PROVINCE OF NOVA SCOTIA)
COUNTY OF HALIFAX)

IN THE MATTER OF :	The Medical Act, S.N.S. 1995-96, c.10,
	-and-
IN THE MATTER OF:	A Complaint of the College of Physicians and Surgeons of Nova Scotia against Dr. Paul S. Hingley, of Truro, in the County of Colchester, Province of Nova Scotia.

HEARING COMMITTEE DECISION

Members of Hearing Committee:	W. Mark Penfound, Q.C., Chair Dr. Ann Brooks Dr. Eugene G. Nurse Dr. Robert N. Anderson Mrs. Dawn Valardo
Counsel:	Marjorie A. Hickey, Q.C. for the College of Physicians and Surgeons of Nova Scotia Joel Pink, Q.C. for Dr. Paul S. Hingley
Date of Hearing re Charges:	April 20, 1998
Date of Decision re Charges:	April 20, 1998
Date of Hearing re Penalty:	February 10 & 11, 1999
Date of Decision re Penalty:	May 10, 1999

PROVINCE OF NOVA SCOTIA)
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IN THE MATTER OF:	**The *Medical Act*, S.N.S. 1995-96, c.10,**
	-and-
IN THE MATTER OF:	**A Complaint of the College of Physicians and Surgeons of Nova Scotia against Dr. Paul S. Hingley, of Truro, in the County of Colchester, Province of Nova Scotia.**

DECISION

Counsel:	Marjorie A. Hickey for the College of Physicians and Surgeons of Nova Scotia Joel Pink, Q.C. for Dr. Paul S. Hingley
Members of Hearing Committee:	W. Mark Penfound, Q.C., Chair Dr. Ann Brooks Dr. Eugene G. Nurse Dr. Robert N. Anderson Dawn Valardo
Date of Hearing:	April 20, 1998
Date of Decision:	April 20, 1998

INTRODUCTION

The names of the complainants do not appear in this Decision in accordance with the submissions of counsel and the views of the Panel.

The College of Physicians and Surgeons ("College") sent a Notice of Hearing dated January 30, 1998 ("Notice"), to Dr. Paul S. Hingley, which Notice was delivered by Registered Mail on February 4, 1998. The Notice stated that in consequence of complaints made against him, a hearing was to be held on the following charges:

> That being registered under the Medical Act, R.S.N.S. 1989, c.278 (now S.N.S., 1995-96, c.10), and being a medical practitioner in the Province of Nova Scotia, it is alleged that :

1. From June, 1984, to and including December, 1990, during the time when you were in a psychiatrist/patient relationship with patient A:

   (a) You engaged in inappropriate and unprofessional conduct with patient A;

   (b) [ ];

   (c) You entered into a sexual relationship with patient A;

2. From March, 1986, to approximately June 1987, during the time when you were in a psychiatrist/patient relationship with patient B:

   (a) You engaged in inappropriate and unprofessional conduct with patient B;

And that in relation to the above, you are guilty of professional misconduct.

Particulars of the above allegations of misconduct are as follows:

1(a) You engaged in inappropriate and unprofessional conduct with patient A:

In particular, you did one or more of the following:

(i) You suggested she attend therapy sessions without wearing underclothing;

(ii) You suggested she expose her breasts to you;

(iii) You suggested she wear a bikini under her clothing when attending a therapy session and show her body to you;

(iv) You encouraged her to masturbate;

(v) You encouraged her to read pornography;

(vi) You gave her gifts of a personal nature [ ];

(vii) [ ];

(viii) [ ];

(ix) You focused excessively on sexual matters during therapy;

(x) [ ].

1(b) [ ]:

In particular, you did one or more of the following:

(i) [
];

(ii) [

]

2(a) You engaged in inappropriate and unprofessional conduct with patient B:

In particular, you did one or more of the following:

(i) You suggested she attend therapy sessions without wearing underclothing;

(ii) You suggested she expose her breasts to you;

(iii) [ ];

(iv) [ ];

(v) You touched her vagina and said "I'd like to have something else in there besides my finger" or words of similar meaning;

(vi) You focused excessively on sexual matters during therapy;

(vii) [ ].

PRELIMINARY ISSUES

At the commencement of the hearing both Counsel made a motion for a publication ban on the names of the complainants and patients of Dr. Hingley.

Subsection 62(3) of the *Medical Act*, S.N.S. 1995-96, c.10 ("Act"), reads as follows:

62(3) Where it thinks fit, the hearing committee may make orders it considers necessary to prevent the public disclosure at a hearing, including orders prohibiting publication or broadcasting of those matters.

Section 64 of the Act reads as follows:

> 64 A hearing committee shall, on the request of a witness, other than the member or associate member, whose testimony is in relation to the allegations of misconduct of a sexual nature by a member or associate member involving the witness, make an order that no person shall publish the identity of the witness or any information that could disclose the identity of the witness.

The allegations of misconduct in this case, in part, are of a sexual nature by a member involving a potential witness, being the complainants and patients of Dr. Hingley.

The Hearing Committee ordered that there be a publication ban on the identity of the complainants and the patients of Dr. Hingley or any information that could disclose the identity of the complainants and patients of Dr. Hingley.

STATEMENT OF ADMISSIONS AND AGREEMENTS

With the consent of both Counsel, the Hearing Committee was presented with a Statement of Admissions and Agreements, signed by Dr. Paul S. Hingley, dated the 16th day of April, 1998 ("Statement").

The Statement provides as follows:

I. I, Dr, Paul S. Hingley, of Truro, Nova Scotia, plead guilty to the following:

That being registered under the *Medical Act*, R.S.N.S. 1989, c.278 (now S.N.S., 1995-96, c.10), and being a medical practitioner in the Province of Nova Scotia,

(1) From June, 1984, to and including December, 1990, during the time when I was in a psychiatrist/patient relationship with Patient "A":

(a) I engaged in inappropriate and unprofessional conduct with Patient "A", in that:

(i) I suggested she attend therapy sessions without wearing underclothing;

(ii) I suggested she expose her breasts to me;

(iii) I suggested she wear a bikini under her clothing when attending a therapy session and show her body to me;

(iv) I encouraged her to masturbate;

(v) I encouraged her to read pornography;

(vi) I gave her gifts of a personal nature; and

(vii) I focused excessively on sexual matters during therapy; and

(b) I entered into a sexual relationship with Patient "A", which included sexual intercourse;

(2) From March, 1986, to approximately June 1987, during the time when I was in a psychiatrist/patient with Patient "B", I engaged in inappropriate and unprofessional conduct with Patient "B", in that:

(i) I suggested she attend therapy sessions without wearing underclothing;

(ii) I suggested she expose her breasts to me;

(iii) I touched her vagina and said "I'd like to have something else in there besides my finger" or used words of similar meaning;

(iv) I focused excessively on sexual matters during therapy;

And that in relation to the above, I am guilty of professional misconduct.

II. Subject to the agreement of the Hearing Committee, the Sentencing Hearing in this matter will be postponed to permit me to attend the Assessment Program at the Abbott-Northwestern Hospital in Minnesota commencing on May 18, 1998, or the next available course, at my cost. The College will make arrangements for the assessment and will forward the Abbott-Northwestern Hospital all information in its possession concerning me, dealing with the present matters outlined in the Notice of Hearing and the prior complaints brought before the College.

III. The Assessment from the Abbott-Northwestern Hospital will be provided to the College, and the Assessment will be admitted at the Sentencing Hearing without calling the author unless either myself or the College wishes to do so.

IV. At the Sentencing Hearing, letters of complaint, my responses to the letters of complaint, and such other information deemed relevant by the College or myself, will be tendered as evidence.

V. I may be called as a witness under Subpeona only, and if I am subpeoned by the College and unsuccessfully challenge the Subpeona, I shall be responsible to pay the costs of the challenge to the Subpeona on a solicitor/client basis to the College.

VI. At the Sentencing Hearing, the College will be free to argue the full range of penalties that are open to be imposed by the Hearing Committee, including revocation.

VII. Subject to the agreement of the Hearing Committee, I shall be suspended from the practice of medicine effective as of May 15, 1998. Until that date, I will only practice with male patients.

VIII. The College will publish notice of my suspension on May 15, 1998, or as soon thereafter as is possible.

IX. Costs of this Hearing before the College, including the Sentencing Hearing (subject to Item No. 5. above) shall be fixed at $10,000.00.

X. My period of suspension commencing as of May 15, 1998, shall be taken into account at the time of the Sentencing Hearing.

After reviewing the charges, allegations and particulars set out in the Notice, and the Statement, and hearing the submissions of Counsel, the Hearing Committee accepted the admissions and agreements in the Statement and entered a finding of guilty of professional misconduct against Dr. Hingley on charge 1(a) and its particulars (i) to (v) inclusive, (vi) in part and (ix), charge 1(c) and charge 2(a) and its particulars (i), (ii), (v) and (vi), all as admitted in the Statement.

There was no evidence adduced and no admissions in the Statement with respect to particulars (vii), (viii) and (x) of charge 1(a), charge 1(b) and all its particulars, and particulars (iii), (iv) and (vii) of charge 2(a). The Hearing Committee records a finding of not guilty of professional misconduct against Dr. Hingley in relation to particulars (vii), (viii) and (x) of charge 1(a), charge 1(b) and all its particulars, and particulars (iii), (iv) and (vii) of charge 2(a) as set out in the Notice.

CONTINUING PUBLICATION BAN

The Hearing Committee hereby orders that the publication ban with respect to the identities of the complainants and other patients of Dr. Hingley shall remain in full force and effect. This publication ban includes the names of these individuals and any information which would or could identify any of them.

The Hearing Committee agreed to file a written decision and then adjourned without day for the Sentencing Hearing in accordance with the agreements in the Statement.

This Decision is being re-issued on May 10, 1999, to comply with the amended publication ban ordered by the Committee during the Penalty Hearing. Square brackets are used to denote the deletions required by this order.

W. Mark Penfound, Q.C., Chair

Dr. Ann Brooks

Dr. Eugene G. Nurse

Dr. Robert N. Anderson

Dawn Valardo

PROVINCE OF NOVA SCOTIA)
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	-and-
IN THE MATTER OF:	**A Complaint of the College of Physicians and Surgeons of Nova Scotia against Dr. Paul S. Hingley, of Truro, in the County of Colchester, Province of Nova Scotia.**

PENALTY DECISION

Counsel:	Marjorie A. Hickey, Q.C. and Michelle Higgins, Articled Clerk for the College of Physicians and Surgeons of Nova Scotia Joel Pink, Q.C. and Deirdre Murphy for Dr. Paul S. Hingley
Members of Hearing Committee:	W. Mark Penfound, Q.C., Chair Dr. Ann Brooks Dr. Eugene G. Nurse Dr. Robert N. Anderson Dawn Valardo
Date of Penalty Hearing:	February 10 & 11, 1999
Date of Penalty Decision:	May 10, 1999

INTRODUCTION

Dr. Hingley admitted certain allegations, for which the Hearing Committee ("Committee") in its Decision on the 20th day of April, 1998 ("Decision") found him guilty of professional misconduct.

The Committee reconvened on the 10th and 11th days of February, 1999, to hear evidence and submissions with respect to penalty.

The Committee continued its order of a publication ban with respect to the identities of the complainants and other patients of Dr. Hingley and any information which would or could disclose the identity of the complainants and patients of Dr. Hingley.

The Decision set out in full the allegations and particulars against Dr. Hingley contained in the Notice of Hearing, not all of which were admitted. At the request of the complainant, Counsel for the College of Physicians and Surgeons of Nova Scotia ("College") asked that the publication ban extend to those allegations and particulars which were not admitted. Counsel for Dr. Hingley agreed. As there is sensitive material contained in these allegations and particulars, the Commitee orders the publication ban be extended to include any information relating to any of the allegations and particulars in the Notice of Hearing which were not admitted by Dr. Hingley in the Statement of Admissions and Agreements dated the 16th day of April, 1998. This includes allegation 1(a) and particulars (vii), (viii) and (x), allegation 1(b) and all its particulars and allegation 2(a) (iii), (iv) and (vii). Accordingly square brackets are used to denote deletions required by this ruling in both this Penalty Decision and the Decision.

Pursuant to Section 62(2) of the *Medical Act*, S.N.S. 1995-96, c.10 ("Act"), the Committee agreed to the request of Counsel for the College that the Hearing be closed to the public for the evidence of a witness known as Patient A in the allegations ("Witness A").

Patient B in the allegations, particulars and admissions ("Patient B") was unable to attend the hearing on penalty. She suffers from [ ] and was concerned about the impact of providing testimony on her medical condition. Counsel for both parties agreed it would not be necessary for her to appear to give evidence and all of the material in terms of her letters to the College and Dr. Hingley's responses would be introduced in the joint exhibit books.

In addition to Witness A, the Committee heard evidence from Dr. Paul Hingley, Dr. John Bradford on behalf of Dr. Hingley and Dr. Michael Teehan on behalf of the College,.

The names of the complainants do not appear in this Penalty Decision in accordance with the submissions of counsel and the views of the Panel.

By agreement of Counsel, the Committee received a three volume Joint Exhibit Book.

EVIDENCE

At the initial hearing, the Committee received a Statement of Admissions and Agreements, but did not receive any evidence. This Penalty Decision will set out the facts placed in evidence at the Penalty Hearing supporting the admissions of the allegations and particulars and the factors to be considered in determining the appropriate sanction.

Dr. Paul Hingley is 48 years of age and lives in Truro, Nova Scotia. He has been married for 24 years and has two children. He graduated from St. F. X. University in 1972. He obtained his MD from Dalhousie Medical School in 1976. After completing his internship in 1977, he practiced for one and a half years as a general practitioner in Port Hawkesbury, Nova Scotia. He returned to Dalhousie in 1979 to take a residency in psychiatry.

In 1983, after finishing his residency at Queen's University, he started a general practice with an interest in psychiatry in Truro at the Colchester Mental Health Centre. In 1985 Dr. Hingley received his fellowship from the Royal College of Physicians and Surgeons. In addition to his work at the Mental Health Centre, he also worked at the Nova Scotia Residential Centre and the Nova Scotia Youth Training Centre.

In 1986 he opened a private practice, where he spent half his time, the other half continuing with the Residential Centre, the Youth Training Centre and the Mental Health Centre. In 1994 his private practice became full-time.

In 1984, Witness A, [ ], became a patient of Dr. Hingley, on a referral from her family doctor. She had been experiencing anxiety and panic attacks and was feeling unable to cope with many things, including the raising of her child. Her visits were on a regular weekly basis until approximately 1989, when they became more sporadic until they ended in 1990.

They took place alone with Dr. Hingley at the Colchester Mental Health Centre for the first two years and afterwards at his private office.

From the beginning, Dr. Hingley focused excessively on sex. He believed her problems were based on sexual repression. In order to help herself and her marriage, he told her she would need to become sexually liberated and be more sexually assertive and expressive.

Early in the therapy, Dr. Hingley suggested she attend sessions without underclothing as one of the ways to deal with her sexual repression.

She had no self esteem and disliked every aspect of herself. Within the first six months, Dr. Hingley suggested she expose her breasts to him. For her to accept herself, he told her to take a risk with him, that he was a safe person, and his office a safe area. Exposing herself to him was a way of learning how to take risks and accept her body. When she resisted, he indicated her response was a symptom of her sexual repression.

During the first year of therapy, due to anxiety and stress, she lost weight. After telling Dr. Hingley she had purchased a bikini bathing suit, he suggested she wear it under her clothing and show him her figure during the therapy session. When she wore the bathing suit to a session, she was embarrassed to tell him she was wearing it. Upon discovering she had it on, he encouraged her to disrobe and show him her body.

Dr. Hingley felt society in general had strange and repressed ideas around sexuality. With his help she would become sexually liberated which would be helpful for her marriage. He told her husbands liked him because he helped sexually liberate their wives.

When Dr. Hingley took her history, he asked whether she masturbated. She replied she did not as [ ] . She recalled him saying "That's something we'll have to do something about." In the following sessions, he would ask her if she masturbated and fantasized, suggesting she examine her values in that regard, learn how to have sexual fantasies and how to please herself sexually. When she indicated her discomfort with this type of discussion, he responded, it was something she could do for herself and would make a great deal of difference.

As she was experiencing extreme anxiety at the time, she began to have doubts about her feelings. She began to entertain the thought that maybe he was right and she was wrong to be uncomfortable. She began to comply with his suggestions.

As the time progressed over the first couple of years, Dr. Hingley began to eroticize the relationship. Gradually more erotic topics were introduced, [ ]. [ ]. [ ]. [ ]. She believed he was sexually excited during these sessions.

He encouraged her to develop a repertoire of things that were sexually exciting, one of which was to read pornographic material. He gave her a book called "Women write Erotica" which he had purchased for himself, but did not find it steamy enough. The discussion of pornography was more prominent near the end of the first year. Once they became sexually involved and he had accomplished his goal, his efforts to eroticize the relationship ceased.

[ ]. Other gifts included a pearl ring, a heart bracelet, a window ornament and a cross pen. He also gave her gifts other patients had given him but which he couldn't take home. These included a eucalyptus wreath and a charcoal sketching of a cat. She recalled Dr. Hingley saying many times that "he had pictures of cats in his office and ... that he liked to have lots of pussy around".

Sex was a part of every session. When she questioned his focus on sex, although he stated a willingness to talk about other things, she was timid and not able to direct the discussion herself. He would always bring it back to sex and make her feel as though she wanted to talk about it anyway.

Dr. Hingley's approach to therapy involved looking at sexuality issues as a way of dealing with personal problems. He told her he used this approach with many women. He knew it wasn't a mainstream or acceptable approach in his profession but his profession and society in general had very repressive attitudes around sexuality. He believed his method worked and it was working for her.

Witness A recalled two occasions of sexual intercourse in Dr. Hingley's office in the Colchester Hospital, prior to him moving into private practice. When he moved into private practice, it became a regular occurrence in therapy sessions.

This continued for two years [ ] . The relationship ended in 1990 when she began dating.

During all her activities with Dr. Hingley, Witness A could never look at him in the face. She remembered being very overwhelmed afterwards. She always referred to him as Dr. Hingley, never by his first name.

Throughout the relationship, when she ultimately complied with his various suggestions, Dr. Hingley would praise her for being "brave and courageous" and a good patient. He would often indicate she was doing better than his other patients. In one instance, she recalled saying she might not come back. He said he would come looking for her. At a time when she needed attention, this made her feel special. It reinforced her compliance as something good which supported her need for attention and approval.

Patient B became a patient of Dr. Hingley in 1986 and continued until 1987. She suffered from anxiety and depression. When she expressed doubt as to whether he would accept her as a patient, Dr. Hingley stated that "Oh no. You are good looking enough."

From the initial visit, Dr. Hingley focused on sexual matters. In order to promote complete trust in him, he requested that she attend sessions with no bra and wear a blouse with buttons. He would request that she open her blouse and expose her breasts to him. She complied after feeling badgered in his office. If she resisted, he would reply "If you win, you lose" which she understood to mean if she didn't comply she wouldn't get better. Towards the end of her visits, she attended sessions with no panties while wearing a skirt. In one instance, with his hand on her vagina, he commented, "I'd like to have something else in there besides my finger."

Following the initial hearing in this matter, as part of the Statement of Admissions and Agreements, Dr. Hingley attended the Professional Assessment Program at the Abbott Northwestern Hospital on May 18, 1998.

The following are excerpts from the Assessment team's formulation, diagnosis, conclusions and recommendations. A review of the data, interviews and psychological testing of Dr. Hingley

> ... demonstrated a clear pattern of sexualization of the therapeutic relationship and sexual acting out in his practice. ...This was inappropriate given the age and gender of his patients and the fact that this behavior was gender specific. ... Patients who did not aggressively resist some of his overtures to discuss sexual topics were then subject to a continuous and increasing sexualization of the therapeutic relationship. This pattern culminated in an active sexual relationship with at least one patient. ...
>
> There seemed to be little or no emotional awareness of the impact of his behavior on his patients. There was a surprising absence of awareness of the particular vulnerability of his often-abused female adolescent patient population, which was a significant portion of his case load. ... In addition, he tended to both verbally denigrate his patients when they challenged him and attack them, believing that they had not been damaged by his behavior.
>
> Dr. Hingley meets the criteria for a Sexual Disorder, Not Otherwise Specified, with compulsive, opportunistic erotization of the therapeutic relationship. In short, his pattern of progressive erotization with the ultimate development of a "special" relationship along with the objectification of his victims, points toward an offender or perpetrator-type pattern. This pattern should be considered predatory. Because of this he is not safe to practice psychiatry at this time. He will need intensive treatment for this disorder, as well as follow-up treatment and close monitoring if he is to return to practice.
>
> .....
>
> ... he stated that deceit and dissembling were justified in order to hold onto his income. In summary, there were interpersonal difficulties involving a reduced ability to make interpersonal and emotional connections, to establish empathy with others, and to demonstrate allegiance to a pattern of ethical behavior. The absence of identification with the victim is of particular importance, particularly in terms of the implications for his treatment and recovery. The absence of identification is often a poor prognostic sign.
>
> Dr. Hingley claims to have discontinued the problematic behavior for several years. ... even if this were accepted at face value, he is still very vulnerable to repeating the same

pattern. That vulnerability will increase if there is any factor that leads to an increase in his sexual drive.

Dr. Hingley will need intensive initial treatment in a program oriented toward sexual offenders. ... There should be a comprehensive and detailed discharge plan, which should be carefully followed. Dr. Hingley will need to engage in outpatient therapy following discharge. He will need close monitoring and confirmation that he has complied with his recovery program prior to any consideration for return to his practice. Should he return to practice, it is likely that there will be careful limitations set upon the type of practice in which he might engage.

.....

CONCLUSIONS

Dr. Hingley is not safe to practice psychiatry at this time. He has a constellation of attitudes that would place him at high risk with anyone with sexual issues. He also has a limited knowledge base regarding the potential impact of sexual abuse on any patients.

RECOMMENDATIONS

1. Intensive treatment in a program with sexual offender orientation.

The treatment should, among other things, focus on helping Dr. Hingley understand the point of view of the victim and be able to empathize more with the victim.

2. Neuropsychological testing

Neuropsychological testing could be administered, ... to rule out cognitive deficits. If present, these problems would be contributory, but would not be causative of his sexual disorder.

3. Further observations and evaluation regarding bipolar disorder

Again, if any mood disorder is found to be present, it would be contributory, as opposed to causative.

4. Medications

5. Follow-up with personal physician

6. Aerobic Exercise

7. High fiber, low fat diet.

After receiving the report and recommendations from Abbott Northwestern, Dr. Hingley made arrangements to see Dr. John Bradford at the Royal Ottawa Hospital in Ontario for treatment. Dr. Bradford is a forensic psychiatrist. He is a Professor of Psychiatry in the Faculty of Medicine and Head of the Division of Forensic Psychiatry at the University of Ottawa. He is also the Director of the Sexual Behaviours Clinic. Dr. Bradford conducted his own evaluation commencing on September 28, 1998. A full sexual behaviours assessment was completed including a sex hormone profile, sexual questionnaires and evaluation of sexual preference using penile tumescence technique and visual reaction time.

Dr. Bradford in his report of January 13, 1999, made certain conclusions and recommendations, of which the following are excerpts:

> ... he now accepts that he has a sexual problem although he sees it as a compulsive hypersexuality or non-paraphilic hypersexuality. This is relevant as he was in absolute denial prior to this. The only paraphilia that he appears to admit to and is supported by the information that I have would be of voyeurism. This is in a nontraditional presentation as part of his sexual professional misconduct although he clearly has had voyeuristic fantasies and interests. ... he clearly has had a problem with boundary violations and professional misconduct. At least part of this occurred from a background of non-paraphilic hypersexuality. At the present time he is not showing non-paraphilic hypersexuality when the assessment was completed. However I believe that his sexuality at the present time is simply suppressed because of the psychosocial stress that he is under, and the history is supportive of non-paraphilic hypersexuality having been a problem in the past.
>
> He continues to show some cognitive distortions that are present. In the records that I reviewed including his very strong letters written when he was in a phase of complete denial he clearly showed not only denial but also serious cognitive distortions. Although he has progressed from this point there continue to be problems in this regard. As a result of this he is in need of some intensive psychiatric treatment. He is in need of at least one month intensive treatment package that would confront his cognitive

distortions and that would set him up with some cognitive behavioural strategies to deal with these problems. He would then require openended ongoing psychiatric monitoring and treatment which would have to be set up in Nova Scotia. On the intensive treatment package I would be willing to provide that through the Sexual Behaviours Clinic at the Royal Ottawa Hospital. As part of this treatment in my opinion he also clearly needs medication. This should be serotonin reuptake inhibitor such as Sertraline. The aim of this would be two fold. One is that this is now the accepted treatment for non-paraphilic hypersexuality. In my opinion this problem is simply going to recur once the stress is removed in the future. ... It would also be important that if there is undisclosed or undetected paraphilias at the present time that these would be suppressed by the serotonin reuptake inhibitor. In this regard I am concerned that his computerized self-diagnosis in Psychiatry generated no psychiatric difficulties. This at the very least means some dissimulation or denial of difficulties. Further his sexual desirability score shows an unwillingness on his part to admit to any violation of common social mores which includes even minor issues such as impatience, feelings of anger, etc. It may also mean that denial of his problems with professional sexual misconduct is still operating. If this is the case, his failure to accept complete responsibility for his behaviour is likely to affect his future prognosis. In this regard I have trouble accepting his very strong letters of denial to the College which have narcissistic tones to them (and then the turnaround) admitting his professional sexual misconduct can occur with any meaningful internal psychological change in such a short time. His ongoing cognitive distortions are evidence that this has not occurred.

In the future if the College permits Dr. Hingley to continue to practice medicine, however, there is going to have to be ongoing openended psychiatric monitoring and the psychiatric monitoring should be comprehensive monitoring for any further sexual difficulties both at the personal level and clearly in relation to his practice with adults greater that 19 years of age. Furthermore there has to be some monitoring of his practice in terms of the type of psychotherapy that he does conduct and the type of psychiatric practice that he conducts. This monitoring should be done by professionals that are working in close proximity to him . These professional people would meet once a month and would make a report to the psychiatrists monitoring him, as well as to the Registrar of the College. This is usually a nurse, a secretary, or a family member and there may even be grounds for a patient survey to be completed anonymously at specific intervals, perhaps every six months, to ensure that there are no boundary violations that are occurring. This is relevant if there is a solo private practice. In my opinion the only way of ensuring effective monitoring against future professional sexual misconduct is to restrict his future practice of psychiatry to a setting such as a mental health centre where an effective monitoring program should be in place.

> If the College of Physicians and Surgeons of Nova Scotia has psychiatrists who have training in professional sexual misconduct available, then these psychiatrists should be providing the coordination of the monitoring of Dr. Hingley's practice and also should provide ongoing treatment for Dr. Hingley. I should emphasize that not all psychiatrists have the necessary professional background and training. There should also be a relapse-prevention group for physicians and surgeons with problems of professional sexual misconduct. ...
>
> At the present time he reports that he is aware of boundary violations. I was not impressed necessarily with him in relation to this because of ongoing cognitive distortions that would facilitate boundary violations. He needs to be treated specifically on boundary violations on an ongoing basis as part of his ongoing psychiatric treatment. In my opinion with the appropriate treatments; the appropriate practice monitoring; a relapse-prevention group; treatment for non-paraphilic hypersexuality and sexual disfunction; and of course Dr. Hingley's acceptance and active participation in these programs, the risk of future professional sexual misconduct will be minimal.

Further to his report, Dr. Bradford testified as to the psychiatric mechanism operating at the time that Dr. Hingley engaged in the sexual relations with the complainant. He breached boundaries in the therapeutic relationship with patients. He was inappropriately sexually preoccupied. This was a manifestation of non-paraphilic hypersexuality. He used cognitive distortions to justify the boundary violations with his patients.

Hypersexuality is an increase in the biological sex drive, and if it's non-paraphilic it means that it's non-deviant. The usual clinical manifestations include inappropriate sexuality, often high-risk sexuality, promiscuity, and inappropriate sexual liaisons in a way that endangers either professional status or family status. These persons seem to have difficulty controlling it even though they're aware that it's destructive to them.

In Dr. Hingley's case, he took inappropriate sexual histories, when they were not appropriate to the presenting condition of the patient. Taking histories about masturbatory fantasies may be relevant in the case of a person presenting with voyeurism or pedophilia, but it wouldn't be relevant for a patient presenting anxiety and depression. The sexual history would be typically brief for an average psychiatrist who did not work with sexual problems on a significant level. In his case, the sexual history was far more extensive than it should have been for the

circumstances. He carried his sexual preoccupation into the situation, sexualizing the interaction. It was inappropriate, distorted and interfered with the therapeutic alliance.

Another cognitive distortion involved projecting onto the patients that they had instigated the sexual interactions within the therapy, ignoring the fact that he sexualized it from the beginning.

Dr. Bradford, in explaining cognitive distortions, suggested an individual develops a way of thinking that justifies their sexual behaviour. It is a rationalization for their behaviour. If these remain, a person can easily relapse into the inappropriate behaviour.

In Dr. Bradford's report, he stated Dr. Hingley was not showing non-paraphilic hypersexuality at the time of the assessment. However, he believed that his sexuality was suppressed because of psycho-social stresses. The stresses, he testified, include legal problems, problems with the College, financial problems and threats to his professional career. It's suppressed as opposed to in remission in the sense that it's been treated and therefore controlled.

With respect to whether, if Dr. Hingley's condition has been suppressed for roughly a nine-year period, it was possible that he could continue to control or suppress his condition in the future, Dr. Bradford stated that although possible, he would not be comfortable making that assumption for the future. Even though it's suppressed, intervention is necessary.

When asked whether there were any risks associated with Dr. Hingley continuing his treatment of male patients, Dr. Bradford expressed concern if he was treating male patients with problems in their relationships with females. He was concerned about Dr. Hingley's attitudes toward women. Since psychiatrists counsel people in relationships, if he continued to carry his negative attitudes towards women into a therapy situation, he could damage the male patient.

In addressing the form of treatment for cognitive distortions, Dr. Bradford suggested there is usually an intensive cognitive behavioral program established. The cognitive distortions are identified and then dealt with individually in terms of how they came about and how wrong they are, in order to bring about a process of cognitive restructuring to change the person's thinking. In the first instance, this can be done in an intensive, brief period. However, the

treatment process must be open-ended as individuals with the passage of time can slip back into the same cognitive distortions.

With respect to whether cognitive distortions are curable, Dr. Bradford took a conservative approach. Based on many years of working with people with sexual problems, he suggested distortions can be identified, a person may accept them, cognitive restructuring may have occurred, but human nature is such that it is easy to slip back into the cognitive distortions in the future. In his opinion significant inroads can be made but there is always a danger of relapse. This principle applies in relation to professional sexual misconduct, be it physician, psychologist or anybody else.

In terms of monitoring, in Dr. Bradford's opinion, a mental health setting is preferred. Usually in that setting there would be a peer professional, a psychiatrist, that would provide surveillance. Also there might be a secretary, maybe a nurse. First, the person would explain to the surveillance team the nature of his problem, for example, that he sexualizes his relationships with patients. The team would then watch what the person does. They would meet on a monthly basis, prepare a report which would go the supervising psychiatrist and the College. In a private psychiatric practice, although possible, this would be very difficult. The difference between a private practice setting and a clinic setting is that patient complaints tend to come to the fore much quicker in a clinic setting. Patients complain to secretaries. There is a freer flow of information than in an office practice. In this instance, Dr. Bradford felt a clinic setting would be a healthier environment than an office practice.

Also, in a mental health clinic, it's less threatening and thus more acceptable to do patient satisfaction surveys or even anonymous surveys. He believed these tools need to be available if the responsibility is to make sure that the risk of harm to patients in the future is absolutely minimized. In a clinic setting they are available and a much safer way of proceeding.

With respect to the feasibility of monitoring in the context of private practice, Counsel for Dr. Hingley put certain assumptions to Dr. Bradford. Firstly, in the context of private practice assume it was possible to arrange for a psychiatrist to be assigned to monitor Dr. Hingley in his private practice of male patients. Secondly, assume that the supervising psychiatrist were to attend Dr. Hingley's office on a regular basis to evaluate treatment methods based on (a) interviewing Dr. Hingley and, (b) reviewing the patient charts. Thirdly, assume that the supervising psychiatrist

would seek certain ad hoc or anonymous questionnaires to be completed by male patients on a monthly basis. Based on these assumptions, Dr. Bradford stated this was a surveillance strategy which conceivably could work. However, he had never done it and was more comfortable recommending a clinic setting where the informal flow of information is unrestricted.

Dr. Bradford also made the following comments with respect to Dr. Hingley's practice of psychotherapy:

> ... if he's going to treat patients and given the difficulties he's had at this moment in time, I think that his standards of practice need to be clear and concise, and if [he is] going to do therapy, it's going to have to follow a model that is clear. And I still think there's some areas there that need to be cleaned up. And that, I think, goes to professional standards of practice in psychiatry.
>
> .....
>
> ... as part of the conditions of his practice, if he was going to practice psychotherapy, I think he would need a psychotherapy supervisor, somebody who would look at what he's doing, even if it's with males. Because his psychotherapy practice in the past hasn't followed any clear model and was clearly not an accepted model of practice. So there needs to be some retraining.

THE LAW

The authority of the Committee to impose specific sanctions is found in section 66 (2) of the Act, which provides as follows:

> A Hearing Committee
>
> (e) shall determine whether the member or associate member is guilty of charges relating to a disciplinary matter, and
>
> (i) where there is a guilty finding, may determine that

(A) the registration, license or specialist's license, or both, of the member or associate member be revoked, and that member or associate member's name be stricken from the registers in which it is entered,

(B) the license or specialist's license, or both, of the member be suspended

(I) for a fixed period, or

(II) for an indefinite period until the occurrence of some specified future event or until compliance with conditions prescribed by the committee,

(C) conditions, limitations or restrictions be imposed on the license or specialist's license, or both, of the member or associate member,

(D) the member or associate member undergo such treatment or re-education as the committee considers necessary,

(E) such fine as the committee considers appropriate to a maximum of fifteen thousand dollars be paid by the member or associate member to the College for the purpose of funding medical education and research as determined by the Council,

(F) the member or associate member be reprimanded, and

(G) such other disposition as it considers appropriate be imposed, ...

When making dispositions under section 66 (2), section 66 (3) of the Act indicates,

> the committee may impose one or more of the penalties set out therein, or the committee may make such other dispositions as it considers appropriate, in accordance with the objects of the Act.

The objects of the College are set out in section 4 (3) of the Act, as follows:

In order that the public interest may be served and protected, the objects of the College are to

(a) regulate the practice of medicine and govern its members in accordance with this Act and the regulations;

(b) establish, maintain and develop standards of knowledge and skill among its members;

(c) establish, maintain and develop standards of qualification and practice for the practice of medicine;

(d) establish, maintain and develop standards of professional ethics among its members; and

(e) administer this Act and perform such other duties and exercise such powers as are imposed or conferred on the College by or under any Act (emphasis added).

Thus, when imposing a sanction, the Committee must consider whether the sanction will serve and protect the public interest.

The courts have consistently held that it is the role of the self-governing professional body to determine the proper penalty. The Committee considered the case of *McKee v. College of Psychologists (British Columbia)*, [1994] 9 W.W.R. 374, where the British Columbia Court of Appeal at page 376, confirmed this role, as follows:

> In cases of professional discipline there is an aspect of punishment to any penalty which may be imposed and in some ways the proceedings resemble sentencing in a criminal case. However where the legislature has entrusted the disciplinary process to a self-governing professional body, the legislative purpose is regulation of the profession in the public interest. The emphasis must clearly be upon the protection of the public interest, and to that end, an assessment of the degree of risk, if any, in permitting a practitioner to hold himself out as legally authorized to practice his profession. The steps necessary to protect the public,

> and the risks that an individual may represent if permitted to practice, are matters that the professional's peers are better able to assess that a person untrained in the particular professional art or science.

In the course of reviewing sanctions, courts have provided guidelines for self-governing professionals disciplining their members by setting out factors to be considered in determining the appropriate sanction. Both Counsel referred to the case of *Jaswal* v. *Medical Board (Newfoundland)* (1996), 138 Nfld. & P.E.I.R. 181 (Nfld.T.D.). At page 194, the Court summarized these factors as follows:

> A sentencer should not impose a sentence simply to coincide with what has actually happened; rather, the sentencer should be led to the proper penalty by the application of principles applicable to the case at hand. From the cases cited, the following is a non-exhaustive list of factors that ought to have been considered:
>
> 1. the nature and gravity of the proven allegations.
>
> 2. the age and experience of the offending physician.
>
> 3. the previous character of the physician and in particular the presence or absence of any prior complaints or convictions.
>
> 4. the age and mental condition of the offended patient.
>
> 5. the number of times the offence was proven to have occurred.
>
> 6. the role of the physician in acknowledging what had occurred.
>
> 7. whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made.
>
> 8. the impact of the incident on the offended patient.
>
> 9. the presence or absence of any mitigating circumstances.
>
> 10. the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe an proper practice of medicine.

11. the need to maintain the public's confidence in the integrity of the medical profession.

12. the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct.

13. the range of sentence in other similar cases.

James Casey, in his text, *Regulation of Professions in Canada* (Carswell, 1994), at page 14-5, sets out a number of mitigating factors which may be considered:

1. Attitude since the offence was committed. A less severe punishment may be imposed on an individual who genuinely recognizes that his or her conduct was wrong.

2. The age and inexperience of the offender.

3. Whether the misconduct is the individual's first offence. It has been suggested that the penalty of revocation should be reserved for repeat offenders and the most serious cases.

4. Whether an individual has pleaded guilty to the charge of professional misconduct which has been taken as showing the acceptance of responsibility for his or her actions. However, a refusal to admit guilt is not to be taken as justifying a higher penalty since a person charge with the offence of professional misconduct is entitled to have the case against him or her proven and to make full answer and defense without fear of the threat of increased penalty.

5. Whether restitution has been made by the offender.

6. The good character of the offender.

7. A long unblemished record of professional service.

Two of the factors set out in *Jaswal* are the impact of the various incidents upon the patients involved and the degree to which offensive conduct is regarded as being the type of

conduct that is outside the range of permitted conduct. Madame Justice McLaughlin of the Supreme Court of Canada, in *Norberg* v. *Wynrib* (1992), 92 D.L.R. (4th) 449 made the following observations at page 491:

> ...A physician holds a great power over the patient. The recent decision of the Ontario Court (General Division) in *College of Physicians and Surgeons of Ontario* v. *Gillen* (1990), 1 O.R. (3d) 710, contains a reminder that a patients vulnerability may be as much physical as emotional, given the fact that a doctor (at p. 713) 'has the right to examine the patient in any state of dress or undress and to administer drugs to render the patient unconscious'. Visits to doctors occur in private: the door is closed; there is rarely a third party present; everything possible is done to encourage the patient to feel that the patient's privacy will be respected. This is essential to the meeting of the patient's medical and emotional needs; the unfortunate concomitant is that it also creates the conditions under which the patient may be abused without fear of outside intervention. Whether physically vulnerable or not, however, the patient, by reason of lesser expertise, the 'submission' which is essential to the relationship, and sometimes , as in this case, by reason of the nature of the illness itself, is typically in a position of comparative powerlessness. The fact that society encourages us to trust our doctors, to believe that they will be persons worthy of our trust, cannot be ignored as a factor inducing a heightened degree of vulnerability; see Shirley Feldman-Summers, 'Sexual Contact in Fiduciary Relationships', in Glen O. Gabbard, ed., **Sexual Exploitation in Professional Relationships** (Washington, D.C.: American Psychiatric Press, 1989), at pp. 204-05. The recently issued **Final Report of the Task force on Sexual Abuse of Patients** (Toronto, 1991), commissioned by the College of Physicians and Surgeons of Ontario, makes highly instructive reading in this regard. In the words of the Task Force, at p. 79:
>
> > Patients seek the help of doctors when they are vulnerable — when the [sic] are sick, when they are needy, when they are uncertain about their physical or emotional health. The physician has the knowledge, the skills, and the expertise the patient needs to heal. The patient often suspends both judgment and personal power idealizing the doctor in order to feel secure. The physician, therefore, has more power that the patient, and this power can be used to invade sexual boundaries and to force sexual compliance. Physical force is not necessary.

SUBMISSIONS

Counsel for Dr. Hingley submitted the general principles to be considered with respect to sentencing are deterrence and rehabilitation. The protection of the public can adequately be achieved under certain circumstances through the rehabilitation of the practitioner.

The principle of specific deterrence is encompassed under the considerations of rehabilitation and the principle of general deterrence should not unduly interfere with the practitioner's reform.

He submitted this is not the worst case scenario in that there was no violence involved and the sexual intercourse was consensual. The maximum penalty, revocation of the practicing license, should be reserved for only the worst offence and offender. There must be a just proportion between the offence committed and the sentence imposed. Fairness demands that the sentence, since it is imposed upon an individual offender, must be one that is primarily and essentially appropriate to the offender.

Further, he submitted the totality principle requires an assessment of the total impact of a sentence being imposed in relation to the seriousness of the conduct and impact upon the offender. The purpose is to ensure that a series of sentences, each properly imposed in respect to the offence for which it relates, is an aggregate, just and appropriate. Cumulative sentences may offend the totality principle if the aggregate sentence is substantially above the normal level of a sentence for the most serious of the individual offences involved, or its effect is to impose upon the offender a crushing sentence. The best means of ensuring that the totality principle is applied is the imposition of concurrent sentences.

Counsel for Dr. Hingley proposed the following as a penalty:

1. Dr. Hingley be suspended from the practice of psychiatry for a period of twelve months commencing May 15, 1998.

2. After completion of the twelve twelve month suspension, Dr. Hingley be issued a restricted licence to practice psychiatry with adult males only in a private practice.

3. Within the next three months, Dr. Hingley attend a 30-day intensive treatment program at the Sexual Behavioral Clinic at the Royal Ottawa Hospital. A copy of any report, assessment, summarizes and recommendations from the Clinic to be provided to the Registrar of the College of Physicians and Surgeons of Nova Scotia.

4. Dr. Hingley undergo ongoing psychotherapy to deal with the issue of boundary violations and any other issues identified through the assessment at the Sexual Behavioral Clinic and the Abbott Northwestern Hospital Professional Assessment Program. The psychotherapist who will provide the treatment must be approved by the Registrar of the College. Psychotherapy would continue until the College decides otherwise. The psychotherapist shall provide reports with respect to the treatment of Dr. Hingley to the Registrar of the College of Physicians and Surgeons of Nova Scotia, and semi-annually thereafter until the termination of Dr. Hingley's suspension. Dr. Hingley will abide by the recommendations contained in the psychotherapist's report, including any recommendations to continue psychotherapy beyond the termination of Dr. Hingley's suspension.

5. Dr. Hingley's practice during his restricted licence period be monitored.

6. Before returning to the full practice of psychiatry restricted to males only, if Dr. Hingley has otherwise satisfied the conditions outlined above, he shall receive an independent psychiatric assessment. The psychiatric assessment shall be provided to the Registrar of the College, who must be satisfied with a relative degree of certainty that such report, and from the reports of the other psychotherapists treating Dr. Hingley, that he does not pose a risk to the public in the event he returns to psychiatric practice.

Counsel for the College suggested the purpose of the disciplinary process in self-regulating professions requires more than minimizing the risk to the public. This is not criminal conduct for which the focus is the principles of deterrence and of rehabilitation.

Self-regulating professions, such as the medical profession, are given the privilege of self-governance in order to both serve and protect the public interest. To meet this objective, the public must have confidence in the regulatory process that licenses its physicians and that the sanctioning process will ensure the full integrity of the medical profession. This requires more than simply assessing the risk that Dr. Hingley poses to the public.

In this case, there has been sexual misconduct between a psychiatrist and a patient in a psychotherapy setting over a lengthy period of time, with frequent occurrences of sexual intercourse. This is the type of offence that strikes at the very heart of the integrity of the medical profession, particularly in the fields of psychiatry and psychotherapy. A sanction which minimizes the risk to the public must be considered in the context of a self-regulatory profession maintaining the public's confidence in that profession and ensuring the integrity of that profession.

It is the submission of the College that Dr. Hingley's license to practice be revoked. He could take the treatment program recommended by Dr. Bradford. The College can then assess the outcome of that program. Dr. Hingley could then apply for reinstatement in two years. It will also have a better sense of Dr. Hingley's attitude toward treatment, and whether or not Dr. Hingley truly has accepted responsibility for his actions, thereby meeting the initial threshold required for successful rehabilitation.

ANALYSIS

Counsel for both parties have referred to the factors set out in *Jaswal*. The following is an analysis of the facts with respect to those factors.

The first of the factors is the nature and gravity of the proven allegations. Dr. Hingley has admitted the allegations in the Statement of Admissions and Agreements. These include a sexual relationship with Witness A over a lengthy period of time, requesting she attend the sessions without wearing underwear, suggesting she expose her breasts, suggesting she wear a bikini, encouraging her to masturbate, encouraging her to read pornography, giving gifts of a personal nature and focusing excessively on sexual matters.

In addition, there is a second set of admissions with respect to Patient B, which include asking the patient to come to therapy without wearing underwear, suggesting she expose her breasts to him, and focusing excessively on sexual matters, as well as, touching her vagina and making a sexual suggestion.

Counsel for Dr. Hingley admits that the actions of Dr. Hingley are serious and suggests that the fragile mental condition of the complainant increases the gravity of the offence.

Dr. Michael Teehan gave opinion evidence as to the expected standards of ethical and clinical practice of psychiatry. He is an Associate professor in the Department of Psychiatry, Dalhousie University and a staff psychiatrist in the Department of Psychiatry, Queen Elizabeth II Health Sciences Centre. He referred to three statements setting out standards of ethical conduct in matters of sexual relationships between a psychiatrist and patient.

The Hippocratic Oath, which every physician takes on entering the practice of medicine, indicates that sexual contact between a doctor and his or her patient is fundamentally improper. It is commonly recited, in part, as follows:

> Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption and further from the seduction of females or males, of freemen and slaves.

In October, 1978, the Canadian Psychiatric Association adopted the Canadian Medical Association Code of Ethics Annotated for Psychiatrists, prepared by Clive Mellor, M.D. and published at (1980), 25 The Canadian Journal of Psychiatry 432. Under Annotation #1: Respect for the Patient, in addressing the nature of the psychiatrist/patient relationship, it provides,

> The ethical psychiatrist will scrupulously avoid using this relationship to gratify his own emotional, financial and sexual needs.

On June 1, 1985, the Canadian Psychiatric Association approved a statement on sexual misconduct, whereby it emphatically reaffirmed its resolute policy that sexual relationship in all its forms between a psychiatrist and his patient is a grave violation and abuse, on the part of the psychiatrist, of the patient/doctor relationship. It unequivocally condemned such misconduct and deemed it totally unacceptable under any and all circumstances.

Dr. Teehan also provided a copy of Sexual Exploitation of Patients, The Position of the Canadian Psychiatric Association, prepared by U. Sreenivasan, M.D., and approved by the Canadian Psychiatric Association on September 27,1988. After referring to the Annotated Code of Ethics, it states,

> Physicians enjoy a privileged relationship with patients based on trust. The power and prestige of the physician, with the right to touch and explore physically and

> psychologically, place him or her in an advantageous position. It cannot be accepted that physicians and patients are ever similar to any consenting adults. To maintain trust, the physician must avoid initiating or responding to any forms of sexual advances. Sexualizing the relationship is a clear breach of trust. The outcome is destructive for both, but the patient suffers the greater damage as the dependent partner in the diad.

And further in this position paper, the Canadian Psychiatric Association acknowledged the importance of, *inter alia*, the following issues:

> 1. The nature of psychotherapy poses special problems, one of which is the idealization and erotic valuation of the therapist. Some psychotherapy has as a central feature the management of transference and counter-transference and, *therefore psychiatrists may be considered more culpable than other physicians if they engage in sexual activity with their patients* (emphasis added).
>
> 2. Eroticizing the physician/patient relationship is unacceptable under any circumstances and cannot be rationalized as therapy.

Dr. Teehan opined there were no circumstances, during a psychiatrist/patient relationship, in which a sexual relationship would be proper or ethical and that the consent of the patient would have no impact on the propriety of the sexual conduct. He further stated,

> It is recognized that the particular situation in which a patient consults a doctor, a psychiatrist, places that individual in a position of reduced power in the relationship. In the course of treatment there are the stirring up of the feelings called -- technically called transference feelings which can distort the reality of the true relationship between people. And in that context there is recognized to be greater danger of transgression of these boundaries.
>
> The responsibility rests with the psychiatrist to ensure that this does not happen, and specifically, psychiatrists are warned that they must not accept, for instance, advances from patients or treat those advances as though they were occurring outside of that therapeutic relationship.

In discussing the precautions usually taken to ensure that boundaries are not transgressed, Dr. Teehan stated,

> Most significantly is the monitoring of one's own behaviour so that there's no suggestion by word or act of encouragement to the patient to engage in any affectionate or erotic behaviour. Some individuals ensure that there is a physical setting where that also is not encouraged in the sense of there being other people in the building or nearby, or ensuring that there is -- there are no physical possibilities in the environment to allow intimate behaviour to occur.

Dr. Hingley encouraged and initiated erotic and intimate behaviour. He structured the sessions and environment to promote it.

In the opinion of Dr. Teehan, all of the admissions of Dr. Hingley, were behaviours which fell below the standard of ethical behaviour. The Committee finds the offences to be very serious. They are clearly violations of the ethical standards of practice in place for all physicians, particularly for psychiatrists.

The second factor to be considered is the age and experience of the offending physician.

Counsel for Dr. Hingley submits that at the time the offences took place he was immature emotionally and very inexperienced in the field of psychiatry. In 1984 he had only been in general practice with an interest in psychiatry for one year. It was a full year later that he became a member of the Royal College. The misconduct could be attributed to inexperience. His inappropriate choice of treatment methods was consistent with his level of inexperience. Further when he learned in 1990, after he had practiced psychiatry for a total of six years, that his methods of treatment were not appropriate, he tried to reform himself.

While Dr. Hingley had only been practicing psychiatry for a year when he started the relationship with Witness A, he had been a physician for at least seven years. In addition, the relationship continued for six years and the sexual intercourse component did not start for almost two years.

The Committee does not accept that the misconduct of Dr. Hingley can be attributed to his inexperience. He was aware of the content of the Hippocratic Oath and the Code of Ethics.

He had been in practice for a few years before he became involved in the most serious activity. He testified he knew at the time his sexual activities with Witness A were wrong but he did not appreciate it was wrong. The Committee does not accept this distinction. Although as early as 1986 he sought out and read materials on the issue of sexual involvement between psychiatrists and patients, he stated, he couldn't relate to it as being wrong. Only in 1998 after his visit to Minnesota and Ottawa and reading articles on the nature of the actual transference within a therapeutic relationship did it make sense to him.

The Committee also rejects the suggestion that Dr. Hingley's inappropriate choice of treatment methods was consistent with his level of inexperience. Dr. Teehan stated that he could not conceive of any clinical need for the behaviours that were undertaken.

In the opinion of Dr. Bradford, Dr. Hingley was not following any traditional psychotherapy during his treatment of the complainants. His theory in dealing with females and liberalizing their sexual attitudes, sounded more like a philosophy as opposed to any type of known therapy. The therapeutic involvement was for his own vicarious sexual interest and related to his hyper-sexuality.

In Dr. Bradford's view, Dr. Hingley's explanation as to why he engaged in this form of therapy and the acts of intimacy with the complainants, was completely distorted. He rationalized this was acceptable therapy because at the end of the process the patients seemed to have done okay. This is a cognitive distortion. There was nothing in his therapy that would help a successful outcome.

The Committee finds the therapy undertaken was not for the benefit of the patients but the sexual gratification of Dr. Hingley.

The third factor is the previous character of the physician and in particular the presence or absence of any prior complaints or convictions.

Counsel for Dr. Hingley submitted that any prior complaints took place during the same period of time as the misconduct which gives rise to the current complaints and no corrective penalty was received by Dr. Hingley prior to such misconduct. For reference, the time period of the subject misconduct is 1984 to 1990.

The record reveals a complaint from a young female patient in May, 1986. In the spring of 1985, she was suffering from depression after having taken an overdose of sleeping pills. She complained that at the initial assessment, Dr. Hingley focused on sexual matters, including telling her she was cute and had a sexy body, asking about her sex life, suggesting she should engage in sexual activity, and saying he would like it if she could relax in his presence, enough to be able to strip off her clothes and play with herself.

In September of 1986, the Provincial Medical Board wrote to Dr. Hingley, emphasizing the necessity of having a third person present or close by during interviews with female patients, particularly those who might be emotionally upset. This was two years after the commencement of the therapy sessions with Witness A and within some months of the commencement of the sexual relationship with Witness A, and again within some few months of the commencement of the therapy sessions with Patient B. The letter did not register or influence the manner in which Dr. Hingley conducted his therapy sessions with female patients other than he stopped seeing young girls.

The Committee finds that despite being warned in September of 1986 of the importance of having a third person present or close by during interviews with female patients, Dr. Hingley did not heed this warning and engaged in the admitted misconduct with Witness A and Patient B.

A complaint from a seventeen year old female patient was filed in May, 1992. It details actions of Dr. Hingley between September of 1983 and September of 1985, a period that overlapped his contact with Witness A. In June, 1994, Dr. Hingley was found guilty of professional misconduct in that he encouraged his patient on several occasions to become aroused and to masturbate at home and in his presence; he advised the patient not to be surprised or upset if he had a wet spot on his trousers at the end of the session; he asked the patient to remove her shirt and then told her to touch and squeeze her breasts; after the patient removed her shorts and underwear in the washroom in his office and returned he then touched her genital area and inserted his finger into her vagina, following which he stated she required no further treatment. Dr. Hingley complied with all the restrictions and terms of the sentence imposed in that case.

There are remarkable similarities in the findings of these two complaints to the admissions of Dr. Hingley with respect to Witness A and Patient B. The Committee has considered that

Dr. Hingley did not have the benefit of the decision on the second complaint at the time he engaged in the misconduct in this case.

A further complaint was filed in November, 1992. Dr. Hingley admitted he told his male patient with respect to his girlfriend, "When you're feeling morose, just jump her bones. That should bring you out of it." This conduct occurred in 1992, after both previous complaints had been filed with the Provincial Medical Board. This conduct concerns the Committee, particularly in respect to the suggestion on behalf of Dr. Hingley, that there would be no risk to male patients if he is allowed to continue in practice.

The Committee finds Dr. Hingley does have a prior history, including a conviction relating to conduct that took place at the same time that he was engaging in the misconduct with Witness A and Patient B. He has been found guilty by his governing body of matters involving similar sexual misconduct. He was warned by the Provincial Medical Board during the time of the occurrence of the current misconduct of the necessity of having a third person present or close by during interviews with female patients. This is not a case of a respected psychiatrist with one allegation of misconduct in an otherwise unblemished career.

The fourth factor for consideration under *Jaswal* is the age and mental condition of the offended patient.

Witness A was [ ] at the time she first became a patient of Dr. Hingley and she remained his patient until she was [ ]. She had been experiencing anxiety and panic attacks. It had progressed to the point where she felt that she was unable to cope. In her original letter of complaint, she described her situation as follows:

> It was a time of acute crisis for me. I felt completely shattered, as if my personality had been entirely wiped out. I was very dependent upon my husband and barely able to get out of the house.

Patient B was [ ] years old at the time of her first contact with Dr. Hingley. She was referred because of chronic anxiety and episodes of depression.

The Committee was provided with the written opinion of Dr. Gail Robinson. She described the Doctor - Patient relationship as follows:

> The basis of the relationship between the doctor and the patient is one of trust. The patient comes to the doctor at a time when she is vulnerable and/or needy. The doctor is seen as a trained, knowledgeable individual who is in a position to alleviate the patient's pain and distress. Society reinforces the perception that the physician is a respectable and trustworthy person. The patient must trust that the physician has his or her best interests at heart. Because of her lack of knowledge about the techniques, the patient may not be clear about whether the doctor is behaving inappropriately or has crossed a boundary. The patient's vulnerability is enhanced by her disclosure of her life history. The physician is in a position to learn all about the most secret, intimate, and vulnerable areas of the individual's life. The physician, on the other hand, may disclose only that information which he chooses. All of these factors seek to enhance the power and balance between a physician and a patient.

The Committee finds both patients were in a vulnerable state when they came to Dr. Hingley for help. Their reliance and dependence on him only served to heighten that vulnerability.

The next factor under *Jaswal* is the number of times the offence was proven to have occurred.

The sexual involvement between Dr. Hingley and Witness A continued for an extended period. Although the exact number of times is unknown, sexual intercourse occurred on a regular basis over two years. Other incidences of misconduct such as suggestions to expose her breasts and to come to therapy without underwear also occurred on a frequent basis.

With relation to Patient B, the evidence does not disclose the number of times incidents of misconduct occurred. With the exception of admission 2(iii), they occurred on more than one occasion over more than one year.

In both cases, these were not one time occurrences, but frequent episodes.

The next factor in *Jaswal* is the role of the physician in acknowledging what had occurred.

Counsel for Dr. Hingley submits that Dr. Hingley has accepted full responsibility for his misconduct and has expressed remorse for the harm that he has caused his former patients.

Dr. Hingley's attitude since the offences were committed is important in the consideration of this factor. He went to considerable lengths in his replies to the College to attack and threaten the complainants. In his detailed responses he suggested that Witness A suffered from false memory syndrome or, alternatively, she was part of the radical feminist group that was conspiring against him. He also alleged that she was incorrect in recalling some peculiar features of his penis, putting her to the embarrassment of describing his anatomy in some detail.

When asked why he wrote the letters in the way he did, Dr. Hingley stated there were two reasons. First, he wanted to protect his other patients by continuing to practice as long as possible, thereby giving them more time to adapt. Second, it was a defense mechanism. Counsel for Dr. Hingley referred to an article written by V.W. Hilton, When We Are Accused. Her theory suggests that instinctively there is a three-part response to accusations. One, denial. I didn't do it. Two, a defense mode. I did the best I could. And three, blame. She knows better than this. This accusation is pathological.

While attending the mandated assessment program at the Abbott Northwestern Hospital after making the admissions of misconduct, Dr. Hingley's attitude caused the Assessment Team in their report to state that Dr. Hingley "believed that he has been unfairly punished by the Board, and that there are women who have adopted a victim status, who have gone about targeting and destroying males". Further in the report, the Assessment Team stated,

> Later in the week, [Dr. Hingley], stated that the program seemed to be as rigid in viewpoint toward therapist-patient sexual relationships as the College's were in Canada. He brought a number of documents with him to substantiate his personal viewpoint on therapist-patient sexual relationships, i.e. that the patient had rights as a consenting adult, and that there were circumstances in which such sexual relationships were acceptable.

In his evidence Dr. Hingley suggested that some of his comments at Abbott Northwestern may have been misperceived. Although the issue of consent was very important to him, he was focusing on issues of patient consent generally. He did concede, however, that at the time of the assessment at Abbott Northwestern, he believed if a patient consented there may be

circumstances where a sexual relationship was appropriate. He now believes that there are no circumstances in which a sexual relationship between a physician and a patient is acceptable.

The Assessment Team also reported that when discussing the incidences reported to the College with Dr. Hingley, he demonstrated little or no emotional awareness of the impact of his behaviour on his victims. He showed very little capacity to empathize with the position of his female patients. They stated that,

> The absence of identification with the victim is of particular importance, particularly in terms of the implications for his treatment and recovery. The absence of this identification is often a poor prognostic sign.

Immediately after returning from the assessment at the Abbott Northwestern Hospital, Dr. Hingley wrote a letter to the College. It appears to be a letter setting out Dr. Hingley's understanding of his problem as well as an apology to the complainants and the College. The Committee notes it is not an apology for his actions but rather an apology for taking so long to reach an understanding of his problem.

The Committee is concerned about the sincerity of this letter. Dr. Hingley was prompted to write the letter as a result of advice received in Minnesota that such a letter would be an appropriate response on receiving a complaint.

This concern is strengthened by the report of Dr. Bradford. He conducted an assessment of Dr. Hingley in September, 1998, only four months after the letter of apology. Dr. Bradford reported that Dr. Hingley was angry about the Abbott Northwestern report. If Dr. Hingley was sincere in May about his acceptance of the assessment from Abbott Northwestern, why in September did he display anger about that very assessment to Dr. Bradford.

Indeed, Dr. Bradford's gave evidence that at the time of his assessment in September, 1998, Dr. Hingley had not come to terms psychologically with the acceptance of full responsibility for his conduct to his patients.

The Committee remains concerned about Dr. Hingley's attitude and is not satisfied that Dr. Hingley has genuinely accepted full responsibility for his misconduct.

The Committee has not taken account of Dr. Hingley's failure to plead guilty at an earlier stage of this proceeding. It has accepted the submissions of Counsel that it was Dr. Hingley's right to have the case proven against him, and he was under no legal obligation to plead guilty to the offences at any earlier stage. The Committee has relied on the cases of *College of Physicians and Surgeons of Ontario* v. *Boodoosingh* (1990), 73 O.R. (2d) 478 (Ont. H.C.J.) and *College of Physicians and Surgeons of Ontario* v. *Gillen* (1990), 1 O.R. (3d) 710 (Ont Court, Gen. Div.) in support of these principles.

The Committee has recognized that Dr. Hingley did plead guilty. He did not put the complainants or the College through the necessity of proving the allegations.

The next factor in *Jaswal* is whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made. The report of Price Waterhouse Coopers indicates that since the restriction of his practice to males only in June, 1997, Dr. Hingley has lost approximately $167,000.

The next factor in *Jaswal* is the impact of the incident on the offended patient.

Witness A gave extensive evidence as to the impacts on her life as the relationship progressed. Her relationships with her husband, her [ ], her family, other men and her family doctor were affected by Dr. Hingley's actions.

The major impact was on her relationship with her husband and consequently her marriage. When she began therapy with Dr. Hingley, she was an extremely dependent person and relied heavily on her husband. He told her that she shouldn't discuss the sessions with her husband.

She felt she was "living a dual life"- one in the therapy sessions and another in the rest of her life. The erotic nature of the sessions gave her feelings of deceit and secrecy. She knew that her husband would not understand or approve. The wall of secrecy would not permit an honest marital relationship. She believes her relationship with Dr. Hingley was the direct cause of her marital breakup. It is apparent that Dr. Hingley deliberately undermined her marriage by replacing her dependency on her husband with a dependancy on him.

Even when she was considering separation, Dr. Hingley wanted her to stay in the marriage and continue to have her needs met with him. The separation took place in [ ], which ultimately led to a divorce.

[

]

Her relationship with her family outside her marriage was also impacted. Dr. Hingley discouraged her from having contact with her family. He told her they were unhealthy and that she should depend on him.

Nine years after her therapy ended she still has difficulty with sexual relationships. She feels suspicious and needs to be careful around men. She testified that she

> couldn't engage in sexual activity without picturing myself in some fashion as I had been with Dr. Hingley and feeling like I just couldn't get away from it. ... those memories would intrude on me all the time.

There is a positive relationship on an intellectual level with her family physician. She trusts him implicitly. However, she suffers from recurrent nightmares, where a trusted male figure would suddenly become sexually interested in her. These dreams often extend to her family doctor. She is still uncomfortable with any kind of physical examination by her family doctor or any other male doctor.

Finally, Witness A explained she is still repulsed by memories of particular scenes with Dr. Hingley. She has difficulty forgiving herself for being taken in. She can't share her experience with most of her family and friends. She continually has to be careful about how much she tells anyone and is always concerned about what they might find out. She feels sad about the loss of six years of her life. If she had received good help, this time might not seem lost or distorted.

Counsel for Dr. Hingley submitted that although the impact of the misconduct on Witness A had negative effects, she did successfully complete an [ ], an indication of her emotional strength and a reflection of her commitment to dealing with any long-

lasting negative side effects. The Committee accepts his submission that her success should not be attributed to Dr. Hingley. Also, the Committee does not diminish the significance of the impacts caused by Dr. Hingley because of the strength of character of Witness A in continuing her efforts to achieve her goals.

Patient B did not give evidence as to the impact of Dr. Hingley's misconduct on her. However, Dr. Hingley testified Patient B could have suffered the same harm as Witness A as a result of his misconduct.

The next factor in *Jaswal* is the presence or absence of any mitigating factors.

A number of mitigating factors were submitted for consideration by Counsel for Dr. Hingley. These include the following:

1. Admission of guilt thereby relieving College and complainants the necessity of proving the allegations. The Committee finds however that the attitude of Dr. Hingley since the offences were committed does not mitigate in favour of Dr. Hingley.

2. The financial loss Dr. Hingley has suffered as a consequence of his actions. The Committee however gives this factor relatively minor weight in comparison to the aggravating factors and the objects of the College to serve and protect the public.

3. The age and inexperience of Dr. Hingley at the time of the offence. The Committee does not consider this a mitigating factor, but in the event it is, it is given little weight. Dr. Hingley had been a practicing physician for a number of years and was fully familiar with the Hippocratic Oath and the appropriate ethical considerations. He knew his conduct was wrong but says he didn't appreciate it was wrong. The Committee does not accept this distinction and finds that he knew or ought to have known and appreciated that his conduct was entirely inappropriate.

4. Dr. Hingley voluntarily stopped seeing young female patients because the College was concerned "his frank style may be misinterpreted". The Committee does not consider this a mitigating factor. The College concluded after a full investigation that there was a risk to all female patients and it was therefore in the interest of the public to restrict Dr. Hingley's practice. He was given an opportunity to voluntarily restrict his practice to male patients

until the hearing concluded. He refused, so, in the public interest, temporary conditions were placed on his license. Dr. Hingley failed to comply with the conditions and temporary suspension was imposed. Ultimately, Dr. Hingley and the College came to an agreement on the restrictions under which Dr. Hingley could continue practicing until the hearing.

5. At the time of the misconduct, Dr. Hingley had not had the benefit of the deterrent and rehabilitative effect of the earlier probationary supervision from practice in July of 1994 to 1996.

6. No complaints have been filed against Dr. Hingley for his psychiatric treatment after 1990.

7. He has renounced his experimental psychiatric methods that were adopted in the early periods of his practice, which resulted in boundary violations and focussing on topics of a sexual nature with female patients. The Committee does not accept that boundary violations occurred as result of experimental psychiatric methods but rather Dr. Hingley seeking personal sexual gratification.

8. Dr. Hingley's credibility to his other patients as indicated by letters of support. The letters of support were written at the request of Dr. Hingley following his temporary suspension and a letter which he posted in his office telling his patients why he could not continue their treatment. In this letter he asked his patients to write to the College to express their concerns about whether the actions of the College were in the public interest and to comment on power imbalance issues in their therapy. The Committee considers this letter to have been totally inappropriate. It signified an unwillingness to co-operate with the College and caused anxiety to patients rather that assisting them in adjusting to the transfer of their care. The College was so concerned about the content of this letter that as part of the agreement with Dr. Hingley, it took the unusual step of sending a letter to his patients explaining the circumstances around its decision respecting Dr. Hingley. The Committee does not consider this a mitigating factor.

9. Dr. Hingley is no different than any other person in that he may suffer from psychiatric disorders. The Committee accepts this may be a mitigating factor but finds the duty of the College to serve and protect the public weighs heavy in the balance.

The next factor under *Jaswal* is the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine.

Counsel for Dr. Hingley submitted that in terms of specific deterrence, Dr. Hingley had admitted his misconduct. This provided confirmation that he would not engage in this conduct in the future. At the time of the misconduct in this case, he had not had the benefit of a penalty in relation to an earlier instance of misconduct, indicating that the issue of specific deterrence was no longer immediate. Also, there had been no written complaints to the College in the last eight years.

With respect to general deterrence, he submitted that a penalty to suspend would deter other psychiatrists. Additional restrictions such as the requirement to attend an assessment at the Royal Ottawa Hospital Sexual Behaviour Clinic and other counseling as required as well as a partial publication ban would also act as a general deterrent to other psychiatrists.

Further, he urged the Committee to take account of Dr. Hingley's previous history when he received a penalty of two years probation and a six months suspension of his license, which has now been completed.

Counsel for the College submitted that sexual misconduct is one of the most condemned areas of misconduct in the medical profession. Members must know that if they engage in this type of misconduct, the consequences are severe. The consequences must be more than restrictions on a licence and a suspension because these issues involve more than simply assessing risks to the public.

The next factor in *Jaswal* is the need to maintain the public's confidence in the integrity of the medical profession.

Counsel for Dr. Hingley submitted that this would be achieved through strict conditions on his practice, ongoing therapy and monitoring.

Dr. Bradford has indicated that there are still certain risks with Dr. Hingley being permitted to continue his practice with males only. This, Counsel for the College submits, could jeopardize public trust and confidence in the integrity of the medical profession.

The next factor in *Jaswal* is the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct. There is no dispute the type of conduct which occurred in this case clearly falls outside the range of permitted conduct.

The final factor in *Jaswal* is the range of sentence in other similar cases. Both counsel have submitted cases which cover the full range of sentence from revocation of a licence to a short suspension.

Although all cases have been considered, the following cases were highlighted by Counsel for Dr. Hingley.

In the case of *College of Physicians and Surgeons of Ontario* v. *Boodoosingh* (1990), 73 O.R. (2d) 478, the Ontario High Court reduced a penalty of revocation to a three month suspension and a reprimand. A psychiatrist was found guilty of having sexual relations with a vulnerable 30-year-old female patient in a state of depression.

Among the distinguishing features of this case are the doctor had no prior record of misconduct. He practiced medicine for 22 years, with substantial involvement in community work and academic achievement. Sexual intercourse only occurred once within several weeks of the last therapy session. The Court also found the Committee had committed an error in imposing the maximum penalty of revocation in part on the ground that he had not pleaded guilty and had shown no remorse. The Court stated the penalty of revocation should be reserved for repeat offenders and the most serious cases.

The Committee finds the case of *Dr. I.F.K.* v. *The College of Physicians and Surgeons of British Columbia*, [1998] B.C.J. No. 577 (B.C.C.A.) not relevant because the Court set aside the findings of the Tribunal and the lower court and dismissed the complaint.

In the case of *Dr. O.J.O.* v. *The College of Physicians and Surgeons of British Columbia*, [1995] B.C.J. No. 2313 (B.C.S.C.), a physician was found guilty of unprofessional conduct on the basis that he engaged in a personal and an intimate relationship with a former patient either during or shortly after the termination of his professional relationship with her. The College in that particular case imposed a six-month suspension, a $5,000 fine, and costs of $30,000. The Court upheld the findings and penalty.

In effect the relationship did not begin until after the physician-patient relationship ended. The patient and the doctor married before the complaint was initiated by the patient's former husband. The doctor and his wife enjoy a happy and fulfilled marriage. These factors all serve to distinguish this case from the case at hand.

In the case of *Joseph Charalambous* v. *The College of Physicians and Surgeons of British Columbia*, [1988] B.C.J. No. 3052 (B.C.S.C.), a physician became involved with a 15-year-old patient and cohabited with her, during which time he had sexual intercourse with her. The committee imposed a six-month suspension and a $30,000 fine. On appeal, the Court found the punishment unduly harsh and ordered the penalty be reconsidered. In doing so, Mr. Justice Gibb stated:

> As to punishment, it is extremely harsh. The fine is the maximum which may be levied under the Act. The costs award is double the amount of the fine. The obligation to fine and pay $30,000 after tax while suspended from the means of earning a livelihood represents potential financial ruin for this relatively young family. How is Dr. Charalambous to pay if he can't practise? The objective is to punish, not to destroy.

The Committee observes that the Court may have been influenced to make the above comments about the harshness of the penalty due to the fact that the doctor subsequently married the patient and they now have a family. In effect it is an additional punishment on the patient, his wife.

In the case of *Dr. X* v. *The College of Physicians and Surgeons of British Columbia*, [1990] B.C.J. No. 1316 (B.C.S.C.), a doctor was found guilty of unprofessional conduct for having sexual intercourse with a patient. He was suspended from the practice for one year and fined him $5,000. The Court upheld the finding of unprofessional conduct, but the matter of punishment was referred back to the committee for reconsideration. The committee reconsidered the penalty and reduced the suspension to six months and a fine of $5,000.

The case can also be distinguished. Here, there was a single act of sexual intercourse between two homosexual adults. The doctor had no prior record. The patient had just learned that he had tested positive for the AIDS virus and announced that he would not practice safe sex. With this concern, the doctor tried to show the patient that he was still sexually attractive and wouldn't

necessarily be rejected as a sexual partner on the partner learning he had the virus, provided he practiced safe sex. The Committee in that case stated that although Dr. X's intentions might not have been improper, his judgment was, and he should have known that his sex act would likely have a negative impact on the patient.

In the case of *Re MacDonald and the College of Physicians and Surgeons of New Brunswick* (1992), 91 D.L.R. (4th) 190 (N.B.C.A.), the committee imposed a one-year suspension upon a physician who admitted sexual impropriety consisting of two instances of consensual intercourse with a patient, once in 1983 and once in 1984. Although he may have been convicted of 11 counts of inappropriate sexual remarks, sexual touching, as well as sexual intercourse with a variety of patients, a number of which were adolescent at the time, the Committee was only entitled to consider the admitted conduct. The committee emphasized the public criticism and outcry against such sexual impropriety.

On appeal, the Court was only concerned the committee gave undue consideration to society's perceived views and criticisms of this kind of conduct on the part of physicians. It allowed the appeal and substituted a lesser period of nine months' suspension.

The Committee does not agree with Counsel for Dr. Hingley that the facts of the *MacDonald* case are much worse than the case at hand. It is apparent that only the admitted misconduct was considered.

The case of *John G. Patterson* v. *The College of Physicians and Surgeons of British Columbia* (1988), 25 B.C.L.R. (2d) 199 (S.C.) can also be distinguished. The doctor admitted to sexual intercourse with a patient. The Inquiry Committee of the College found that the conduct was unprofessional but would not categorize it as infamous. The Council of the College rejected the report of the Inquiry Committee and found the conduct to be unprofessional and infamous. It imposed a suspension of the doctor's practice for 1 year and fined him $5,000. The Court allowed the appeal and the decision of the Council was set aside. The evidence of the complainant before the Committee was not reliable. While the Committee found that the doctor should have known that the patient was a more vulnerable patient, there was no evidence that the doctor took advantage of her. This was a case in which a patient voluntarily agreed to engage in sexual relations with a physician and not a case in which a physician by virtue of his position gained an advantage and thereby exercised some power or persuasion over the patient. The question of discipline was remitted to Council for reconsideration.

In the case of *Dr. M.* v. *The College of Physicians and Surgeons of British Columbia*, [1997] B.C.J. No. 297 (B.C.S.C.), a physician was found guilty of infamous conduct for having engaged in sexual intercourse with a patient on two occasions, while treating her for depression. The Committee imposed an 18-month suspension of his licence and a $10,000 fine. The Court in reviewing the case dismissed the appeal but stated that the penalty imposed was so wrong, that it would have substituted a harsher penalty such as a longer suspension or the erasure of the name of the doctor from the register. Since the College did not cross-appeal, this option was not open to the Court.

In the case of *McKee* v. *The College of Psychologists of British Columbia*, [1992] 4 W.W.R. 197 (B.C.S.C.), a psychologist was found by the Board to be in breach of ethical standards of psychologists by entering into a "dual" relationship in that he was sexually intimate with a client. The Board cancelled the appellant's licence as a registered psychologist without giving reasons. The appeal was allowed on the basis that taking all the circumstances into consideration, a lifetime suspension could not be justified and the penalty was varied to a two-year suspension. The Court concluded that the Board had little or no experience with sentencing. The Court also noted that a lifetime revocation in Canada for this offence is not in keeping with historical precedents.

The psychologist did not have an unblemished record. However, there was conflicting evidence as to whether it was the doctor or the female patient who had initiated the relationship. There was also conflicting evidence as to the impact on the patient. On the one hand there was evidence to indicate the effect of the relationship on her was to improve her life, as well as to make her happy and be fulfilled. Alternatively, the complainant indicated that she felt very used, as well as ashamed, and that it caused her a lot of grief.

Counsel for Dr. Hingley, however, did not refer to the fact that the *Mckee* case was further appealed to the Court of Appeal reported in [1994] 9 W.W.R. 374. The appeal was allowed. The Court found that the learned chambers judge apparently held the opinion that the cancellation of registration was irreversible. He referred to the penalty as a "lifetime suspension". The court concluded the cancellation of registration did not mean that the psychologist could not apply again to be registered. As the Board had not given reasons for penalty, it was not possible to say if the Board acted upon the correct understanding of its powers. It was unclear if the Board intended to deny a right to apply for registration in the future. The matter was referred back to the Board.

In the case of *The College of Physicians and Surgeons of Nova Scotia* v. *Dr. J. G. Seaman* (1996) unreported, the Hearing Committee accepted the recommendation of the Investigative Committee respecting a settlement agreement. A family practitioner was found guilty of having sexual intercourse with a patient, giving the patient "morning after" pills and failing to maintain appropriate boundaries. The physician had voluntarily suspended himself from practice for approximately 12 months prior to the decision being rendered.

The Committee suspended the physician from practice for a period of two years, including the one year suspension already served. It should be noted this was a family practitioner and not a psychiatrist, he had no history of complaints or convictions and there was only one patient involved.

Counsel for the College also submitted a number of cases, some of which the Committee considers relevant to review.

In the case of *Re Scott and the College of Physicians and Surgeons of Ontario*, [1995] O.C.P.S.D. No. 22, a psychiatrist had been treating a patient over a 12-year period with psychotherapy and other forms of treatment. After one or two years of psychiatric treatment, the relationship became sexualized and regular sexual intercourse occurred on an ongoing basis for several years. Dr. Scott was aware of the patient's marital difficulties and described details of his own personal problems. He acted as her treating psychiatrist throughout the course of their sexual relationship. Ultimately, the sexual relationship was terminated by the complainant, and the professional relationship ended soon thereafter.

Dr. Scott pleaded guilty to the allegation of professional misconduct, and the College determined that erasure from the register was the appropriate penalty.

In the case of *Warnes* v. *The College of Physicians and Surgeons of Ontario* (1992), 62 O.A.C. 258 (Ont. Ct. Gen. Div.), a well-respected psychiatrist pleaded guilty to sexual misconduct arising from his sexual involvement with one patient over a two-year period. The College revoked his licence to practice.

The Committee in its decision made the following comments:

> There is a perception that a licence to practice implies a warranty of propriety or a stamp of approval, and when it is so severely violated, a severe penalty is required to protect the integrity of the profession. A significant sentence is necessary to send a loud and clear message of repudiation to the public and of deterrence to the profession. Under the existing policies of the College, the fact that the doctor whose licence has been revoked has the right to apply after one year for consideration of his fitness to hold one of the several types of licence to practice makes rehabilitation and proof thereof his own responsibility and indicates consideration of his welfare.

In reaching its decision to dismiss the appeal, the Court commented on the submission that the revocation of a licence was a professional death sentence, as follows:

> We do not agree with counsel for the appellant that a professional death sentence has been pronounced. It will be up to the appellant to show the College, (if, as and when he does so) that he is fit to accept the onerous duties, the onerous trust and the onerous responsibilities undertaken by a person licensed as a physician and surgeon in the Province of Ontario. The future of the appellants medical life lies with him and any committee to which he may apply.

In the case of *The College of Physicians and Surgeons of Ontario* v. *K* (1987), 36 D.L.R. (4th) 707 (Ont. C.A.), a psychiatrist was found guilty of professional misconduct for his involvement with two patients.

He started seeing one patient in 1973, and behaving in an intimate and unprofessional manner in 1974. Sexual intercourse began in 1974, which continued for several years. In 1978, the patient and Dr. K. bought a farm and moved in together.

Certain facts are remarkably similar to the case under consideration. The following excerpts from the Court of Appeal decision are informative:

> She was referred to the respondent by another doctor in 1973. She was having matrimonial difficulties and was extremely anxious and depressed. She had physical ailments as well. Her anxiety and depression were not by reason of any sexual problems. However, from the very

> first interview with the respondent discussions of sex played a very large part and seemed to be the primary topic of discussion.
>
> She testified that the first discussion related to masturbation. The subject was raised by the respondent, and when she advised her that she had not engaged in masturbation, the respondent told her that she was inhibited for not doing so. The discussion then turned to voyeurism, and the respondent advised her that he was a voyeur and that it was quite natural. ...he discussed the use of vibrators and asked her if she had a vibrator and encourage her to get one.

The second patient started in the summer of 1977. In the therapy sessions, there was an undercurrent of sexuality in the discussions. This eventually led to fondling and kissing during the sessions. Two incidents of sexual intercourse later occurred at her residence. This relationship then continued for about two years.

The College revoked Dr. K.'s licence to practice. The Divisional Court quashed the decision of the Discipline Committee. The Court of Appeal allowed the appeal and restored the decision of the Discipline Committee.

In the case of the *Provincial Medical Board* v. *Dr. Rafferty* (1994, unreported), Dr. Rafferty had engaged in a sexual relationship with a patient on several occasions. The Hearing Committee found that Dr. Rafferty also had an alcohol problem and a drug-abuse problem. They concluded that Dr. Rafferty's name should be erased from the medical register and that he would not be able to apply for reinstatement for a period of less than 18 months. This was a decision of the predecessor Board to the College of Physicians and Surgeons of Nova Scotia.

The Committee has given special attention to cases where sexual intercourse occurred and those cases involving psychiatrists. The nature of the psychiatrist-patient relationship is particularly relevant in the context of sexual misconduct, as the patient is in an extremely vulnerable state having placed their trust in the psychiatrist.

As noted, Counsel for Dr. Hingley has submitted that this case is not the worst case scenario as there was no violence involved and the sexual intercourse was consensual. Dr. Hingley is not the worst offender. However, this is not a case of a single patient or one or two acts of intercourse or where the consensual acts may have been initiated by the patient or where the acts

took place near the end or after the termination of the physician-patient relationship. It is not a case of a physician having a clean record.

In the Committee's view, the misconduct in this case is very serious. The cases of *Scott* and *Warnes* are particularly instructive because of the similarity of the facts. Considering all of the cases submitted and recognizing the distinguishing features noted, the Committee is persuaded that this case lies at the upper end of the range of possible sentences.

In addition to the factors in *Jaswal*, a key factor is the question of potential for rehabilitation.

In that regard, the letter that Dr. Hingley wrote to the College in May of 1998, after attending Abbott Northwestern Hospital is of interest. Dr. Hingley writes:

> As well, the fact that I have pursued a pattern of denial in regard to these allegations would make it likely that if I was dealing with a male patient with similar problems, I would not see these problems; that is, I would have blind spots in regard to this area.

A key premise in the proposal of Counsel for Dr. Hingley and in Dr. Bradford's recommendations involves Dr. Hingley's acceptance of responsibility for the misconduct. In Dr. Bradford's opinion, this is step one in any treatment program. As of September 1998, the time of Dr. Bradford's assessment, he did not think Dr. Hingley had come to terms psychologically with the acceptance of full responsibility for his conduct towards his patients. Although Dr. Hingley has professed his acceptance, the Committee is concerned about the sincerity of Dr. Hingley in this regard.

The Committee was provided with a copy of the final report of the Task Force on Sexual Abuse of Patients which was commissioned by the College of Physicians and Surgeons in Ontario in 1991. Dr. Bradford agreed with the following statement from page 25 of the report:

> The Task Force has listened to significant debate about whether or not physicians who sexually abuse can be rehabilitated. We have heard from a number of experts in the field of rehabilitation. We also met with survivors of sexual abuse whose physician abusers had been disciplined by the College and pronounced rehabilitated, only to abuse again. The mandate of the College is to protect the public. Therefore, the perspective in which rehabilitation must be reviewed is not whether or not an abuser is treatable or entitled to

> rehabilitation, rather the issue is whether rehabilitation can be successful and extensive enough to return him to practice without risk of harm to future patients. This implies a very high standard of certainty that the abuser will not abuse again.

On page 26, in concluding that portion of the report, the task force says:

> The task force is convinced that the College, in order to meet its statutory obligation to the public, must require evidence of a clear rehabilitation plan with clear goals; then evidence that the plan has been followed by the doctor; then evidence of positive outcomes; and then evidence of a clear plan for reinstatement with practice limitations where appropriate.

The Committee is concerned about the potential for rehabilitation of a doctor who draws a distinction between knowing his conduct is wrong and appreciating it is wrong.

Counsel for the College submits the public should not have to take the risk of the uncertainty of when or if step one will be reached. The public should not have to bear the risk of the uncertainty of the outcome of Dr. Bradford's recommendations. Rather, the onus should be on Dr. Hingley to take the treatment, see how it works, and then, should he wish, he can return to the College in two years' time to seek reinstatement once all of these uncertain variables are known.

Under the provisions section 69 of the Act, a physician, whose licence has been revoked, can apply for reinstatement once two years have passed.

In order to minimize the risk to the public, Counsel for Dr. Hingley has proposed monitoring of Dr. Hingley's private practice with males only, ongoing psychotherapy treatment and a psychiatric assessment before returning to the practice of psychiatry. The Registrar of the College, must be satisfied with a relative degree of certainty that such report, and from the reports of the other psychotherapists treating Dr. Hingley, that he does not pose a risk to the public if he returns to psychiatric practice.

There is evidence of the impracticality of putting monitors in place in the private practice of psychiatry. It is not practical to have another psychiatrist present while a therapy session is

taking place. If Dr. Hingley is allowed to return to practice with males only, Dr. Bradford would be more comfortable with a system of monitoring in a mental health setting.

With respect to conditions in a sentence which results in a third party making a discretionary decision about the ability of a practitioner to return to practice, reference is made to the case of *Dhawan* v. *College of Physicians and Surgeons of Nova Scotia* (1998), 168 N.S.R. (2d) 201 (N.S.C.A.).

In that case, the hearing panel had imposed a requirement that the licence suspension remain in effect until the physician satisfied the Registrar that he had complied with the recommendations resulting from a mandatory assessment. The Court in striking out the portion delegating the Committee's powers to the Registrar made the following comment:

> In extending the suspension in the event that in the opinion of the Registrar of the College the appellant failed to follow such recommendations, the Committee has, in effect, delegated the power to impose a continued suspension of licence and to determine the duration of such continued suspension to the Registrar. This, I think, it cannot do. Such proposed suspension does not fall within the terms of s. 66(2)(c)(i)(D) or (G) of the Act. The Committee, and only the Committee, may impose the penalty. It has fixed a period of six months for the suspension. It has erred in law in delegating to the registrar permission to extend that period.

The Committee is concerned about the possible effect of the *Dhawan* case on the imposition of a penalty which includes a condition the fulfillment of which is subject to the discretion of a third party.

Finally, the Committee was reminded of the words from the Ontario Task Force on Sexual Abuse of Patients in the physician-patient relationship. Although Dr. Bradford suggested not all of the recommendations from this report have been widely accepted, the following passage at page 24, is probably non-contentious.

> A permanent revocation of licence is not the removal of any right the physician may have to livelihood, particularly given the level of education physicians have. In 1988, the Ontario Court of Appeal clearly stated there is no constitutional right to practice medicine. Rather, it is the removal of the privilege of practicing medicine, and the privilege of receiving the public's highest level of trust.

PENALTY

The Committee has considered the submissions of Counsel, including the authorities provided to it. We have also considered all of the circumstances of this particular case and taken into account the appropriate factors which ought to be considered.

Dr. Hingley violated in the gravest manner the patient-psychiatrist relationship. He did it over a protracted period of time. He did it knowingly. He did it with two patients he knew were very vulnerable. He displayed a disregard for his patients and a lack of appreciation of boundary issues. Two female patients put their trust and confidence in Dr. Hingley and were subjected to extremely inappropriate and unacceptable behaviour.

The Committee is not satisfied that the reasons for Dr. Hingley's conduct lie entirely in a psychiatric disorder. We believe that he knew and appreciated that his conduct was wrong. His experimental therapy was intended for his own sexual gratification. We have doubts about his sincerity that he has accepted full responsibility for his conduct.

With respect to penalty, the Committee has determined in accordance with Section 66(2)(e)(i)(A) of the Act, that the registration and license of Dr. Hingley be revoked and that his name be stricken from the registers in which it is entered.

In accordance with the Statement of Admissions and Agreements, Dr. Hingley shall pay costs fixed in the amount of $10,000.00, which the parties have agreed includes Harmonized Sales Tax.

The Committee approves of the Court's reasoning in *Warnes*, noted earlier, with respect to this not being a professional death sentence. Under the provisions of the Act, Dr. Hingley will have a right to apply to the College for reinstatement. The Committee has heard extensive evidence and submissions and considered this matter carefully. The Committee wishes to provide the College with the benefit of its considerations if and when Dr. Hingley applies for reinstatement. In addition to the requirements under the Act, the Committee recommends the following be considered by the College:

1. Dr. Hingley should complete an intensive treatment program of the type recommended by Dr. Bradford at a sexual behaviour clinic.

2. Dr. Hingley should follow the long term management program recommended by the sexual behaviour clinic.

3. Dr. Hingley should attend a continuing medical education course at Dalhousie University or other institution acceptable to the College, dealing with the principles and methods of contemporary psychotherapy and obtain an evaluation acceptable to the College.

4. Dr. Hingley should obtain a psychiatric evaluation with particular reference to the psychiatric disorders identified by Dr. Bradford and the Abbott Northwestern Hospital assessment. This evaluation should be done by a psychiatrist satisfactory to the College and the treatment plan if any should be monitored in accordance with a plan acceptable to the College.

5. If a licence is approved it should be a defined license to practice psychiatry restricted to males over 19 years of age.

6. If a licence is approved, Dr. Hingley's practice should be monitored under terms satisfactory to the College, having consideration to the recommendations of Dr. Bradford.

W. Mark Penfound, Q.C., Chair

Dr. Ann Brooks

Dr. Eugene G. Nurse

Dr. Robert N. Anderson

Dawn Valardo