IN THE MATTER OF: **The *Medical Act*, S.N.S. 2011, c.38**

and

IN THE MATTER OF: **A Settlement Agreement**

BETWEEN:

The College of Physicians and Surgeons of Nova Scotia

(the "College")

-and-

Dr. George Richardson

("Dr. Richardson")

HEARING COMMITTEE REASONS FOR DECISION

Hearing Committee:
Mr. Raymond F. Larkin, Q.C.
Dr. Erin Awalt
Dr. Michael Teehan
Dr. Gisele Marier
Mr. Alonzo Wright

Counsel:
Jane O'Neill, QC and Daniel Wallace, Counsel for the College of Physicians and Surgeons of Nova Scotia

Mr. Brian W. Downie, QC and Sian G. Laing, Counsel for Dr. George Richardson

A. INTRODUCTION

1. Dr. George Richardson is a medical practitioner in Nova Scotia who engaged in sexual activity with a patient in 1990. On May 11, 2022, the Hearing Committee considered and accepted a Settlement Agreement recommended by Investigation Committee E with amendments. These are our reasons for accepting the Amended Settlement Agreement. The Amended Settlement Agreement is attached as Schedule "A."

B. PROCEDURAL BACKGROUND

2. On January 5, 2022, the Registrar of the College issued a Notice of Hearing to Dr. George Richardson, which included the following allegations:

> 1. You engaged in a sexual relationship with Patient X in 1990. In doing so, you:
>
> a. contravened sections 3, 26, and 28 of the College-endorsed Canadian Medical Association Code of Ethics (1986); and
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> b. engaged in professional misconduct under the Medical Act, 1989.
>
> 2. In your April 25, 1990 letter, you advised the Provincial Medical Board that you had transferred Patient X to a certain named physician when that was not the case. In doing so, you:
>
> a. contravened sections 25 and 26 of the College-endorsed Canadian Medical Association Code of Ethics (1986); and
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> b. engaged in professional misconduct under the Medical Act, 1989.

3. The central allegation in the Notice of Hearing is that Dr. Richardson engaged in a sexual relationship with a patient more than 30 years ago. The Notice of Hearing alleges professional misconduct under the *Medical Act*, R.S.N.S. 1989, c.278. Fairness to Dr. Richardson requires that the standards of professional conduct that applied to him in 1990, not those that would apply in 2022, must be used in assessing the allegations in the Notice of Hearing and the proposed Settlement Agreement.

4. On February 16, 2022, Dr. Richardson filed a motion requesting the Hearing Committee to stay hearing this matter because the passage of more than 30 years since

the alleged events made it unfair to proceed. He relied on Section 53(2) of the *Medical Act*, S.N.S. 2011 c.38, which requires a hearing to be conducted in accordance with the principles of natural justice. The Committee received affidavit evidence and written submissions and met to hear the parties on the Motion on March 2, 2022. We decided that we could not consider the Motion without further evidence and set the matter for hearing on May 9th, 10th and 11th, 2022.

5. At the March 2 hearing, the College proposed a publication ban on the name of Patient "X" and on any information that could identify her. Dr. Richardson consented to the publication ban, and the Hearing Committee decided that a publication ban was necessary and therefore granted the order proposed by the College.

6. Shortly before the hearing scheduled for May 9, 10 and 11, 2022, the Hearing Committee was notified that the College and Dr. Richardson had reached a Settlement Agreement and that Investigation Committee E recommended the proposed Settlement Agreement. The scheduled hearing was cancelled, and the hearing on the proposed Settlement Agreement was held on May 11, 2022.

7. At the hearing, the Hearing Committee suggested amendments to the proposed Settlement Agreement. The Registrar of the College and Dr. Richardson accepted our suggestions for amendments, and the Hearing Committee accepted the amended Settlement Agreement, which took effect on May 11, 2022, with written reasons to follow.

C. FACTS

8. The proposed Settlement Agreement recommended by Investigation Committee E included a series of admissions by Dr. Richardson as follows:

> 9. Dr. Richardson makes the following admissions:
>
> a. Dr. Richardson admits that Patient X was his patient beginning in January 1990. Dr. Richardson admits that Patient X was a vulnerable patient seeking counselling for sexual abuse and incest.
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> b. Dr. Richardson admits that he physically embraced Patient X during a counselling session. Dr. Richardson admits that this constituted an error in judgment and inappropriate physical contact with a patient, which was aggravated by the vulnerable nature of Patient X.

c. Dr. Richardson admits that he had sexual intercourse with Patient X while she was his patient.

d. Dr. Richardson further admits that he told Dr. Bernie Steele. Registrar of the Provincial Medical Board of Nova Scotia, in his April 25, 1990 letter that he had arranged transfer of Patient X to a certain named physician and that physician had agreed to accept the referral. Dr. Richardson had not done so. Dr. Richardson admits that his April 25, 1990 lacked appropriate candour as it omitted important information, specifically that he had had sexual intercourse with Patient X.

V. DISPOSITION

10. Dr. Richardson admits that each of his above actions set out in paragraphs 9(b) and (c) constituted an error in judgment, a boundary violation and an inappropriate breach of the physician-patient relationship. Dr. Richardson admits that his actions constituted professional misconduct under the *Medical Act*, 1989. Dr. Richardson further admits that his actions constituted a violation of sections 3 and 28 of the Canadian Medical Association Code of Ethics (1986):

3. An ethical physician will ensure that his conduct in the practice of his profession is above reproach, and that he will take neither physical, emotional nor financial advantage of his patient;

28. An ethical physician will conduct himself in such a manner as to merit the respect of the public for members of the medical profession;

11. Dr. Richardson admits that his actions constituted professional misconduct under the *Medical Act*, 1989. Dr. Richardson further admits that his conduct set out in paragraph 9(d) constituted a violation of sections 25 and 26 of the Canadian Medical Association Code of Ethics (1986):

25. An ethical physician will recognize that the profession demands of him integrity and dedication to its search for truth and its service to mankind;

26. An ethical physician will recognize that self-discipline of the profession is a privilege and that he has a responsibility to merit the retention of this privilege.

> 12. Dr. Richardson accepts a 6 month suspension, which will be deemed to have commenced on March 31, 2022, the date upon which Dr. Richardson provided an undertaking to cease providing medical care to patients while on his medical leave.
>
> 13. Dr. Richardson accepts that, upon his return to practice, he will be permanently required to have a practice monitor for all patient encounters.
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> 14. Dr. Richardson shall post a sign in the waiting room and any examination rooms stating that he is to have a practice monitor present for all patient encounters.

9. Counsel for the College and Dr. Richardson also agreed that the Hearing Committee could rely on the facts set out in Paragraphs 45 and 46 of Dr. Richardson's written submissions, which provide as follows:

> 45. It bears acknowledging that Dr. Richardson's license to practice medicine was revoked effective February 15, 2011 for professional misconduct after admitting to a long-standing substance abuse disorder involving both alcohol and drugs. In the latter part of 2010, Dr. Richardson began seeing several treatment providers (and continues to see his family doctor) for support in recovery. Over the next several years, Dr. Richardson made tenacious efforts to rehabilitate himself, personally and professional, and in 2013 was reinstated. He returned to full-time practice at the Woodlawn Medical Clinic where he maintained a large family medicine practice and provided coverage at the walk-in duty clinic. Since that time, Dr. Richardson had been providing compassionate and conscientious care to his patients in an underserviced community. He is highly regarded by his patients and peers. He has since practiced without incident. He has matured, personally and professionally, and is no longer the person he was in 1990.
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> 46. Dr. Richardson has been deeply distressed by this process because it has undermined the strides he has made over the past decade to turn his life and career around. As a result, Dr. Richardson has experienced a great deal of anguish and anxiety in respect of this complaint over the past 20 months and went on a medical leave of absence from practice as a result on March 17, 2022. These mitigating factors should be taken into account when considering the proposed Settlement Agreement.

D. STATUTORY PROVISIONS

10. *Medical Act*, R.S.N.S. 1989, c.278:

2(d) “professional misconduct” means that a qualified medical practitioner has:

(ii) been guilty, in the opinion of the Board, of misconduct in a professional respect or of conduct unbecoming a medical practitioner, or of incompetence, or;

34 Following an investigation, the Board shall receive a written report from the Discipline Committee of its findings and recommendations, and if the Board considers that a qualified medical practitioner has been guilty of professional misconduct or that the complaints against him have been proved in that he is incapable or unfit to carry on the practice of medicine, the Board may, by order,

(a) cause the name of the qualified medical practitioner to be erased from the Medical Register or the Temporary Medical Register;

(b) suspend the qualified medical practitioner from the practice of medicine for a period of time prescribed by the Board;

(c) cause the name of the qualified medical practitioner to be erased from the Medical Register and entered upon the Temporary Medical Register subject to whatever terms or conditions the Board may prescribe;

(d) reprimand the qualified medical practitioner; or

(e) suspend the imposition of punishment and place the qualified medical practitioner on probation upon whatever terms the Board may prescribe. 1973, c. 66,s. 1.

11. *Medical Act*, S.N.S. 2011, c.38, Section 51:

51. Where an investigation committee refers a matter to a Hearing Committee, the College may, before the commencement of a hearing by the Hearing Committee, enter into a Settlement Agreement with the respondent, to be dealt with in accordance with the regulations. 2011, c. 38, s. 51.

12. *Medical Practitioners* R*egulations*, N.S. Reg. 225/2014:

Preparing and tendering Settlement Agreements

101 (1) A proposed Settlement Agreement may be initiated in writing by the Registrar or the respondent at any time before a hearing begins.
(2) **A proposed Settlement Agreement must include all of the following:**

(a) sufficient facts and admissions to support the agreed disposition;

(b) an agreement on costs;

(c) the respondent's consent to a specified disposition conditional on the acceptance of the Settlement Agreement by an investigation committee and a Hearing Committee.

(3) A Settlement Agreement may include any disposition that could be ordered by a Hearing Committee under the *Act* or these regulations.

(4) If both the Registrar and the respondent agree with the content of a proposed Settlement Agreement, the Registrar must refer the Settlement Agreement to an investigation committee for consideration in accordance with Section 102.

(5) The Registrar and the respondent may agree to use a mediator to prepare a Settlement Agreement, and the costs for the mediator must be divided equally between the College and the respondent unless otherwise agreed.

(6) If the Registrar and the respondent cannot agree on the content of a proposed Settlement Agreement, the matter must be referred for a hearing.

Investigation committee recommendations on Settlement Agreement

102 (1) An investigation committee may recommend acceptance of a Settlement Agreement if it is satisfied that all of the following conditions are met:

(a) the public is protected;

(b) the conduct or its causes can be, or have been, successfully remedied or treated, and the respondent is likely to successfully pursue any remediation or treatment required;

(c) the content of the proposed Settlement Agreement provides sufficient facts and admissions to support the agreed disposition;

(d) settlement is in the best interests of the public and the profession.

(2) If an investigation committee recommends acceptance of a Settlement Agreement, the investigation committee must refer the Settlement Agreement to the Hearing Committee for consideration in accordance with Section 103.

(3) If the investigation committee does not recommend acceptance of a Settlement Agreement, the investigation committee must do 1 of the following:

(a) recommend changes to the Settlement Agreement that:

(i) if agreed upon by the Registrar and the respondent will result in acceptance by the investigation committee, or

(ii) if not agreed upon by the Registrar and the respondent will result in rejection by the investigation committee;

(b) reject the Settlement Agreement and refer the complaint considered by the investigation committee to a Hearing Committee for a hearing.

Hearing Committee acceptance or rejection of Settlement Agreement

103 (1) **If a Hearing Committee accepts a Settlement Agreement, the Settlement Agreement forms part of the order of a Hearing Committee disposing of the matter and, except as provided in subsections 104(3) and (4) for breaches of the Settlement Agreement, there is no hearing.**

(2) **If a Hearing Committee does not accept a Settlement Agreement, it must do 1 of the following**:

(**a) suggest amendments to the Settlement Agreement and return it to the Registrar and the respondent for review;**

(b) reject the Settlement Agreement, in which case the matter is referred to another panel of a Hearing Committee for a hearing.

(3) If both the Registrar and the respondent do not agree with the amendments to a Settlement Agreement suggested under clause (2)(a), the Settlement Agreement is deemed to be rejected and the matter must be referred to another panel of the Hearing Committee for a hearing.

(4) **If both the Registrar and the respondent agree with the amendments to a Settlement Agreement suggested under clause (2)(a), the Settlement Agreement must be approved by a Hearing Committee.**

(5) A person who sits on a panel of a Hearing Committee that considers a Settlement Agreement must not sit on a panel of a Hearing Committee that conducts a hearing related to the same complaint.

Settlement Agreements and hearings

104 (1) If a Settlement Agreement is rejected by a Hearing Committee, a hearing must proceed without reference to the Settlement Agreement or any admissions contained in the Settlement Agreement until after the Hearing Committee has determined whether professional misconduct, conduct unbecoming, incompetence or incapacity has been proven.

(2) Before deciding whether to award costs in a hearing, a Hearing Committee may be given a copy of any Settlement Agreements exchanged between the parties.

(3) An admitted breach by a respondent of any term in an accepted Settlement Agreement must be referred to a Hearing Committee for a hearing.

(4) An alleged breach by a respondent of any term in an accepted Settlement Agreement must be referred to an investigation committee as a Registrar's complaint.[**emphasis added**]

E. SETTLEMENT AGREEMENTS GENERALLY

13. In Re *Dearman*, 2021 CanLII 130277(N.S.C.E.S.), the Hearing Committee recently set out its approach to Settlement Agreements as follows:

> 8. This process permits the College Registrar to agree to a proposed Settlement Agreement and refer that agreement to an Investigation Committee. If the Investigation Committee is satisfied that the proposed Settlement Agreement meets the stringent requirements set out in Section 102 of the Regulations, the Committee can recommend acceptance of the Settlement Agreement by the Hearing Committee. A Settlement Agreement recommended for approval by an Investigation Committee and accepted by the Hearing Committee becomes an order of the Hearing Committee and disposes of the matter referred to hearing, and no hearing is required.
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> **9. The Hearing Committee has three options:**
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> **a) accept the Settlement Agreement recommended by the Investigation Committee;**
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> **b) suggest amendments to the Settlement Agreement, and if the Registrar and the medical practitioner agree, the amended Settlement Agreement is accepted by the Hearing Committee; or**
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> **c) reject the Settlement Agreement, and the matter is referred to a different panel of the Hearing Committee for a hearing.**
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> 10. In its decision dated June 26, 2019, in Re *Jones*, 2019 CanLII 92700 (N.S.C.P.S.), the Hearing Committee set out its approach to applying Section 103 of the Medical Practitioners Regulations and deciding whether or not to accept a proposed Settlement Agreement. The decision included the following:
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> > 30. In its previous decisions, the Hearing Committee has accepted the principle of deference to the Investigation Committee's recommendation for approval of a Settlement Agreement reached between the Registrar and a practitioner. There are good reasons for this.
> >
> > 31. In most cases, the Investigation Committee will have a much more detailed knowledge of the facts than a Hearing Committee because of their involvement in

investigating a complaint over an extended period of time. Furthermore, the Investigation Committee makes a recommendation of a Settlement Agreement within a legislative framework in Section 102 of the Medical Practitioners' Regulations which ensures a rigorous and exacting approach to whether a complaint should be settled.

32. In our view, Settlement Agreements should be encouraged because they permit the Registrar and the Investigation Committee to negotiate the resolution of complaints without the delay and expenses of a formal hearing. As in this case, there may be significant issues of proof that make the outcome of a formal adjudicated hearing uncertain. Likewise for the practitioner subject to a complaint, the prospect of success in a hearing may be uncertain, and the possibility of a significant costs award provide an incentive to make appropriate admissions and consent to a disposition they can accept. Some agreed dispositions are possible in a Settlement Agreement that may not be possible in a formal hearing.

33. It is true that the Settlement Agreement process is not as transparent to the public as a formal hearing but to be acceptable Settlement Agreements have to include detailed statements of the facts. The decision of a Hearing Committee to accept a Settlement Agreement requires the reasons for accepting it. These are made public.

…

36. The Hearing Committee does not just rubberstamp a Settlement Agreement recommended by the Investigation Committee. We not only assess the criteria for the recommendation of a Settlement Agreement by the Investigative Committee set out in Section 102 of the Medical Practitioners Regulations, but we examine the Settlement Agreement closely for its consistency with the purposes of the College, as set out in Section 5 of the *Medical Act* which provides as follows:

5 In order to

(a) serve and protect the public interest in the practice of medicine; and

(b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall

(c) regulate the practice of medicine and govern its members through:

(i) the registration, licensing, professional conduct and other processes set out in this Act and the regulations,

(ii) the approval and promotion of a code of ethics,

(iii) the establishment and promotion of standards for the practice of medicine, and

(iv) the establishment and promotion of a continuing professional development program; and

(d) do such other lawful acts and things as are incidental to the attainment of the purpose and objects of the College. 2011, c. 38, s. 5.

37. In our opinion, the public interest in the practice of medicine is first and foremost the protection of the public. Members of the public as patients depend fundamentally on the assessment, diagnosis and treatment of illness or injury by medical practitioners for life, health and happiness. The public depends on medical practitioners working in accordance with the accepted standards of the practise of medicine, including high standards of integrity and ethics. The College strives to ensure the protection of the public by regulating the practice of medicine and governing the conduct of its members to the high standards that the public expects.

38. Serving and protecting the public interest in the regulation of professional conduct under the Medical Act also requires fair treatment of medical practitioners who are subject to complaints. There is a strong public interest in ensuring that the process for the Investigation and adjudication of complaints, and the substance of decisions made in that process, are fair to the medical practitioners.

> 39. There is an important public interest in finding appropriate dispositions that keep medical practitioners in practice so they can serve the public in accordance with the standards of the medical profession. There continues to be a shortage of physicians in Nova Scotia. If possible, medical practitioners who engage in professional misconduct should be returned to practice with appropriate conditions and restrictions.
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> 40. There is also a public interest in maintaining the credibility of the College as a regulator of the practice of medicine. It is important that the public is assured that genuine complaints are not swept under the rug, and that the College is effective in protecting the public and in maintaining high standards among medical practitioners.
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> **41. In our view, in considering whether to accept this Settlement Agreement, the Hearing Committee has to balance all of these aspects of the public interest so that the approval of this Settlement Agreement serves to protect the public, treats Dr. Jones fairly, and maintains the confidence of the public and profession in the College.**
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> **42. We recognize that there can often be more than one reasonable conclusion about how to balance these aspects of the public interest in assessing a particular Settlement Agreement. If the Investigation Committee recommends a disposition that falls within a reasonable range of alternative conclusions we will defer to their judgment. [emphasis added]**

14. The Hearing Committee defers to the judgement of the investigation committee on whether or not to accept a proposed settlement agreement, provided it falls within a range of reasonable dispositions. We consider whether the proposed settlement agreement serves to protect the public, treats the medical practitioner fairly, and maintains the confidence of the public and the profession in the College.

15. Counsel for Dr. Richardson argues that the Hearing Committee should accept a higher degree of deference to the recommendation of Investigation Committee. He submits that we should adopt the approach to joint submissions on penalties discussed in the decision of the Ontario Divisional Court in *Timothy Bradley v. Ontario College of Teachers*, 2021 ONSC2303(CanLII) which includes the following passage:

> 13. In this case, the Discipline Committee referred to the *Anthony Cook* decision as the guiding authority on the issue of whether it could reject the joint submission on penalty, but it misunderstood the stringent nature of the public interest test and thereby misapplied it. In particular, the Discipline Committee did not find that or articulate any basis for finding that serving the two month penalty in the summer was so **"unhinged from the circumstances of the offence and the offender that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down".** [...] **[Emphasis added]**

16. In Re *Damacen*, in paragraphs 20 to 27, the Hearing Committee rejected the "unhinged" test derived from the criminal justice system and adopted in Ontario physician regulation decisions. We do not accept the extension of the "unhinged" test to professional regulation generally, as stated in *Bradley v. Ontario College of Teachers*, for the same reasons. This test is inconsistent with the provisions of the *Medical Act* and the Medical Practitioners Regulations.

17. In this case, the "unhinged" approach is not consistent with Section 103 of the Medical P ractitioners Regulations. Section 103 authorizes the Hearing Committee to accept a proposed Se ttlement Agreement but requires that "where it does not accept a Settlement Agreement," it m ust either suggest amendments to the Settlement Agreement or reject it. As will be discussed be low, we have applied the general principle of deference to the judgement of the Investigation C ommittee on whether Dr. Richardson engaged in professional misconduct and the a ppropriateness of a six month suspension from practice but we did suggest amendments to the proposed Settlement Agreement. The Registrar and Dr. Richardson agreed to these suggestions, and we applied Section 103(4) of the Medical Practitioners Regulations to approve the amended Settlement Agreement.

18. There are no provisions like Section 103 in the Ontario legislation governing physicians and surgeons analyzed in Re *Damacen* or in the legislation applied in *Bradley v. Ontario College of Teachers.* In our opinion, the "unhinged" approach used under the Ontario legislation does not reflect the settlement agreement provisions in the *Medical Act* and the Medical Practitioners Regulations. Accordingly, in deciding whether to accept the proposed Settlement Agreement, we have applied the deferential approach to settlement agreements set out in our decision in *Re Damacen*.

F. PROFESSIONAL MISCONDUCT

19. A settlement agreement must include facts and admissions to support the agreed disposition in the settlement agreement. We agree that the admissions of Dr. Richardson in the proposed Settlement Agreement are sufficient to support the conclusion that he engaged in professional misconduct as defined in Section 2 of the *Medical Act*, R.S.N.S. 1989, c.278. Both Dr. Richardson's sexual relations with Patient X and his lack of candour with the Registrar of the Medical Board of Nova Scotia amounted to professional misconduct in 1990.

a) SEXUAL RELATIONS WITH PATIENT X

20. Dr. Richardson admits that he had inappropriate physical conduct with Patient X and sexual intercourse with her while she was his patient. In our recent decision in Re *Moodley*, 2021 CanLII 43606 (N.S.C.P.S.), the Hearing Committee addressed the power imbalance between a physician and their patient. In paragraphs 33 to 35, we stated the following:

> 33. Patients seek assessment or treatment from a physician because of the physician's expertise and experience on a health issue. Patients are vulnerable in that relationship. When a person is sick or injured, they are at their most vulnerable. Patients are in a relationship where the physician has far more power than the patient because of their expertise and experience. In that relationship with its power imbalance, patients trust that the physician is concerned with their needs only.
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> 34. Conduct that in other circumstances might be unobjectionable is entirely unacceptable in the physician-patient relationship. If a physician indulges in their own sexual needs by asking questions and making comments of a sexual nature without any medical relevance, such talk constitutes an abuse of the unequal power in the relationship; the physician's needs have taken precedence over the patient's needs.
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> 35. While this type of conduct is harmful to the patient, it also damages the medical profession's reputation and confidence in the College as a regulator. The trust that patients repose in their physicians will be eroded if the medical profession tolerates or minimizes this kind of abuse of power.

21. The power imbalance between Dr. Richardson and Patient X is more profound than that discussed in Re *Moodley*, where no inappropriate contact or sexual intercourse occurred.

22. Furthermore, Patient X was a vulnerable patient seeking counselling for sexual abuse and incest and, therefore, particularly vulnerable to the power imbalance in her relationship with Dr. Richardson. Dr. Richardson admits that his inappropriate physical conduct with Patient X during that counselling session was aggravated by the vulnerable nature of Patient X. In our opinion, this was an abuse of the unequal power relationship between Dr. Richardson and Patient X.

23. Dr. Richardson also admits that he had sexual intercourse with Patient X while she was still a patient. In our opinion, sexual intercourse with a vulnerable patient seeking counselling for sexual abuse and incest was a very serious abuse of the physician-patient relationship. It constituted a fundamental breach of the trust required in that relationship.

24. These principles apply as much in 1990 as they do today. We do not have to weigh whether changing public attitudes toward sexual misconduct in professional relationships are a factor in deciding whether Dr. Richardson's conduct amounted to professional misconduct. In 1990, sexual relations with a patient amounted to a serious breach of physician ethics. Dr. Richardson acknowledged that in 1990 he was subject to the Canadian Code of Ethics (1986), which at that time included the following paragraphs:

> 3. An ethical physician will ensure that his conduct in the practice of his profession is above reproach, and that he will take neither physical, emotional nor financial advantage of his patient.
>
> 28. An ethical physician will conduct himself in such a manner as to merit the respect of the public for members of the medical profession.

25. In our opinion, Dr. Richardson violated the prohibition on taking advantage of their patient. In doing so, he did not conduct himself in such a manner that would maintain the respect of the public for members of the medical profession.

26. The decisions of disciplinary tribunals and courts in other provinces in the 1990s recognized that it is professional misconduct for a physician to have a sexual relationship with a patient. For example, in *Ontario (College of Physicians and Surgeons of Ontario) v. Irvine* 1996 O.N.C.P.S.D.23*,* the Discipline Committee of the Ontario College states bluntly on page 4 that "… a sexual relationship with a patient is always wrong."

27. This statement reflected the decisions of the Ontario Divisional Court and the Court of Appeal in the *College of Physicians and Surgeons of Ontario v. Boodossingh*, (1990) 73O.R.

(2d)478 (Ont.Div.Ct.); 12O.R.(3d)707 (Ont. C.A.). In the Court of Appeal decision, the court stated as follows:

> The allegation against the doctor was that he engaged in improper relations with his patient, the complainant, in the fall of 1985. The doctor is a psychiatrist and the complainant attended upon him for therapy required in large part because of her unsatisfactory relationships with men. In the course of that therapy, the parties developed a relationship which culminated in one single instance of sexual intercourse taking place in the complainant's home arranged beforehand by both parties.
>
> The Committee found this to be disgraceful, dishonourable and unprofessional conduct and we see no reason to interfere in that finding. Indeed, the doctor conceded that if the conduct took place (which for the purposes of this appeal is conceded) the Committee could come to no other conclusion. The whole ground of appeal by the doctor is that the relationship of doctor and patient had ended before the sexual intercourse took place. We cannot accept that argument. Whether the relationship had been formally ended or not (and there was evidence of further treatment thereafter), the influence of the doctor remained and he took advantage or might appear to have taken advantage of that influence improperly. The appeal against conviction must be dismissed.

28. The issue of sexual misconduct by physicians was extensively examined by the Ontario College of Physicians and Surgeons in the early 1990s. In the Final Report of the Task Force on Sexual Abuse of Patients (November 25, 1991), on page 12, the report states the following:

> Due to the position of power the physician brings to the doctor-patient relationship, there are NO circumstances – NONE – in which sexual activity between a physician and a patient is acceptable. Sexual activity between a patient and a doctor ALWAYS represents sexual abuse, regardless of what rationalization or belief system the doctor chooses to use to excuse it. Doctors need to recognize that they have power and status, and that there may be times when a patient will test the boundaries between them. It is ALWAYS the doctor’s responsibility to know what is appropriate and never to cross the line into sexual activity.[emphasis in the original]

29. Application of the ethical standards of 1990 to the admissions of Dr. Richardson in the proposed Settlement Agreement leads without a doubt to the conclusion that Dr. Richardson engaged in professional misconduct within the meaning of the *Medical Act* as it existed in 1990.

b) LACK OF CANDOR AND COMMUNICATIONS WITH THE MEDICAL BOARD

30. In paragraph 9(d) and paragraph 11 of the proposed Settlement Agreement, Dr. Richardson makes the following admissions:

> 9. Dr. Richardson makes the following admissions:
>
> > d. Dr. Richardson further admits that he told Dr. Bernie Steele. then Registrar of the Provincial Medical Board of Nova Scotia, in his April 25, 1990 letter, that he had arranged transfer of Patient X to a certain named physician and that physician had agreed to accept the referral. Dr. Richardson had not done so. Dr. Richardson admits that his April 25, 1990 lacked appropriate candour as it omitted important information, specifically that he had had sexual intercourse with Patient X.
>
> 11. Dr. Richardson admits that his actions constituted professional misconduct under the *Medical Act*, 1989. Dr. Richardson further admits that his conduct set out in paragraph 9(d) constituted a violation of sections 25 and 26 of the Canadian Medical Association Code of Ethics (1986):
>
> > 25. An ethical physician will recognize that the profession demands of him integrity and dedication to its search for truth and its service to mankind;
> >
> > 26. An ethical physician will recognize that self-discipline of the profession is a privilege and that he has a responsibility to merit the retention of this privilege.

31. Dr. Richardson’s lack of candour with the Registrar of the Provincial Medical Board, particularly in the context of having engaged in sexual intercourse with a patient, was professional misconduct. He admits that it breached the Canadian Medical Association Code of Ethics (1986).

32. Both the sexual activity with Patient X and the lack of candour with the Medical Board are professional misconduct and a breach of ethics within the standards that applied to Dr. Richardson in 1990.

G. DISPOSITION

33. The proposed Settlement Agreement between the College and Dr. Richardson recommended by Investigation Committee E includes a six month suspension from practice deemed to have begun on March 31, 2022, and a permanent requirement of having a patient monitor for all patient encounters. Also, it included a payment of $2,500 in costs to the College. We must assess whether the disposition recommended by the Investigation Committee falls within the range of reasonable alternative dispositions. That involves balancing all aspects of the public interest that apply to the proposed Settlement Agreement, whether the Settlement Agreement serves to protect the public and treats the medical practitioner fairly, and whether it would maintain the confidence of the public and profession in the College.

a) COSTS

34. The proposed Settlement Agreement includes a provision for the payment of costs in paragraph 15 as follows:

> 15. Dr. Richardson agrees to pay costs to the College in the amount of $2,500 inclusive of H.S.T., representing a portion of the College's costs of investigating this matter. These costs shall be payable by Dr. Richardson in monthly instalments of $250 commencing on September 1 2022 following the acceptance of the Settlement Agreement by the Hearing Committee.

35. We see no reason not to accept the recommendation from Investigation Committee E related to costs. Settlement Agreements include compromises between the College and the medical practitioner involved. An agreed amount of costs is a practical device that recognizes other compromises in substantive aspects of the Settlement Agreement.

b) SUSPENSION

36. The proposed Settlement Agreement includes the following provision for a suspension from practice:

> 12. Dr. Richardson accepts a 6 month suspension, which will be deemed to have commenced on March 31, 2022, the date upon which Dr. Richardson provided an undertaking to cease providing medical care to patients while on his medical leave.

37. If Dr. Richardson had engaged in misconduct in 2022 which included sexual intercourse with a vulnerable patient, serious consideration would have to be given to whether a suspension from practice was proportionate to the misconduct. However, the sexual misconduct admitted by Dr. Richardson occurred more than three decades ago, in 1990. While the assessment of whether sexual activity with a patient constituted professional conduct has not changed since 1990, what has changed is the assessment of the appropriate and proportionate sanction where a physician engages in sexual misconduct which includes sexual intercourse with a patient. If this misconduct occurred in 2022, such conduct would invite consideration of the revocation of a medical practitioner's license to practice. However, in 1990, Court and tribunal decisions in cases involving sexual intercourse with patients determined that a suspension from practice, not revocation of the right to practice, was the appropriate sanction.

38. For example, in *Boodossingh*, cited above, the Discipline Committee of the College of Physicians and Surgeons of Ontario revoked the license of a psychiatrist who engaged in a single act of sexual intercourse with a vulnerable patient. The Ontario Divisional Court substituted a three-month suspension from practice saying, “The penalty of revocation should be reserved for repeat offenders and the most serious cases.” The Ontario Court of Appeal upheld that conclusion.

39. In *Ontario (College of Physicians and Surgeons of Ontario) v. Turton*, 1994 ONCPSD 15. th e Discipline Committee of the Ontario College imposed a six month suspension from practic e where Dr. Turton had sexual intercourse with a patient he had treated the previous day in an e mergency department of a hospital. The Discipline Committee emphasized the isolated nature o f the incident and Dr. Turton's guilty plea, which enabled the complainant to avoid the ordeal of testifying. The College ordered a six month suspension with the potential of a reduction to three months if Dr. Turton undertook a course of psychotherapy.

40. In *College of Physicians and Surgeons of Ontario v. Gillen,* [1994] 1 O.R. (3d), the Ontario Divisional Court, upheld by the Court of Appeal, set aside a decision revoking Dr. Gillen’s license to practice and substituted a nine month suspension from practice where the physician took adv antage of an unwilling patient when he placed his penis in the hand of a young female patient w ho was semi-conscious.

41. In *Ontario (College of Physicians and Surgeons of Ontario) v. Irvine*, 1996 ONCPSD 23, the Discipline Committee imposed a six month suspension from practice where, in 1985, Dr. Irvine was involved sexually with a long-standing patient. The sexual activity was consensual; the physician admitted to the misconduct and accepted full responsibility.

42. In *MacDonald v. The Council of the College of Physicians and Surgeons of New Brunswick*, 1992 (CarswellNB239) N.B.C.A. the New Brunswick Court of Appeal set aside a one-year suspension from practice and substituted a nine month suspension where a physician had engaged in two instances of consensual sexual misconduct with a patient, one in 1983 and one i n 1984.

43. Previous decisions of tribunals and courts are a strong indication of whether a disciplinary sanction is proportionate to the seriousness of the misconduct of a physician. From our review of these decisions, we agree that it was reasonable for Investigation Committee E to conclude that, in 1990, the standards that applied to Dr. Richardson in assessing the appropriate sanction for his misconduct would appropriately result in a suspension from practice.

c) LENGTH OF SUSPENSION

44. The specific circumstances of each case must be considered to assess whether the length of a suspension is proportionate to the seriousness of the misconduct. As can be seen from the decisions in the 1990s era, the sanctions in cases that included sexual intercourse with patients ranged from three months to nine months, depending on the facts of each case.

(i) SERIOUS NATURE OF THE MISCONDUCT

45. Dr. Richardson’s conduct was very serious. An aggravating circumstance is the particularly vulnerable condition of Patient X. She sought counselling to deal with previous sexual abuse and incest. There was an unequal power relationship between her and Dr. Richardson, and he took advantage of that. The length of the suspension should reflect an unequivocal denunciation of this conduct. Another aggravating circumstance is Dr. Richardson's lack of candour in communications with the Medical Board.

46. A significant mitigating circumstance is that Dr. Richardson’s misconduct in 1990 was an isolated incident more than 30 years ago. He has admitted the misconduct and has taken responsibility for his actions. He has spared the complainant the burden of testifying in an adversarial process by agreeing to the proposed Settlement Agreement. Given the passage of more than three decades, the College may well have had difficulty proving the allegations in the Notice of Hearing. Dr. Richardson gave up the possibility that those allegations could be dismissed because of prejudice to him from the long delay or that the allegations would not be proven on the balance of probabilities after so much time.

(ii) DETERRENCE OF SIMILAR CONDUCT

47. In deciding on the length of a suspension from practice for sexual misconduct, deterrence of such conduct by the medical practitioner in the future is a significant consideration. In this case, specific deterrence of Dr. Richardson is not a factor. There's no evidence that he needs to be deterred. However, general deterrence is relevant. The length of a suspension for misconduc t should send a message to other medical practitioners that the College will not tolerate sexual misconduct. The six month suspension recommended by Investigation Committee E sends that message. A longer suspension within the three to nine month range of the 1990s standard woul d not necessarily send a stronger message.

(iii) PUBLIC CONFIDENCE IN THE ABILITY OF THE COLLEGE TO REGULATE PHYSICIANS IN THE PUBLIC INTEREST

48. Public attitudes toward sexual misconduct have evolved since 1990. Some members of the public will think that the College should have revoked Dr. Richardson's license to practice or imposed a much longer suspension. However, fair-minded members of the public will recognize that the disposition of this case has to reflect the law as it existed in 1990 and the standards governing tribunals and courts dealing with such issues under the 1990 legal framework. The six month suspension in a proposed Settlement Agreement falls squarely within the legal framework that was in effect when Dr. Richardson engaged in his misconduct.

(iv) REHABILITATION OF THE PHYSICIAN

49. One of the factors that should be considered in assessing the length of the suspension is the likelihood of a physician continuing misconduct. Dr. Richardson has had difficulties with drug and alcohol abuse which led to the revocation of his license in 2011. His reinstatement in 2013 reflects his efforts to rehabilitate himself. He has returned to full-time practice and has been highly regarded by his patients and peers. He has provided further valuable service to the community without other incidents.

50. Within the range of suspensions from practice for similar acts of professional misconduct in 1990, considering the specific facts discussed above, we have concluded that the six month suspension from practice in the proposed Settlement Agreement is proportionate to the seriousness of Dr. Richardson's misconduct.

51. Accordingly, in our opinion, the six month suspension recommended by Investigation Co mmittee E falls within the range of reasonable dispositions in all of the circumstances.

H. EFFECTIVE DATE OF THE SUSPENSION

52. The proposed Settlement Agreement provides that the six month suspension shall be deemed to start on March 17, 2022, when Dr. Richardson went on a medical leave of absence from practice due to the anguish and anxiety that he had experienced arising from this complaint.

53. The Hearing Committee suggested to the parties that the six- month suspension should start on the date of the approval of the Settlement Agreement rather than at the proposed start date of March 17, 2022. In our opinion, an actual six month suspension from practice is necessar y for denunciation and general deterrence of similar sexual misconduct by medical practitioners despite Dr. Richardson's voluntary leave from practice in March.

54. The Registrar and Dr. Richardson agreed with the suggestion, and the Settlement Agreement has been amended accordingly.

I. PERMANENT REQUIREMENT OF A MONITOR

55. The proposed Settlement Agreement includes a provision that Dr. Richardson is permanently required to have a practice monitor for all patient encounters. Paragraphs 13 and 14 of the proposed Settlement Agreement include the following:

> 13. Dr. Richardson accepts that, upon his return to practice, he will be permanently required to have a practice monitor for all patient encounters.
>
> 14. Dr. Richardson shall post a sign in the waiting room and any examination rooms stating that he is to have a practice monitor present for all patient encounters.

56. Previous decisions of the Hearing Committee in sexual misconduct cases have included the requirement of a practice monitor. This requirement is an important method of protecting the public from a repetition of sexual misconduct. However, the condition of a permanent requirement to have a practice monitor present for all patient encounters must be supported by the admitted facts in the proposed Settlement Agreement. In this case, Dr. Richardson's misconduct is an isolated incident of sexual activity with one patient more than 30 years ago. There is no basis for inferring from the admitted facts that there is a risk that he will repeat this misconduct.

57. The College accepts the facts stated in Dr. Richardson's submissions that he had practiced without incident since 2013, when he was reinstated to practice. He has matured, personally and professionally and is no longer the person he was in 1990.

58. The requirement of a practice monitor for all patient encounters would be a considerable burden given the nature of general medical practice. It would likely require the full-time employment of a professional monitor in circumstances where there is no evidence of any risk to his patients. In our opinion this requirement is not necessary in this case.

59. Accordingly, we suggested to the parties that paragraphs 13 and 14 of the proposed Settlement Agreement be deleted. Dr. Richardson and the Registrar agreed with this suggestion. Accordingly, the amended Settlement Agreement was approved by the Hearing Committee in accordance with subsection 103(4) of the Medical Practitioners Regulations.

J. CONCLUSION

60. In our opinion, the proposed Settlement Agreement agreed to between the College and Dr. Richardson, recommended by Investigation Committee E and amended in accordance with Section 103(4) of the regulations falls within the range of reasonable dispositions in all of the circumstances of this case. Accordingly, we accept the amended Settlement Agreement and adopt it as an order of the Hearing Committee.

THIS DECISION made at Halifax, Province of Nova Scotia this ___ day of _______ 2022.

____
Mr. Raymond F. Larkin, QC

____
Dr. Erin Awalt

____
Dr. Michael Teehan

____
Dr. Gisele Marier

____
For Mr. Alonzo Wright

Schedule “A”

PROVINCE OF NOVA SCOTIA)
CITY OF HALIFAX)

IN THE MATTER OF: **The College of Physicians and Surgeons of Nova Scotia**

- and –

IN THE MATTER OF: **Dr. George Richardson**

NOTE: THE COMPLAINANT'S NAME AND ANY INFORMATION THAT MAY REVEAL THE IDENTITY OF THE COMPLAINANT IS SUBJECT TO A PUBLICATION BAN

SETTLEMENT AGREEMENT

Dr. George Richardson, a medical practitioner in the Province of Nova Scotia, and a member of the College of Physicians and Surgeons of Nova Scotia (the "College"), hereby agrees with, and consents to, the following in accordance with the provisions of the *Medical Act*, RSNS 1989, c 278 and the *Medical Act,* SNS 2011, c 38:

I. COMPLAINT TO THE COLLEGE

1. On October 15, 2020, Patient X filed a complaint against Dr. Richardson.

2. Patient X stated that, in or about May to August, 1987 or 1988, she saw Dr. Richardson for a counselling session. During that session, Dr. Richardson began discussing his own personal issues about his wife and children. At the conclusion of the counselling session, Dr. Richardson hugged and kissed her. Patient X stated that she had "maybe 3" appointments with Dr. Richardson like this.

3. Patient X stated that Dr. Richardson called her at home and set up a meeting at a local motel where they had intercourse.

4. Patient X stated that Dr. Richardson then ended the relationship because he was concerned his receptionist was becoming suspicious, and he felt badly and told his wife and another doctor in his clinic.

II. STEPS TAKEN BY INVESTIGATION COMMITTEE

5. Investigation Committee E was responsible for the investigation of this complaint.

6. The Investigation Committee considered correspondence from Patient X, and correspondence from Dr. Richardson responding to Patient X's complaint. In addition, the Committee considered the following:

    - MSI billing information for Patient X from January 1, 1988 to December 31, 1993;

- Dr. Richardson's letter to Dr. Bernie Steele, then Registrar of the Provincial Medical Board of Nova Scotia, dated April 25, 1990;
- An interview of Patient X conducted by investigator Ms. Brenda Kops on behalf of the Committee on January 12, 2021;
- Notice of Action, Statement of Claim, and Notice of Defence filed in the Nova Scotia Supreme Court;
- An interview of Dr. George Richardson held on April 1, 2021;
- An interview of Dr. Cooper Brian Stacey held on May 13, 2021;
- Investigation Report from Progress Investigations dated May 31, 2021; and
- An interview with Dr. John Banks held on July 8, 2021.

7. The Investigation Committee referred the matter to hearing.

III. ALLEGATIONS IN THE NOTICE OF HEARING

8. In the Notice of Hearing, the College made the following allegations:

    1. Dr. Richardson engaged in a sexual relationship with Patient X in 1990. In doing so, he:

        a. contravened sections 3, 26, and 28, of the College-endorsed Canadian Medical Association *Code of Ethics (1986)*; and
        b. engaged in professional misconduct under the *Medical Act*, 1989.

    2. In his April 25, 1990 letter, Dr. Richardson advised the Provincial Medical Board that he was transferring Patient X to a certain, named physician when he had not done so. In doing so, he:

        a. contravened sections 25 and 26 of the College-endorsed Canadian Medical Association *Code of Ethics (1986)*; and
        b. engaged in professional misconduct under the *Medical Act*, 1989.

IV. ADMISSIONS

9. Dr. Richardson makes the following admissions:

    a. Dr. Richardson admits that Patient X was his patient beginning in January 1990. Dr. Richardson admits that Patient X was a vulnerable patient seeking counselling for sexual abuse and incest.

    b. Dr. Richardson admits that he physically embraced Patient X during a counselling session. Dr. Richardson admits that this constituted an error in judgment and inappropriate physical contact with a patient, which was aggravated by the vulnerable nature of Patient X.

    c. Dr. Richardson admits that he had sexual intercourse with Patient X while she was his patient.

d. Dr. Richardson further admits that he told Dr. Bernie Steele, then Registrar of the Provincial Medical Board of Nova Scotia in his April 25, 1990 letter that he had arranged transfer of Patient X to a certain named physician and that physician had agreed to accept the referral. Dr. Richardson had not done so. Dr. Richardson admits that his April 25, 1990 lacked appropriate candour as it omitted important information, specifically that he had had sexual intercourse with Patient X.

V. DISPOSITION

10. Dr. Richardson admits that each of his above actions set out in paragraphs 9(b) and (c) constituted an error in judgment, a boundary violation and an inappropriate breach of the physician-patient relationship. Dr. Richardson admits that his actions constituted professional misconduct under the *Medical Act, 1989*. Dr. Richardson further admits that his actions constituted a violation of sections 3 and 28 of the Canadian Medical Association *Code of Ethics (1986)*:

    3. An ethical physician will ensure that his conduct in the practice of his profession is above reproach, and that he will take neither physical, emotional nor financial advantage of his patient;

    28. An ethical physician will conduct himself in such a manner as to merit the respect of the public for members of the medical profession;

11. Dr. Richardson admits that his actions constituted professional misconduct under the *Medical Act, 1989*. Dr. Richardson further admits that his conduct set out in paragraph 9(d) constituted a violation of sections 25 and 26 of the Canadian Medical Association *Code of Ethics (1986)*:

    25. An ethical physician will recognize that the profession demands of him integrity and dedication to its search for truth and its service to mankind;

    26. An ethical physician will recognize that self discipline of the profession is a privilege and that he has a responsibility to merit the retention of this privilege.

12. Dr. Richardson accepts a 6-month suspension, effective upon approval of the settlement agreement.

VI. COSTS

13. Dr. Richardson agrees to pay costs to the College in the amount of $2,500 inclusive of HST, representing a portion of the College's costs of investigating this matter. These costs shall be payable by Dr. Richardson in monthly instalments of $250 commencing on the first day of September 2022 following the acceptance of the Settlement Agreement by the Hearing Committee.

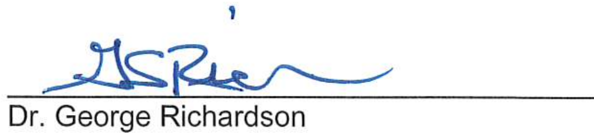
VII. PUBLICATION

14. This Settlement Agreement and any decision rendered by a Hearing Committee approving it, shall, subject to the Publication Ban, be published on the College's website.

VIII. EFFECTIVE DATE

15. This Settlement Agreement shall only become effective and binding when it has been accepted by the Hearing Committee appointed to hear this matter.

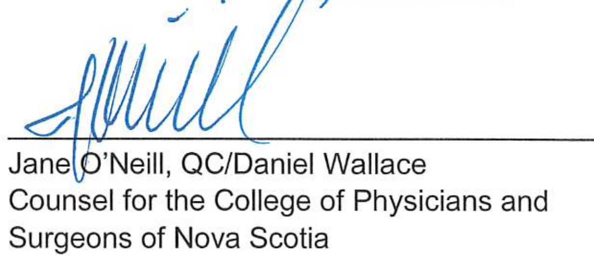
Witness



Dr. George Richardson

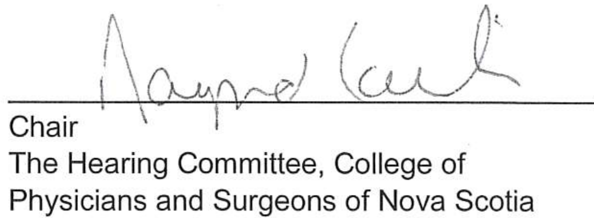
Dated May 11, 2022

Witness



Jane O'Neill, QC/Daniel Wallace
Counsel for the College of Physicians and Surgeons of Nova Scotia

Witness



Chair
The Hearing Committee, College of Physicians and Surgeons of Nova Scotia

Dated May 11, 2022