NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Ayoob Mossanen, this is notice that the Discipline Committee ordered a ban on the publication, including broadcasting, of the name or any information that could identify the complainants and with respect to a witness whose testimony is in relation to allegations of a member's misconduct of a sexual nature involving the witness, pursuant to subsection 47(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the Regulated Health Professions Act, 1991.

Also, under s. 45(3) of the Code, the Committee ordered a ban on publication of the name of the patients or any information that could disclose the identity of the patients referred to orally and in written documents in the third party records motion and at the hearing.

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. Mossanen, 2018 ONCPSD 54

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. AYOOB MOSSANEN

PANEL MEMBERS: **DR. M GABEL (CHAIR)**
DR. R. SHEPPARD
MR. J. LANGS
DR. P. CHART

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS A. BLOCK

COUNSEL FOR DR. MOSSANEN:

MR. A. MATHESON
MR. W. MAIN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R.W. COSMAN

PUBLICATION BAN

Hearing Date: August 10, 2018
Decision Date: August 10, 2018
Release of Reasons Date: October 9, 2018

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on August 10, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct, and setting out the Committee's penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notices of Hearing dated November 23, 2016, November 15, 2017 and March 20, 2018 alleged that Dr. Ayoob Mossanen 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 engaged in sexual abuse of a patient;

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 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

3. under paragraph 1(1)1 of O. Reg.856/93 in that he has contravened a term, condition or limitation on a member's certificate of registration.

The Notice of Hearing dated March 20, 2018 also alleged that Dr. Mossanen is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Mossanen admitted that he has engaged in an act of professional misconduct 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, and that he has contravened a term, condition or limitation on his certificate of registration. The College withdrew the allegations of sexual abuse and incompetence.

THE FACTS

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

Background

1. Dr. Ayoob Mossanen ("Dr. Mossanen") is an 80 year-old physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College) on November 26, 1970.

2. Dr. Mossanen holds RCPSC certification in neurology and practiced at the Pain & Disability Assessment Center in Toronto, Ontario, until his resignation on October 26, 2017.

Patient A

3. On a date in 2006, Patient A sustained injuries in a motor vehicle accident. Dr. Mossanen was retained by Patient A's legal counsel to conduct an independent medical examination ("IME").

4. Patient A attended Dr. Mossanen's office on a date in 2007. At that time, she reported headache, neck pain, mid and lower back pain and lower abdominal pain. Patient A was in

her mid-30's.

5. After interviewing Patient A, Dr. Mossanen instructed Patient A to remove her top and provided her with a gown. Patient A followed his instructions.

6. Dr. Mossanen examined Patient A's nervous system, cranial nerves, motor system, gait, neck, back, facet joints, shoulders, lower extremities, sacro-iliac joint and lower abdominal area. Dr. Mossanen's examination included straight leg raising (including hip flexion), and bending each of Patient A's knees toward the chest. In examining Patient A's fundi, Dr. Mossanen placed his face very close to hers. She could feel his breath. Patient A recalls Dr. Mossanen touched her face.

7. Dr. Mossanen asked Patient A to remove her pants. Patient A was upset and cold and did not wish to remove her pants. As Patient A recalled, Dr. Mossanen assisted her in removing her pants during the course of the examination.

8. Without an adequate explanation to Patient A, Dr. Mossanen manipulated Patient A's legs as part of his examination. In doing so, he came close to Patient A's symphysis pubis, causing her discomfort.

9. Without an adequate explanation to Patient A, Dr. Mossanen palpated Patient A's lower abdomen, including near her symphysis pubis. To do so, Dr. Mossanen rolled down Patient A's underwear exposing her lower abdomen and the upper part of her pubic area.

10. Patient A became increasingly upset and uncomfortable, and was crying extensively. She found Dr. Mossanen sharp and impatient and did not understand why he was palpating her near her pelvic area, and why he was pushing and pulling on her legs, as part of his examination. She forced her legs shut.

11. Dr. Mossanen terminated the IME and advised Patient A he could not complete the examination.

12. Dr. Mossanen failed to explain to Patient A the steps of his examination, failed to explain that he would be palpating a sensitive area of her anatomy, and failed to obtain Patient A's informed consent, causing Patient A considerable distress. Dr. Mossanen failed to show adequate sensitivity and respect for Patient A's comfort, which was unprofessional.

13. In November 2015, Patient A complained to the College regarding her experience with Dr. Mossanen.

Patient B

14. On a date in 2016, Patient B sustained injuries in a motor vehicle accident. Dr. Mossanen was retained by Patient B's legal counsel to provide an IME.

15. Patient B attended Dr. Mossanen's office on a date in 2017. At that time, she reported neck pain, chest pain, interscapular, lower and whole back pain, right groin pain, post-nose fracture, vague cracking sensation in the toes without any pain, right and left upper extremity stiffness and intermittent tingling of the hands and feet. Patient B was in her mid-30's at the time.

16. Dr. Mossanen's physical examination included investigation of Patient B's nervous system (including cranial nerves, fundi and visual fields, and hearing), musculoskeletal, motor, and sensory systems as well as an examination of the left and right side of her groin.

17. As part of the examination of Patient B's cranial nerves, Dr. Mossanen examined Patient B's eyes. This involved coming in very close to Patient B's face, which made Patient B very uncomfortable. Dr. Mossanen failed to adequately explain the steps of his examination and the purpose of his examination, making Patient B uncomfortable.

18. Further to Patient B's complaint of right groin pain, without an adequate explanation to Patient B, Dr. Mossanen palpated Patient B's right and left inguinal ligament. Without an adequate explanation to Patient B by Dr. Mossanen, the examination was performed with

Patient B's pubic hair and the top of her vulva exposed. In palpating the area, Dr. Mossanen incidentally touched the area of Patient B's pubic bone. The examination caused Patient B considerable distress.

19. At the time of Patient B's IME, Dr. Mossanen was required to have a College-approved practice monitor present during the entirety of the encounter (see paragraph 21 below). The practice monitor, a registered nurse, was present and observed Dr. Mossanen's entire examination of Patient B. The practice monitor did not observe any touching that she considered inappropriate.

20. Dr. Mossanen failed to explain the steps of his examination, failed to explain that he would be palpating a sensitive area of Patient B's anatomy, and failed to obtain her informed consent, causing Patient B considerable distress. Dr. Mossanen failed to show adequate sensitivity and respect for Patient B's comfort which was unprofessional.

Breach of the Section 37 Order

21. On January 6, 2017, the Inquiries Complaints and Reports Committee made an Order under section 37 of the *Health Professions Procedural Code*. A copy of the Order is attached at Tab A (the "Section 37 Order") [to the Agreed Statement of Facts].

22. Under the Section 37 Order, Dr. Mossanen was prohibited from engaging in professional encounters with female patients of any age unless the patient encounter took place in the presence of an approved practice monitor. Dr. Mossanen was required to ensure that the practice monitor remained in the examination room or consultation room and carefully observed all physical examinations.

23. A term of the Order required Dr. Mossanen to ensure that each patient scheduled for an appointment with him was directly notified, prior to the appointment, of the details of the practice restriction set out in paragraph 22 above.

24. Dr. Mossanen contravened a term, condition and limitation on his certificate of registration by failing to notify several of his patients, including Patient B, that he was required to have a practice monitor present for all professional encounters with female patients.

25. A term of the Order required Dr. Mossanen to ensure that each practice monitor maintain a patient log of all in-person professional encounters with female patients (the "Log") and further, that Dr. Mossanen ensure the practice monitor submit the original Log to the College on a monthly basis.

26. Dr. Mossanen contravened a term, condition and limitation on his certificate of registration by failing to ensure that all three College–approved practice monitors submitted their patient logs to the College on a monthly basis as required.

ADMISSION

27. Dr. Mossanen admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct, in that:

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

    (b) he has contravened a term, condition or limitation on his certificate of registration, under paragraph 1(1)1 of O.Reg. 856/93.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statements of Facts. Having regard to these facts, the Committee accepted Dr. Mossanen's admission and found that he committed an act of professional misconduct, in that he has engaged in an act or omission

relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and in that he has contravened a term, condition or limitation on his certificate of registration.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Mossanen made a joint submission as to an appropriate penalty and costs order. The order proposed by the parties included that Dr. Mossanen attend before the panel to be reprimanded, and that he pay costs to the College in the amount of $6000.00 within thirty (30) days of the date of the order, or in accordance with a payment plan approved by the College.

The College filed as an exhibit an undertaking signed by Dr. Mossanen on August 7, 2018. This contains his acknowledgement that he had resigned from the College on October 26, 2017 and his undertaking not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction.

Counsel for Dr. Mossanen filed as exhibits letters of support from three of Dr. Mossanen's colleagues and friends, which were considered by the Committee in its deliberations.

Penalty Principles

The principles governing the imposition of penalty following a finding of professional misconduct are well established. Protection of the public is the paramount consideration. Other principles include maintenance of public confidence in the integrity of the profession and in the College's ability to regulate the profession effectively in the public interest, denunciation of wrongful conduct, specific deterrence as it applies to the member, general deterrence as it applies to the membership of the profession as a whole, and, where applicable, the rehabilitation of the member. Aggravating and mitigating factors specific to the case should be considered. The penalty imposed should be proportional to the nature of the misconduct committed. The

Committee is guided by previous decisions of the Discipline Committee in similar cases, although it is not bound by these decisions.

Finally, the Committee is aware of the established legal principle that a joint submission must be accepted by the Committee, unless to do so would bring the administration of justice into disrepute or is otherwise contrary to the public interest.

The Nature of the Misconduct

With respect to Patient A, there were a number of aspects to the examination conducted by Dr. Mossanen which caused the complainant severe distress. Dr. Mossanen failed to explain to her the nature of the examination he would perform, and the reasons for his actions. He failed to obtain her consent, leaving her uninformed and unprepared. The examination itself caused Patient A to feel discomfort and distress by the manner in which Dr. Mossanen examined her fundi, manipulated her legs, and palpated her lower abdomen. He rolled down her underwear exposing her upper pubic area, which the patient experienced as insensitive and in violation of her privacy. She became upset, crying uncontrollably, and found Dr. Mossanen's manner sharp and impatient, which further contributed to her distress.

With respect to Patient B, Dr. Mossanen failed to explain the steps and the purpose of his examination and, without explanation, caused the complainant discomfort and emotional distress by the manner in which he palpated her inguinal ligaments, with her pubic area partially exposed. He also failed to obtain her informed consent, and he failed to show respect for the complainant by the insensitive manner in which he examined her.

Furthermore, Dr. Mossanen failed to comply with the terms of the interim order made under s. 37 of the Code. Dr. Mossanen both failed to inform his patients directly that he was required to have a practice monitor present in examinations of female patients, and he failed to ensure that practice monitor logs were submitted on a monthly basis to the College as required.

Case Law

The Committee reviewed four previous decisions of the Discipline Committee which were provided by counsel, each of which bore some similarities to the current matter.

In *CPSO v. Jiaravuthisan* (2016), the physician failed to maintain the standard of practice and engaged in unprofessional conduct. The misconduct consisted of poor communication and failure to obtain informed consent, and lack of sensitivity and respect for the privacy of two patients. The physician resigned from the College and undertook not to re-apply. He was reprimanded and ordered to pay costs.

In *CPSO v. Roche* (2017), boundary violations in relation to the patients were admitted. The physician, a psychiatrist, was found incompetent, found to have engaged in disgraceful, dishonourable or unprofessional conduct and failure to maintain the standard of practise of the profession. The penalty was a reprimand and costs order, in light of the physician's resignation from the College and undertaking not to re-apply. The Committee stated in accepting the jointly proposed penalty that revocation would have been warranted if the physician had not resigned and undertaken not to reapply to practise medicine.

In *CPSO v. Guindon* (2012), the physician committed acts of professional misconduct by failure to maintain the standard of practice of the profession, disgraceful, dishonourable or unprofessional conduct, and by contravening the terms of an undertaking to the College. The penalty consisted of a reprimand and costs order, in light of the physician's resignation from the College and undertaking not to re-apply.

In the recent case of *CPSO v. Choong* (2018), the physician, 81 years of age, subjected a young female patient to violations of her privacy and bodily integrity during the course of a physical examination, in a manner found to be below the required standard of practice, and also causing embarrassment and physical distress to the patient. The physician resigned from the College and signed an undertaking not to re-apply in Ontario or elsewhere, and was reprimanded and ordered to pay costs to the College.

Analysis

Dr. Mossanen's misconduct in relation to the two complainants was, in each case, similar, and similarly disturbing to the Committee. The patients were women who saw Dr. Mossanen for assessment of their pain. They were vulnerable both physically and emotionally. By their descriptions of their interactions with Dr. Mossanen, acknowledged by him in his acceptance of the Agreed Statement of Facts, it is clear that Dr. Mossanen was insensitive in the extreme to the vulnerabilities of these patients. His manner was abrupt and impatient. He did not explain to these patients the examinations which he would be performing or the reasons for his actions. He did not obtain the consent of his patients. He intruded on their privacy in a most insensitive and disrespectful fashion, leaving them feeling exposed, violated, and traumatized. Both patients were left feeling emotionally distraught, perceiving that they had been victimized and abused.

The Committee views Dr. Mossanen's failure to comply with the terms of the s.37 order as a very serious matter. An order of this nature is put in place to protect the public, and must be honoured. Dr. Mossanen's failure to do so demonstrates disrespect for the authority of his governing body, undermines the authority of the College, and compromises the ability of the College to fulfill its primary mandate, the protection of the public.

The misconduct committed by Dr. Mossanen reflects a failure in his professional obligations towards his patients, and towards his governing body. All patients have a right to be treated by medical professionals with respect and dignity. Effective communication, the development of rapport, and the principle of informed consent are core elements of the physician-patient relationship which cannot be neglected. Dr. Mossanen's failures in this regard left his patients distraught and caused them harm. His disregard for the authority of the College, by violating the s.37 order, cannot be condoned.

The case law reviewed demonstrates that misconduct similar to that committed by Dr. Mossanen has consistently resulted in significant sanction. The penalties imposed in the four cases reviewed reflect the principle that a physician's resignation from the College accompanied by an undertaking not to re-apply to practise medicine in Ontario, or any other jurisdiction, provides a

high level of confidence that the public will be protected. The jointly proposed penalty in Dr. Mossanen's case is strengthened as a result.

The Committee considered the three letters of support submitted by counsel for Dr. Mossanen, but attaches little weight to these. There is no evidence that the authors of the letters have direct knowledge of the issues which were before the Committee and, in any event, the letters are not suggested to be inconsistent with the jointly proposed penalty order.

The misconduct committed by Dr. Mossanen in relation to the two complainants was quite similar; we are not dealing with an isolated incident of poor judgement. This is an aggravating factor. In mitigation, the Committee acknowledges that Dr. Mossanen, by his acceptance of the Agreed Statement of Facts and his agreement to the proposed joint penalty, has demonstrated a willingness to take responsibility for his misconduct, has shortened the proceedings substantially with resulting reduction in costs, and has spared the complainants the stress of having to testify.

The Committee heard that Dr. Mossanen, now aged 80, had previously resigned from the College for health reasons. He now undertakes not to re-apply for registration in Ontario or any other jurisdiction; his medical career is over. The Committee finds it a most unfortunate conclusion to what appears to have been a long and productive career without any prior history of professional misconduct.

The undertaking to not reapply will protect the public by ensuring that Dr. Mossanen will no longer be practising medicine. Public confidence in the integrity of the profession, and the issue of general deterrence, will be served. The public, and the membership, will see that failure by a physician to comply with his professional responsibilities resulting in harm to patients will not be tolerated. Dr. Mossanen has retired from the practice of medicine, has resigned from the College, and will not be re-applying. Accordingly, neither his rehabilitative needs, nor the issue of specific deterrence are relevant in this case.

The Committee accepted the joint submission on penalty as being fair, reasonable, and appropriate, in the circumstances of this case.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of August 10, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Mossanen attend before the panel to be reprimanded.
3. Dr. Mossanen pay costs to the College in the amount of $6,000.00 within thirty (30) days from the date this Order becomes final, or in accordance with a payment plan approved by the College.

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