims of sexual abuse to come forward, it did not consider whether other penalties would accomplish the same objective. The appeal with respect to the

Committee's order of reimbursement of the fund for therapy was also allowed. The Court found that the requirement for reimbursement of the fund was speculative and not reasonable in light of the evidence of one patient that she was not troubled by the physician's conduct. The Committee understands that the College has sought leave to appeal the Divisional Court's decision to the Court of Appeal.

In *CPSO v Dao*, 2018 ONCPSD 56, the physician entered a plea of no contest to allegations of sexual abuse and 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 physician had made remarks of a sexual nature a patient on several occasions. The Committee accepted the joint submission on penalty and ordered a reprimand and a three-month suspension. It also ordered terms, conditions and limitations on his certificate of registration, which included a practice monitor and a requirement to take one-on-one instruction in communication and complete the PROBE course in ethics and professionalism. Dr. Dao was also ordered to reimburse the College fund for patient therapy and to pay costs to the College.

The range of penalties in the cases provided by counsel is very wide. This reflects perceived differences in the severity of the sexual abuse or misconduct, prior misconduct and other aggravating and mitigating factors, and changes in societal values and expectations over time. In many of the cases, were the touching of a sexual nature that resulted in a finding of sexual abuse to occur now, i.e., touching of a sexual nature of the breasts or buttocks, it would result in mandatory revocation under current legislation.

The Committee recognizes that Dr. Phipps's misconduct was egregious, and the Committee has the discretion to revoke Dr. Phipps's certificate of registration. However, the Committee has determined that the appropriate penalty in this matter is a lengthy suspension, the imposition on an indefinite basis of stringent terms, conditions and limitations on Dr. Phipps's certificate of registration, the requirement to reimburse the fund for patient therapy and a reprimand.

The Committee finds the penalties ordered in much older cases such as *Wesley*, *Noriega,* and *Lee* (2009), and in those in which the sexual abuse arose solely from sexual remarks (e.g. *Baird* and *Dao*), to be of limited assistance. Egregious sexual abuse or misconduct involving touching of a sexual nature has been met with revocation in several instances, notably when insight and the potential for remediation are limited, and there is a teenage victim or a specific therapeutic context such as hypnotherapy or psychotherapy, e.g. *Minnes*, *Dubins, Beairsto*. It is also apparent that sexual abuse of a physically intrusive nature has also led to suspensions ranging from six to nine months, e.g. *Peirovy*, *Rakem*, *Maharajh,* and *Yaghini,* although this was before changes in the legislation expanded the scope of mandatory revocation to include the touching of sexual nature that occurred in several of those cases.

Counsel for Dr. Phipps provided several prior discipline cases in which the mental health of the physician or other professional was an issue in respect of their misconduct and penalty.

In *CPSO v McArthur*, 2018 ONCPSD 58, the physician had pled guilty to a number of criminal offences including possession of a controlled substance for the purpose of trafficking. She admitted to professional misconduct on a number of grounds including having been found guilty of an offence relevant to suitability to practise. The physician suffered from a personality disorder, major depressive disorder, bulimia nervosa, and alcohol and drug addiction. The Committee found that either revocation or a two-year suspension would serve the goal of public protection. Because of the unique circumstances of the case and hope of rehabilitation, the Committee directed a two-year suspension. Dr. McArthur had not been in practice for many years as the result of an undertaking, and thus public protection was assured. She faced very considerable challenges in respect of her own health and demonstrating her competence before she might return to practice. *McArthur* is illustrative in that the principle of rehabilitation was given weight once public protection was assured.

In *CPSO v Rathe*, 2006 ONCPSD 18, the physician had been rude and emotionally abusive to a number of patients, and physically abusive to two patients. He had failed twice to appear before the Complaints Committee for a caution to be administered. The physician had opioid use disorder, impulse control disorder and major depressive disorder. The College submitted that

revocation was the appropriate penalty or, in the alternative, a suspension of at least one year. Counsel for the physician submitted that rehabilitation deserved emphasis over punishment. The Committee found that the physician was motivated, had taken steps to deal with his addiction and psychiatric problems, had made changes in his practice management and had had no further concerns or complaints from patients. The Committee directed a six-month suspension, among other orders, having determined that a longer suspension was not appropriate. The issue of very serious misconduct, and particularly sexual abuse, was not present in *Rathe*, nor was there an issue of patient harm. *Rathe* is of use in respect of the consideration given to rehabilitation in the context of treatable addiction and mental health disorders.

In *College of Nurses of Ontario v Lacroix*, 2007 ONCNO 82766, the nurse had been convicted of several criminal offences while on leave from her work, including breaking and entering a home, assault, mischief and breach of recognizance. She admitted to professional misconduct on a number of grounds. She had a history of depression and substance abuse disorders. The jointly proposed penalty included a five-month suspension and ongoing psychiatric monitoring, among other orders. The nurse had no prior history, there had been no concerns with her practice in the several years following the incident, she acknowledged her misconduct, and she participated in treatment with a good outcome. The panel accepted the joint submission while suggesting that suspending the suspension would have been more appropriate. *Lacroix* is an example of the balancing of principles and case-specific factors including consideration of the role of a mental condition in the misconduct. Again, the facts are very different in that there is not the issue of sexual abuse and serious harm to patients, as patients were not involved.

In *Ontario College of Teachers v Klatt*, 2006 ONOCT 23, the teacher acknowledged that he had acted in an unprofessional manner towards a colleague. He had a history of depression. The jointly submitted penalty proposal included a reprimand and a three-month suspension, the latter of which would not be imposed subject to certain conditions. The panel found that the penalty reflected the seriousness of the misconduct while balancing the mitigating circumstance that the teacher had been suffering from depression at the time of the misconduct. The severity of the misconduct and other facts are sufficiently different that the Committee found *Klatt* of little value.

CONCLUSION

The findings against Dr. Phipps are of a very serious nature. His misconduct caused profound and lasting harm to patients, their families, and others. He also breached the trust of his office colleagues. Much of the evidence at the hearing was with respect to Dr. Phipps's patients, but the Committee also takes very seriously the fact that Dr. Phipps took advantage of those with whom he works. No one should be made to feel uncomfortable, or worse, in his or her workplace as a result of a physician crossing such boundaries.

In *CPSO v Yaghini* 2017 ONCPSD 29 (CanLII), the Committee stated:

> Revocation of a member's certificate of registration is the maximum penalty that the Committee can impose. Revocation would carry with it a prohibition against applying for reinstatement for five years. Before imposing this penalty, the Committee must be satisfied that the facts, circumstances and penalty principles justify it. The Committee must make a thorough review of all the relevant facts and circumstances, assiduously weigh all the evidence before it, the findings made, the victim impact statement, the submissions of both counsel, and the advice of its independent legal counsel. It must have regard to all relevant penalty principles. No single factor should be considered in isolation. The Committee sees it as its duty to come to a penalty decision, which is fair, principle-based and commensurate with the misconduct.

Considering the serious nature of Dr. Phipps's misconduct and all of the facts and circumstances of this case, the Committee concludes that suspension of Dr. Phipps's certificate of registration for 14 months, a public reprimand, ongoing monitoring of all patient encounters, and ongoing psychiatric treatment and monitoring, among other terms, conditions, and limitations, is a just and appropriate penalty.

The penalty is within the range of penalties imposed in previous cases, although there is no prior case directly on point and the governing legislation has been amended.

The penalty fulfills the principles set out above, public protection being paramount. The penalty provides for robust protection of patients and serves the principle of rehabilitation in ensuring a competent, well-functioning physician returns to practice following his suspension with effective safeguards in place. Public protection will be achieved by the presence of a College-approved practice monitor in all patient encounters, appropriate signage in Dr. Phipps's clinic to ensure patients are aware of this requirement and publishing the findings and penalty on this matter on the public register. The Committee notes that Dr. Phipps has practised without concerns for four years with similar restrictions in place. Requiring ongoing treatment and monitoring by a psychiatrist reporting to the College will ensure that any relapses of Dr. Phipps's depression, should they occur, will be promptly identified and addressed. This will also serve to protect the public.

The lengthy period of suspension and public reprimand are very serious sanctions and will serve to denounce Dr. Phipps's misconduct. The reprimand will allow the Committee to express directly to Dr. Phipps its abhorrence of his actions in a public forum. Together they will act to deter Dr. Phipps from future misconduct, and act as general deterrents by making the profession aware that such conduct is wholly unacceptable and will not be tolerated.

The Committee recognizes that societal views and tolerance of sexual abuse by physicians have changed. The Committee views the lengthy suspension, reprimand, and practice restrictions as a very serious penalty that properly reflects societal views and should maintain public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest. Public confidence in professional regulation in the public interest is also served by a discipline process that is thorough, fair and transparent.

In respect of rehabilitation, the Committee has found that Dr. Phipps's insight and judgement were impaired around the time of his misconduct. With appropriate treatment, he gained insight into his misconduct and his depression. The Committee accepts that he is genuinely remorseful about the harm he has caused his patients and colleagues, among others. In the Committee's view, Dr. Phipps has a strong prospect of being successfully rehabilitated through health and practice monitoring and those safeguards are in place.

In respect of payment to the patient fund for therapy, College counsel and counsel for Dr. Phipps agree on the amount of $176,660.00, i.e., $16,060.00 per patient as set by regulation for each of the 11 patients for whom there was a finding of sexual abuse. The Committee heard evidence at the liability hearing that two patients were not especially troubled by Dr. Phipps's misconduct; however, it accepts the quantum agreed upon and jointly proposed by counsel.

COSTS

The Committee will consider written submissions on costs to be delivered by each party by September 30, 2019 and then each party may deliver its response in writing by October 7, 2019.

ORDER

The Committee orders and directs that:

1. The Registrar suspend Dr. Phipps's certificate of registration for a period of fourteen (14) months, commencing on October 1, 2019;

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

   (a) Dr Phipps shall not engage in any professional encounters, in person or otherwise ("Professional Encounters)"), with patients of any age, in any jurisdiction, unless the Professional Encounter takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College (the "Practice Monitor"). At all times, Dr. Phipps shall ensure that the Practice Monitor shall:

      i. Remain in the examination room or consultation room at all times during all professional encounters with patients, even if another person is accompanying the patient;

ii. Carefully observe all of his physical examinations with an unobstructed view of the examination;

iii. Refrain from performing any other functions, except those required in the Practice Monitor's undertaking attached as Appendix "A" (the "Practice Monitor's Undertaking"), while observing him in all his professional encounters with patients;

iv. Keep a patient log in the form attached as Appendix "B" to this Order of all the patients with whom Dr. Phipps has an in-person professional encounter in the Practice Monitor's presence (the "Log");

v. Initial the corresponding entry in the records of each patient noted in the Log to confirm that the Practice Monitor was in the presence of Dr. Phipps at all times during in-person professional encounter;

vi. Submit the original Log to the College on a monthly basis; and

vii. Provide reports (as described in the Practice Monitor's Undertaking) to the College on at least a monthly basis.

(b) Dr. Phipps shall post a sign in each of his examination and consultations rooms that states: "Dr. Nigel Mark Phipps must not have professional encounters, in person or otherwise, with patients, unless in the continuous presence of and under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Dr. Phipps must not be alone with patients in any examination or consulting room. Further information may be found on the College website at www.cpso.on.ca;"

(c) Dr. Phipps shall continue therapy with a College-approved psychiatrist, who shall provide written reports to the College quarterly for two years and thereafter, every six (6) months. Dr. Phipps shall meet with the psychiatrist as often as recommended by the psychiatrist;

(d) Dr. Phipps shall inform the College of each and every location where he practices, in any jurisdiction ("Practice Location(s)") within five (5) days of commencing practice at that location; and

(e) Dr. Phipps shall be responsible for all costs associated with implementing the terms of this Order.

3. Dr. Phipps shall reimburse the College funding under the program required under section 85.7 of the Code with respect to eleven (11) patients, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty (30) days of this order in the amount of $176,660.00.

4. Dr. Phipps attend before the panel to be reprimanded;

5. If the parties cannot agree on costs, the Committee will consider written submissions on costs to be delivered by counsel for Dr. Phipps and the College by September 30, 2019 and then each party may deliver its response in writing by October 7, 2019.

APPENDIX "A"

TO THE ORDER OF THE DISCIPLINE COMMITTEE DATED SEPTEMBER 18, 2019

UNDERTAKING OF _____,
PRACTICE MONITOR FOR DR. NIGEL MARK PHIPPS

1. I have read the Order of the College's Discipline Committee dated the 18th day of September, 2019 (the "Order"). I am aware of the College's duty to protect the public. I have asked any questions I may have about the Order and my role as Dr. Phipps's Practice Monitor and have received answers to my satisfaction.

2. I acknowledge that I have reviewed, or will review as soon as practicable, the materials regarding Dr. Phipps provided to me by the College, as well as the College's Guidelines for College-Directed Practice Monitoring.

3. I am a person, 21 years of age or older.

4. I am a regulated health professional. I am a registered member, and have been for at least five (5) years, of the College of _____of Ontario (Registration #_____).

5. Commencing from the date I sign this undertaking with the College, I undertake to act as a Practice Monitor for Dr. Phipps ("Practice Monitor").

6. I undertake to be in the continuous presence of Dr. Phipps at all times when he engages in any professional encounter, in person or otherwise ("Professional Encounter(s)") with any patient. I further understand that Dr. Phipps may not commence or continue any Professional Encounter with any patient without my presence even if another person is accompanying the patient.

7. I undertake not only to be present, but to carefully observe all of Dr. Phipps's Professional Encounters with patients, including but not limited to physical and internal examinations. I undertake that I will maintain a clear and unobstructed view of the entire encounter, including but not limited to any physical and internal examinations.

8. I undertake that I shall not perform any other functions, except those required of me by this Undertaking, while observing each of Dr. Phipps's Professional Encounters with patients.

9. I undertake to keep a patient log in the form attached to the Order as Appendix "B" of all the patients that Dr. Phipps has a Professional Encounter with in my presence (the "Log").

10. I undertake to initial and date the corresponding entry in the records of each patient noted in the Log to confirm that I was in the continuous presence of Dr. Phipps at all times during

each Professional Encounter.

11. I undertake to submit the **original** Log and a written report to the College on the first day of each and every month. I undertake to keep and secure a copy of the original Log. The report will indicate my compliance with my undertaking, Dr. Phipps's compliance with the Order, and any other information I believe will assist the College in its monitoring of Dr. Phipps.

12. If I believe that Dr. Phipps's behaviour and/or actions are improper in any way, I will immediately notify the College.

13. If any patient expresses any concern regarding improper behaviour or actions by Dr. Phipps, I will immediately notify the College.

14. I confirm that Dr. Phipps has consented to my disclosure to the College, and to all other Practice Monitors, of all information relevant to Dr. Phipps's Order, relevant to the provisions of my undertaking, relevant for the purposes of monitoring Dr. Phipps's compliance with the Order and/or otherwise necessary to fulfill the provisions of my undertaking.

15. I undertake to inform the College in writing within 24 hours if there is any change in my status or to the terms of my certificate of registration at the College of _____ of Ontario.

16. I acknowledge that all information that I become aware of in the course of my duties as Dr. Phipps's Practice Monitor is confidential information and that I am prohibited, both during and after the period of monitoring, from communicating it in any form and by any means except in the limited circumstances set out in section 36(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "RHPA").

17. I undertake to notify the College and Dr. Phipps in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.

18. I undertake to inform the College immediately, in writing, if I am unwilling or unable to fulfill any of the provisions of my undertaking.

Dated at _____ this _____ day of _____, 2019

_____	_____
Monitor (*print name*)	Monitor (*signature*)
_____	_____
Witness (*print name*)	Witness (*signature*)

APPENDIX "B"

TO THE ORDER OF THE DISCIPLINE COMMITTEE DATED SEPTEMBER 18, 2019

PATIENT LOG
RE: DR. NIGEL MARK PHIPPS

Patient Name	Date (dd/mm/yyyy)	Patient's Date of Birth (dd/mm/yyyy)	Time (in/out)	Notes

THE DISCIPLINE COMMITTEE OF
THE COLLEGEOF 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. NIGEL MARK PHIPPS

PANEL MEMBERS: **DR. C. CLAPPERTON (CHAIR)**
MAJOR A. H. KHALIFA
DR. J. WATTERS
MR. P. PIELSTICKER
DR. S-M YOUNG

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. E. WIDNER

COUNSEL FOR DR. PHIPPS:
MS. J. STEPHENSON
MS. R. ZATZMAN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

PUBLICATION BAN

Decision on Costs: **October 11, 2019**

DECISION AND REASONS FOR DECISION ON COSTS

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter on July 31, August 1, October 26, 27 and November 13, 2017. At the conclusion of the hearing on the merits, the Committee reserved its decision on finding. On August 27, 2018, the Committee found that Dr. Nigel Phipps committed an act of professional misconduct, in that he engaged in the sexual abuse of patients and 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 in relation to conduct towards patients and three office staff.

From June 24 to June 26, 2019, the Committee heard evidence and submissions on penalty and costs, and at the conclusion of the penalty hearing, reserved its decision. On September 18, 2019, the Committee released its written decision and reasons on penalty and ordered a 14-month suspension of Dr. Phipps's certificate of registration, the imposition of terms, conditions and limitations on his certificate of registration and a reprimand.

With respect to costs, the Committee ordered that if the parties cannot agree on costs, the Committee would consider written submissions on costs to be delivered by counsel by September 30, 2019 and then each party may deliver its response in writing by October 7, 2019, which was subsequently extended to October 15, 2019.

SUBMISSIONS ON COSTS

On September 30, 2019, counsel for the parties indicated that they had agreed on the following costs for the hearing:

- four hearing days at $5,500.00 per day (the then tariff rate for a day of hearing) for the merits phase of the hearing = $22,000.00;
- one hearing day at $10,370.00 for the penalty phase of the hearing = $10,370.00;
- Total: $32,370.00.

DECISION ON COSTS

The Committee finds that this is an appropriate case to award costs to the College and requires that Dr. Phipps do so in the amount agreed to by the parties.

ORDER

1. The Discipline Committee requires Dr. Phipps to pay costs to the College in the amount of $32,370.00 within 60 days of the date of this Order.