## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Richard Nahas, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the witnesses or any information that could disclose the identity of the witnesses under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

The Committee also made an order to prohibit the publication of the identity of the Complainant or any information that could disclose their identity 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. Nahas, 2020 ONCPSD 37**

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

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

**COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. RICHARD NAHAS**

**PANEL MEMBERS:**

**DR. WILLIAM KING - CHAIR**
**MR. JOSE CORDEIRO**
**DR. STEPHEN HUCKER**
**MS LINDA ROBBINS**
**DR. ROBERT SMITH**

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

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**COUNSEL FOR DR. NAHAS:**

**MR. ANDREW MCKENNA**
**MS REEM ZAIA**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR. DAVID ROSENBAUM**

**Hearing Date: July 21, 2020**
**Decision Date and Release of Reasons Date: September 10, 2020**

**PUBLICATION BAN**

## DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario ("the College") heard this matter via videoconference on July 21, 2020**.** At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow. These are the Committee's reasons for decision.

## THE ALLEGATION

The Notice of Hearing alleged that Dr. Nahas 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; 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 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 THE ALLEGATION

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

Counsel for the College withdrew the first allegation in the Notice of Hearing.

## THE FACTS

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

## PART I – FACTS

1. Dr. Richard Nahas is a 46-year-old physician practicing medicine in Ottawa, Ontario. His practice focusses on chronic pain management. In 2001, he obtained his certificate of registration authorizing independent practice from the College and his specialization in family medicine.

### A. Patient A

2. In the fall of 2016, Patient A sought treatment from Dr. Nahas for chronic low back pain. Patient A had three appointments at Dr. Nahas' office.

3. On Patient A's last visit to Dr. Nahas' office, Dr. Nahas treated Patient A by performing trigger point and peripheral nerve block injections, manual therapy, and placed an acupressure seed on Patient A's ear.

### B. Trigger Point Injections

4. In order to perform the injections, Dr. Nahas required access to Patient A's exposed back.

5. Prior to performing the trigger point injections, while Patient A was seated on the examination table with her back to Dr. Nahas, Dr. Nahas made efforts to access Patient A's back by lifting the bottom of her shirt without adequate warning or explanation of what he was doing.

6. Although Dr. Nahas asked Patient A if she required his assistance to lift her shirt, he did not wait for her response before lifting the shirt himself. This conduct caused Patient A to feel upset and uncomfortable.

**C. Manual Therapy**

7. After administering the trigger point injections, Dr. Nahas performed manual therapy on Patient A. This included a manipulation of her left hip and sacroiliac joint, while she was lying supine on the examination table.

8. Patient A was fully clothed during the manual therapy.

9. The manual therapy involved Dr. Nahas placing one of his hands on the inner aspect of Patient A's upper left thigh, an area he described to Patient A as being "a sensitive area".

10. Prior to performing the manual therapy, Dr. Nahas did not adequately explain to Patient A what the manual therapy would involve, including placing his hand on her inner upper thigh. This left Patient A confused and upset.

**D. Acupressure Seed**

11. After performing manual therapy, Dr. Nahas placed an acupressure seed on Patient A's ear. In order to gain access to her ear, Dr. Nahas moved Patient A's hair away from her ear, without adequate warning or explanation of what he was doing. This conduct made Patient A uncomfortable.

**PART II – ADMISSION**

12. Dr. Nahas admits the facts at paragraphs 1 to 11 above, and admits that, based on these facts, he engaged in professional misconduct under:

a) paragraph 1(1)33 of O. Reg. 856/93, 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.

**FINDING**

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission (Liability). Having regard to these facts, the Committee accepted Dr. Nahas' admission and found that he committed 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.

**PENALTY AND REASONS FOR PENALTY**

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

The Committee is obliged to impose a penalty which expresses the well-recognized guiding penalty principles. Protection of the public is the paramount consideration. The penalty imposed should also express the Committee's denunciation of the misconduct, be proportionate to the misconduct, and serve as a deterrent both to the individual member and to the membership as a whole. Further, the penalty should serve to maintain the integrity of the profession and public confidence in the College's ability to

regulate the profession in the public interest. To the extent possible, the penalty should also address the rehabilitative needs of the member.

In deciding whether to accept the penalty jointly proposed by the parties, the Committee carefully considered the nature of the misconduct as described in the Agreed Statement of Facts and Admission, the penalty principles referred to above, the aggravating and mitigating factors discussed below, and prior cases of this Committee which bore similarities to Dr. Nahas' case, in addition to the law relating to joint submissions set out above.

**Aggravating Factors**

There were two aggravating factors. The first was Dr. Nahas' indifference to appropriate, professional, physical boundaries during a medical appointment. This included disregard for the needs and sensitivities of the patient. He failed to explain to the patient, in advance, what actions he was going to take, including making physical contact with a sensitive part of her body.

The second aggravating factor involves the patient's vulnerability as a chronic pain patient. As can be seen from the prior cases (referred to below), a physician must maintain appropriate professional boundaries, in particular with vulnerable patients. Patients place their trust in physicians that they will not, for example, take steps to lift their clothing, or place hands on sensitive parts of their bodies, without first telling them what is going to happen and why.

Patients must have the confidence that physicians will put their needs first, which includes being aware and respectful of their physical boundaries and of their sensitivities.

Counsel for Dr. Nahas took issue with the submission of College counsel that Dr. Nahas' conduct constituted a disregard for patient boundaries. The Committee was satisfied that

Dr. Nahas' failure to provide an adequate explanation prior to lifting the patient's clothing or touching sensitive parts of her body, as described in the Agreed Statement of Facts, did constitute a boundary violation.

**Mitigating Factors**

The Committee accepts as a mitigating factor that Dr. Nahas admitted to his misconduct, thus taking responsibility for his actions and recognizing that his conduct was unacceptable. By so doing, he also reduced the duration of the hearing, originally scheduled for four days, and spared the complainant the stress and inconvenience of having to testify. An additional mitigating factor is that Dr. Nahas has no prior disciplinary history with the College.

**Prior Cases**

Four cases that were previously decided by the Committee were presented by counsel in a joint book of authorities. All involved misconduct that included one or more similar features to that of Dr. Nahas. Although prior decisions of the Committee are not binding as precedent, the Committee has accepted as a principle of fairness that generally, like cases should be treated alike. The cases that the parties presented provided guidance with respect to the range of penalties in such cases, and these assisted the Committee in assessing the suitability and appropriateness of the joint submission in the present case.

*CPSO* v. *Henry,* 2019 ONCPSD 41, involved an anaesthetist who was found to have engaged in disgraceful, dishonourable or unprofessional conduct. He was treating his patient for severe pelvic and hip pain. His treatment included anaesthetic injections, which the patient knew from past experience could be very painful. At a particular appointment, the patient made loud noises in response to the pain that she had experienced with the injections and following those Dr. Henry made an inappropriate

and crude comment to his nurse regarding the patient's noises. The patient was shocked and made to feel very uncomfortable by the comment.

The aggravating factors in the case of Dr. Henry were similar to those in this case: the patient was a vulnerable chronic pain patient whom the physician failed to treat with sensitivity and respect. The mitigating factors in the two cases were the same. Both Dr. Henry and Dr. Nahas admitted their misconduct, thereby saving the time and expense of a contested hearing, and neither of them had any prior disciplinary history.

The penalty in Dr. Henry's case was identical to that proposed in the case of Dr. Nahas, namely, a reprimand, a two-month suspension, a requirement that the physician participate in and complete the PROBE course, and an order for costs.

Boundary violations by a physician can occur both in words and in actions. In contrast to Dr. Henry, Dr. Nahas' boundary violations were of a more physical than verbal nature, but in both cases the physicians failed to treat the patient with the sensitivity and respect that were due to them.

In *CPSO* v*. Fikry,* 2019 ONCPSD 53, there was a finding of disgraceful, dishonourable or unprofessional conduct against a family physician. Dr. Fikry saw Patient A on three occasions. On her last appointment, she presented with respiratory difficulties, in response to which Dr. Fikry performed a chest examination. This involved the lifting of Patient A's shirt while she still had a bra on. As Patient A was leaving at the end of that clinical encounter, Dr. Fikry made a comment to her: "I have something to tell you, but please don't slap my face for it. Your bra, it is very elegant." He made no other remarks. The comment caused Patient A distress, and she did not return to see him.

In Dr. Fikry's case, the aggravating factor was the nature of the misconduct, being a boundary violation with a vulnerable patient, which was the same as in Dr. Nahas' case. The mitigating factors were also similar to Dr. Nahas' case: Dr. Fikry pleaded no contest, thereby saving the patient a potentially emotionally-draining experience in

testifying at the hearing. Also, he saved the College the time and expense of a contested hearing. As well, Dr. Fikry had no prior history before the Committee.

The Committee ordered a reprimand, and a two-month suspension of Dr. Fikry's certificate of registration, and he was required to pay costs.

In *CPSO* v*. Noza,* 2019 ONCPSD 19, a family physician was found to have engaged in disgraceful, dishonourable or unprofessional conduct. At issue in that case was the conduct of a vaginal examination in response to a complaint about heavy vaginal bleeding. Dr. Noza failed to explain to the patient the reason for the examination and what it would involve. He also failed to obtain the patient's informed consent, or to ascertain whether she wanted a chaperone present, as had been his usual practice. He also failed to provide the patient with proper draping or a gown. As a result, the patient became confused and upset.

The Committee ordered that Dr. Noza be reprimanded. His certificate of registration was also suspended for a period of three months, and he was required to complete the PROBE course and to pay costs. The period of suspension was longer than what was sought in Dr. Nahas' case. However Dr. Noza's examination of the patient was more invasive than in Dr. Nahas' case, and Dr. Noza had a prior disposition from the College's Inquiries, Complaints and Reports Committee (ICRC), which had cautioned him regarding the importance of appropriate professional communication.

In *CPSO* v*. Heymans,* 2018 ONCPSD 57, Dr. Heymans, also a family physician, was found to have engaged in disgraceful, dishonourable or unprofessional conduct. He examined a patient in the emergency room in response to a complaint of severe abdominal pain. After examining the patient's abdomen, Dr. Heymans then proceeded to perform a breast examination. However, he did not explain to the patient what he was going to be doing and why he was going to be conducting that examination, nor did he explain the steps that would be involved, or ascertain whether the patient was

comfortable with them or consented to the examination. This left the patient feeling violated and confused.

Dr. Heymans' penalty was a reprimand, a three-month suspension, various terms, conditions and limitations on his certificate of registration (which were particular to the facts of his case), and costs. The longer suspension in Dr. Heymans' case, compared to what was proposed in this case, can be explained by the presence of aggravating factors in Dr. Heymans' case that were not present in this case, notably that Dr. Heymans, who had a sleep disorder, fell asleep while he was speaking with the patient. He also had previously received a written caution from the ICRC with respect to patient boundaries and had been required to complete the Understanding Boundaries Course.

**CONCLUSION**

Each element in the jointly proposed penalty relates to and supports the penalty principles that the Committee needs to consider. The reprimand and the two-month suspension serve to maintain public confidence in the profession and its ability to self-regulate. They do so by demonstrating that there are serious consequences when physicians show disregard for appropriate professional boundaries and for their professional obligation to treat vulnerable patients with sensitivity, thereby causing patients to become confused, upset and uncomfortable.

The penalty will act as a specific deterrent to Dr. Nahas, and a general deterrent, by indicating to Dr. Nahas and to the profession as a whole that such behaviour will not be tolerated by the College. The Committee also notes that the reprimand provides it with the opportunity to express its abhorrence of the misconduct, which is another important penalty principle.

The requirement that Dr. Nahas engage in instruction in boundaries and professional ethics will serve the purpose of rehabilitation, as well as serve to protect the public. It allows Dr. Nahas to reflect on his conduct, and to make changes to ensure that his

future conduct meets the standards of professionalism expected of members of the profession.

**ORDER**

The Committee stated its findings in paragraph 1 of its written order of July 21, 2020. In that order, the Committee ordered and directed on the matter of penalty and costs as follows:

2. **THE DISCIPLINE COMMITTEE ORDERS** Dr. Nahas to attend before the panel to be reprimanded.

3. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to suspend Dr. Nahas' certificate of registration for a period of two (2) months, commencing from September 21, 2020 at 12:01 a.m.

4. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to place the following terms, conditions and limitations on Dr. Nahas' certificate of registration effective immediately:

    a. Dr. Nahas shall comply with the College Policy "Closing a Medical Practice".

    b. Dr. Nahas will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Nahas will complete the PROBE program within 6 months of the date of this Order and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

5. **THE DISCIPLINE COMMITTEE ORDERS** Dr. Nahas to pay costs to the College in the amount of $6,000 within 30 days of the date of this Order.

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

# TEXT of PUBLIC REPRIMAND
# Delivered July 21, 2020
# in the case of the
# COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
# and
# DR. RICHARD NAHAS

Dr. Nahas,

Dr. Nahas, the Committee hopes that this whole experience has driven home to you the vital importance of good patient communication. Patients are entitled to be told what you intend to do and why and, further, to give their permission to proceed. Often a simple “Okay?” will suffice. This is particularly important in the case of an intimate examination or sensitive procedure.

Your conduct with Patient A fell well below the acceptable standard of professionalism.

The period of suspension and the PROBE course which we have ordered should give you ample opportunity to reflect on this principle such that you are never again required to appear before the Discipline Committee.