College bitter as courts quash or reduce MDs’ sexual-abuse penalties

Bill Trent

Résumé : Certains des collèges qui imposent des sanctions disciplinaires à des médecins coupables de violence sexuelle envers des patients déplorent que les tribunaux mirent leurs efforts en cassant ou en réduisant certaines sanctions qu’ils ont imposées. En Ontario, dans quatre cas récents, les tribunaux ont renversé des décisions du Collège pour y substituer les leurs et le Collège craint que cette situation ne lui fasse perdre son droit d’autoréglementation. Cependant, une loi qui devrait bientôt être adoptée en Ontario prévoit des sanctions spécifiques pour la violence sexuelle, mettant ainsi un terme à l’ingérence des tribunaux dans cette province.

Early on the morning of Aug. 25, 1986, a 21-year-old woman, accompanied by her parents, reported to the Emergency Department of the Great War Memorial Hospital in Perth, Ont. The woman complained of chest pain, which Aspirin had not relieved the previous day. Now she also found it difficult to take a deep breath. The duty nurse wrote down the preliminary information, asked her to breathe into a brown paper bag — the woman was hyperventilating — and called the on-duty emergency physician, Dr. Martin Gillen.

Gillen, 35, arrived promptly, listened to the nurse’s summary of the case, and asked the parents to step outside while he examined the patient. After listening to her heart, he ordered a hospital gown for her, returning later to arrange an intravenous infusion. When she asked why this was necessary, he explained he was giving her diazepam to relax her and proceed to examine her chest and abdomen as she drifted off to sleep.

The woman had gone to sleep in the emergency room but during the night was transferred to the recovery room next door. On waking, alone and nervous in unfamiliar surroundings, she was conscious enough to hear other patients talking. Sensing the presence of someone near her, she opened her eyes and saw Gillen in his OR greens. He left, but returned a few minutes later. She watched quietly as he pulled the curtain along one side of the bed and then across the foot of it. Then, shocked, she watched as he drew out his penis.

Not only was this the kind of incident that sends shockwaves through the medical community, but it also put the College of Physicians and Surgeons of Ontario (CPSO) on a collision course with the province’s judiciary. The college responded to Gillen’s actions by revoking his licence to practise. When he appealed, Ontario’s Divisional Court upheld the college’s finding of professional misconduct for sexual impropriety, but substituted a 9-month suspension for the licence re-

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vocation. In April the Ontario Court of Appeal agreed with the lower court’s ruling that revocation was too harsh a penalty, although it dismissed Gillen’s appeal of the finding of guilt.

With that court decision, and others like it, college officials are wondering if court interference in its decisions is becoming the norm rather than the exception. “It’s a matter of grave concern to the profession and to the public,” says Dr. Michael Dixon, the CPSO registrar. “Four recent college decisions have been altered substantially by the courts, in divisional or appeal sessions. We’ve had cases in the past where the courts have disagreed with us on the question of guilt, or that of penalty, but we’ve never had this extent of interference.”

Dixon says that “quite a pattern” appears to be developing in court-altered decisions, although no one knows why. “We are dealing here with fundamental issues of national importance, but the courts have systematically reduced the severity of penalties on matters that we, as a profession, think are very significant. Quite simply, we think we have a better understanding of the implications for the public than the courts do.”

Dixon says the college isn’t going to take continued legal interference with its penalties lying down. If granted leave, it intends to take the matter to the Supreme Court. Proof of its determination is that the quiet, usually sedate college has gone public with this issue.

“We feel the necessity of challenging the courts and we’ve made a fair public show of it,” says Dixon, who is pleased that numerous major newspapers have carried stories and editorials supporting its position. “We’re on the right side of this issue. The courts are really behind the times in understanding the very serious problems involved.”

Dixon says court-altered penalties may well discourage victims of abuse from coming forward to report incidents. “We’ve been criticized in the past because victims had difficulty with the process, and we’ve made a lot of improvements within our capability and within the confines of the law to give them all the support they needed. Even so, it’s a very traumatic process for a victim to have to relive the horror and be subject to cross-examination.”

Dixon adds that the college is also concerned that its decisions may be challenged in court “because doctors think they stand a better chance of getting a lighter penalty and the odds will be with them. We feel we have to establish a bench mark. If the courts are going to set a new standard, so be it, but it’s going to be on their heads, not ours.”

Breaches of fundamental trust is a basic issue, he says. “For a person in a position of authority, like a physician, this is a serious offence — it is quite different from a casual encounter between two people without such an element of trust. When you go to a doctor, you expect you will be treated in a trustworthy manner. That’s the professional ethic and if it is breached, it is a serious offence. The courts don’t seem to make that distinction.”

If disciplinary bodies fail to deal harshly with breaches of ethics, Dixon adds, or if their decisions are continually overturned, they risk losing “the whole privilege of professional self-regulation.”

Judy McSkimmings, a public member of the CPSO’s Discipline Committee and chairperson of the Ottawa-based Women’s Action Centre Against Violence, spent considerable time with the woman involved in the Perth hospital case, and says the emotional trauma the patient faced was severe. “We’re very upset about this. The college finally is giving meaningful sentences and revoking licences, and the courts still are not cooperating. It makes it difficult for women to report abuse when they see that the doctor who had his licence revoked by the college is going to get it back in the courts.”

If the college manages to carry its fight over alleged legal interference to the Supreme Court, the Perth case likely won’t be the centerpiece — the college has already sought leave to appeal to the high court another case of sexual impropriety.

In the Perth case, however, ample support can be found for Dixon’s comments concerning professionalism and trustworthiness. The woman who was assaulted testified before the college that Gillen had placed his penis in her hand, closed her fingers over it and moved her hand back and forth to stimulate himself.

The Discipline Committee
heard that Gillen used tissues to clean himself after ejaculating, and then brought water to wash her hand. When a nurse entered the room and turned on the lights, she was surprised to find the curtain had been drawn because there was no one else in the room. At this point, the patient was crying and shouting: "Get my parents, get the police." The nurse left the room and returned shortly with the parents and the physician. When Allen saw Gillen, she turned to the nurse and yelled, "Get that f---- doctor out of here."

Gillen denied any sexual impropriety. He said the patient might have mistaken a well-known medical procedure, a test in which a patient is asked to pull on two of the doctor's fingers to prove she is conscious, for a sexual act.

With respect to semen-soaked tissues he was carrying, samples of which were taken by police for testing, he said he had been asleep when the duty nurse called. Walking across his room to turn on the lights, he became aware he had had a nocturnal emission. He cleaned his abdomen with tissues, then put them in the back pocket of his greens. He denied ever having a spontaneous erection or ejaculation while awake in a clinical setting.

In response to the charge that he had exposed himself, Gillen denied having put his penis in the patient's hand. He simply was not attracted to females in clinical settings. The confusion, he reasoned, was most likely due to a misinterpretation of the two-finger grip test.

The college chose to believe the complainant. It described her as a "well-adjusted, sensible, stable young woman who gave a strikingly clear, straightforward story that was unshaken by cross-examination." It rejected Gillen's testimony, refusing to believe that "he cleaned up a nocturnal emission with tissue and chose to put it in his pocket instead of disposing of it in the washroom he passed on his way to the emergency room. Further, it is unlikely that a physician would fail to wash his hands after this task before examining a patient. Furthermore, the tissue was described as loose rather than compressed, as might have been expected if a damp tissue had been carried in the pocket of OR greens for an hour.

"It is rare for a 35-year-old man to have a nocturnal emission, and such an occurrence wakes the man in most instances. It is very rare for a patient, after taking [diazepam], to have a sexual fantasy. For these to occur at the same time, and to find semen-soaked tissue as described, makes the combination of coincidence totally improbable."

After consideration of the evidence and submissions of the parties, the college's Discipline Committee concluded unanimously that Gillen was guilty.

College counsel advised the Discipline Committee that it was dealing with particularly serious conduct, for patients must be able to assume that physicians are trustworthy and must feel they are safe from molestation by a doctor if sedated or unconscious. It was important, too, to recognize the horror colleagues feel over his behaviour. Gillen's lawyer, on the other hand, urged the committee to "consider the rehabilitation of the doctor, the contribution to the community this brilliant man can make with his skills, and the effect of the penalty on his practice, his family, and patients."

The committee concluded that revocation of his licence was needed to protect the public and Gillen's "rehabilitation really lies in appropriate psychiatric care. . . . With appropriate treatment, the doctor may one day understand his conduct, overcome the problems he has, and apply for reinstatement."

Although the Appeal Court upheld the Discipline Committee's finding of guilt, it agreed with the Divisional Court's ruling that the college's sentence was too harsh. It stated that "under no circumstances should [Gillen's denial of the event] serve to increase what would otherwise be an appropriate penalty" and "in our view it was neither necessary nor desirable to impose the maximum penalty in order to achieve the desired objective."

The college says firmly that the court decisions concerning Gillen undermine its efforts to

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govern medical practice.

The case involving an Ottawa psychiatrist, Dr. Lal Boodoosingh, which may yet be reviewed by the Supreme Court, causes additional concern. That case involves an intimate relationship the doctor had with a patient in 1985.

The patient, a 30-year-old single woman at the time of the offence, had a psychiatric history dating to 1972, when she was admitted to hospital for a time. Hospitalization also followed the termination of an affair with her married employer. Her psychiatric medical record later documented varying degrees of anxiety and depression. When her therapist moved away, she was referred to Boodoosingh, whom she first saw in 1985.

The patient found the introductory session quite normal; in the second and third sessions, however, she reported a mutual attraction was developing between her and the doctor. She testified at the disciplinary hearing that on the third visit they held hands and hugged one another and, on the fourth, talked about having an affair. Boodoosingh eventually began telephoning her daily. She said a mutual, verbal flirtation developed, and she admitted to fantasizing about going away together. They finally met at her home and had sexual intercourse.

After that encounter the doctor telephoned almost daily, with some conversations lasting up to 2 hours. She wanted to end the relationship. She first threatened to notify the police, but then took her problems to a female psychiatrist: “The patient, feeling betrayed, hesitated to report the matter to the college. The report was made by her present psychiatrist and she still has reservations about the complaint process in that it might open her personal life to the world.”

Two long-time friends who were well-acquainted with her story provided the Discipline Committee with evidence of consistency in her telling of the facts. Her roommate also corroborated her story. Boodoosingh contradicted all relevant testimony given by the patient and her witnesses. He described the patient’s behaviour as hysterical, bent on exploiting him in her fantasy and imagination.

The college sided with the patient, saying her testimony “did not suggest fabrication or vindictiveness and was consistent over the full 3 years since the alleged event. None of the witnesses, including her present psychiatrist, felt that she was untruthful.”

The Discipline Committee decided that the patient’s testimony was “compelling and convincing” and said the facts she described should be accepted as having been established. It found Boodoosingh guilty.

It concluded that even though “the patient was a willing participant, and undoubtedly even encouraged the doctor’s attention, the doctor recognized her vulnerability. . . . Who initiated and promoted the sexual relationship was not as important as was the fact that the doctor was in gross breach of recognized ethics, and in breach of the trust that his patient had placed in him.” It decided to revoke his licence.

When Boodoosingh took the case to Divisional Court, it upheld the finding of guilt but reduced the penalty to a reprimand and 3 months’ suspension from practice. In April, a three-judge Court of Appeal panel upheld the lower court’s decision.

“Clearly, the doctor behaved unprofessionally,” those judges decided, “but it is his first recorded offence and the complainant was a sophisticated woman, and the acts were clearly consensual. The Divisional Court has authority to substitute its view of the appropriate penalty for that of the committee and we can find no error in that substituted penalty.”

At least two other cases have been appealed successfully. Toronto psychiatrist Dr. Paul Vereshack conducted a type of primal therapy; after hearing evidence of an experimental therapy program that included masturbation, genital touching and breast caressing, the college revoked his licence. In court, the revocation was replaced with an 18-month suspension. The court ruled the original sentence was “inappropriate.”

The other case involved a doctor from Kingston, Ont. In 1986 the Discipline Committee found him guilty of professional misconduct for kissing a 20-year-old patient against her will during a medical examination, and ordered a 90-day licence suspension; the court reduced that to a reprimand.

The College of Physicians and
Surgeons of British Columbia, which has faced five court appeals since 1985 and is expecting up to half-a-dozen new ones, is also worried about the potential impact of court rulings. Dr. John Harrigan, a deputy registrar, warns that in some cases the courts have substituted their judgements “for judgements of peer review.” For instance, the college struck the names of two psychiatrists from its register because of sexual improprieties involving patients. The courts overturned both rulings.

Harrigan also recalls the case of general practitioner Dr. Joseph Charalambous, who was charged 5 years ago with improper sexual activity involving a 14-year-old patient. By the time the college inquiry was complete, however, the patient was 15 1/2 years old, had married the doctor, and had a child by him. Despite the flow of events, the college declared the Surrey physician guilty of infamous conduct and sentenced him to a year’s suspension and a fine. Charalambous took his case to court, with minimum success. “They agreed the doctor’s conduct was infamous,” says Harrigan, “but disagreed with the penalty and sent it back to the college to review. We changed it — not a great deal, but some.”

[In February, Charalambous is to stand trial for first-degree murder. He is alleged to have paid to have a 19-year-old patient, Sian Simmonds, murdered to prevent her testifying against him on another charge of sexual misconduct. He has since been charged with sexually assaulting three additional patients. — Ed.]

In most cases, minor modifications of college penalties have satisfied BC’s courts. The college says that even though relatively few appeals of its rulings are successful, it is concerned that the number of appeals is growing. (The Medical Practitioners’ Act stipulates that physicians convicted by their peers may seek redress in court if they feel unfairly treated.)

“The Canadian Medical Protective Association must be instructing lawyers to appeal almost every case in which guilt is found and a penalty imposed . . . ,” says Harrigan. “The thing that concerns us the most is the expense — this is a serious consideration.

“The fact that we’ve been generally successful with appeals is an indication we’re doing things right. Our view is that we do what we think is right; if the courts want to overturn us, so be it. Our duty is to the public and we think we’re fulfilling that by laying charges, proving them and imposing penalties. If anybody gets off here, it’s not because of something we’ve done.”