NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Andre Gagnon, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name and any information that could disclose the identity of the patient referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Gagnon, A. (Re)

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ANDRE GAGNON

PANEL MEMBERS:

DR. R. MACKENZIE (CHAIR)
P. GIROUX
DR. W. KING
DR. E. ATTIA (Ph.D.)
DR. H. SCULLY

Hearing Date:	July 16, 2014
Decision Date:	July 16, 2014
Release of Written Reasons:	August 27, 2014

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on July 16, 2014. At the conclusion of the hearing, the Committee stated its finding orally that the member committed an act of professional misconduct and delivered its penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Gagnon committed an act of professional misconduct:

1. under clause 51(1)(b) of the Code in that the governing body of a health profession in a jurisdiction other than Ontario has found that Dr. Gagnon committed an act of professional misconduct that would, in the opinion of the panel of the Discipline Committee holding the hearing of which this document is notice, be an act of professional misconduct as defined in Ontario Regulation 856/93, made under the *Medicine Act, 1991* ("O. Reg. 856/93"); and

2. under subsection 1(3) of O. Reg. 856/93, in that the governing body of a health profession in a jurisdiction other than Ontario has made a finding of professional misconduct or a similar finding against Dr. Gagnon, and the finding is based on facts which would be an act of professional misconduct as defined in subsection 1(1) of O. Reg. 856/93.

RESPONSE TO THE ALLEGATIONS

Dr. Gagnon admitted the first allegation in the Notice of Hearing, that the governing body of a health profession in a jurisdiction other than Ontario has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of misconduct as defined in the regulations. Counsel for the College withdrew the second allegation in the Notice of Hearing.

FACTS AND EVIDENCE

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

PART I - FACTS

1. Dr. Gagnon is a psychiatrist who obtained his medical degree from the Laval University in 1976, and a fellowship in psychiatry with the Royal College of Physicians and Surgeons of Canada in 1980. He has had a certificate of independent practice from the College of Physicians and Surgeons of Ontario ("CPSO") since February, 1980. He focuses his practice on child and adolescent psychiatry.

2. Dr. Gagnon was Patient A's psychiatrist from April 1994, when she was 14 years old, until February 2009 when Patient A was 28 years old. Dr. Gagnon's treatment of Patient A and interactions with Patient A took place in Québec, where he practices medicine.

3. Patient A was a vulnerable patient with mental health issues that are difficult to treat.

4. Between 2003 and February 2009, Dr. Gagnon violated therapeutic boundaries with Patient A. He also failed to take into account his own capacities and limitations in treating her, in particular between 2003 and 2009.

5. In October 2011, Dr. Gagnon was found guilty by the Collège des médecins du Québec ("CMQ"), the regulatory body for physicians and surgeons in Québec, of having breached the *Code of Ethics of Physicians* in relation to his conduct with and treatment of Patient A. First, Dr. Gagnon was found to have transgressed the limits of the professional relationship, in particular after resuming psychotherapy with Patient A in 2003, and to have abused his position of authority with a

vulnerable young person. In particular, he failed to remain neutral and independent, and failed to reinforce respect for a strictly therapeutic environment. He thereby breached and violated therapeutic boundaries, in an increasingly serious and intense manner, and allowed an emotionally intimate relationship with physical proximity to develop. This was similar to a "father-daughter type of relationship". In particular, Dr. Gagnon:

(i) exchanged a large number of emails with Patient A, which were not or were barely mentioned in her medical file. Many were clearly personal in nature;

(ii) discussed his own personal matters and marital situation with Patient A;

(iii) went out with Patient A after consultation hours, in particular to the movies, and provided therapy sessions at home;

(iv) offered Patient A gifts;

(v) was affectionate towards Patient A, including by holding her hands, hugging, and caressing her;

(vi) visited Patient A at her apartment, in particular to prepare and have a meal with her;

(vii) had Patient A do volunteer work, in particular assisting Dr. Gagnon to prepare for a symposium and do garden work at his home;

(viii) allowed Patient A to live in Dr. Gagnon's family home for several months between the time of his own marital separation and a new relationship.

6. Dr. Gagnon was also found to have failed to take into account his own capacities and limits, in particular during the period from 2003 to 2009. He failed to consult with a colleague or to take into account a colleague's opinion regarding his diagnosis and therapeutic approach for Patient A. Dr. Gagnon failed to refer Patient A to a colleague or other health professional, in particular after May 2008, although she was not making progress in regards to her condition. Dr. Gagnon consulted a colleague who treated his own distress with the situation.

7. The CMQ found that Dr. Gagnon's relationship with Patient A was without any sexual connotation.

8. Attached at Schedule "A" and forming part of this Agreed Statement of Facts and Admission is a copy of the CMQ's decision which was issued in French. Attached at Schedule "B" and forming part of this Agreed Statement of Facts and Admission is a copy of the CMQ's decision translated into English.

PART II - ADMISSION

9. Dr. Gagnon admits the facts set out above and admits that he has committed professional misconduct, in that the governing body of a health profession in a jurisdiction other than Ontario, namely the CMQ in Québec, has found that Dr. Gagnon committed an act of professional misconduct that would be an act of professional misconduct as defined in Ontario Regulation 856/93, made under the *Medicine Act, 1991*.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Gagnon's admission and found that he committed an act of professional misconduct under clause 51(1)(b) of the Code, in that the governing body of a health profession in a jurisdiction other than Ontario has found that he committed an act of professional misconduct that would, in the opinion of the panel, be an act of misconduct as defined in O. Reg. 856/93.

AGREED STATEMENT OF FACTS REGARDING PENALTY

The following facts were set out in an Agreed Statement of Facts Regarding Penalty and presented to the Committee:

1. Dr. Gagnon has no disciplinary history in Ontario. In its decision, the Collège des médecins du Québec ("CMQ") observed that he had no history of disciplinary

action in 31 years of practice in that province.

2. In June 2010, the Board of Directors of Hospital 1 in City X considered Dr. Gagnon's conduct in relation to Patient A. The Board issued a written reprimand to Dr. Gagnon, instructed him to continue ongoing therapy and training in boundary issues, and ordered that he undergo monitoring by his Chief of Department for one year. Dr. Gagnon has undergone continuing therapy, has taken a course entitled "Relentless Hope: The refusal to grieve" offered by the Centre for Treatment of Sexual Abuse & Childhood Trauma in City Y, and underwent a year of monitoring at the hospital.

3. Dr. Gagnon pleaded guilty to professional misconduct before the CMQ, which accepted a joint submission as to penalty. As a result, the CMQ ordered that Dr. Gagnon be suspended for a period of three months, and that Dr. Gagnon publish, at his own expense, a notice of the CMQ decision in a newspaper in the area where he practised. He was also ordered to pay costs of the proceeding against him. Dr. Gagnon served his suspension from practising medicine in Québec between November 14, 2011 and February 14, 2012.

4. In its decision, the CMQ relied on a psychiatric expert report which described Dr. Gagnon as having been overwhelmed by events in dealing with a patient with extreme needs. The CMQ stated that it found it reassuring that the psychiatric expert found that Dr. Gagnon did not "have any judgment disorder" and that the risk that Dr. Gagnon would "commit similar acts again seems very low, in the short, medium or long term".

5. Dr. Gagnon advised the College of the status of the proceedings against him in Québec and, when allegations against him were referred to the Discipline Committee, he waived the Pre-Hearing Conference and his right to disclosure in order to proceed with the discipline hearing on the basis of his admission of professional misconduct.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order, the terms of which include a requirement to complete a College-approved boundaries course, a reprimand and costs to the College for a one-day hearing at the tariff rate. The Committee is aware of the legal standard that a jointly proposed penalty should be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

In considering the appropriateness of the jointly proposed penalty, the Committee considered the nature of the misconduct and its consequences to the public and the profession. The Committee was also mindful of the principles which underlie the crafting of a suitable penalty. These are: protection of the public, the need to maintain the integrity of the medical profession and public confidence in its capability for self-regulation, specific and general deterrence and, where appropriate, rehabilitation of the member.

The Committee reviewed carefully the decision of the CMQ and noted that Dr. Gagnon's offence was serious in that it involved an exceptionally vulnerable patient and a prolonged period of boundary violations. As a mitigating factor, the Committee noted that Dr. Gagnon had, in 31 years of practice, no other history with either the CMQ or this College. It was also noted that Dr. Gagnon had served a significant penalty imposed by both the CMQ and the hospital where he practised.

While Dr. Gagnon does not currently practise in Ontario, he continues to hold a licence enabling him to do so. The Committee found that it was appropriate that, if Dr. Gagnon should decide to establish a future practice in Ontario, he be able to demonstrate that he has undergone a similar process of rehabilitation to that which might be ordered for an Ontario physician in similar circumstances, in addition to the rehabilitation which he has already undertaken.

In addition, while the Committee is aware that Dr. Gagnon was reprimanded by the CMQ, it agreed, as jointly submitted, that a second reprimand was justified to

demonstrate to Dr. Gagnon that his behaviour is equally unacceptable to his colleagues in Ontario. It will also serve to remind Ontario physicians of the need to maintain appropriate therapeutic boundaries.

The Committee found that the order of costs of $4,460 to the College, representing a partial recovery on the costs of conducting the hearing, is appropriate. The Committee therefore accepted the joint submission and made the following order.

ORDER

The Discipline Committee delivered its finding and penalty and costs order in a written Order at the conclusion of the hearing on July 16, 2014, the terms of which are the following:

1. Dr. Gagnon has committed an act of professional misconduct under clause 51(1)(b) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, in that the governing body of a health profession in a jurisdiction other than Ontario has found that Dr. Gagnon committed an act of professional misconduct that would be an act of professional misconduct as defined in Ontario Regulation 856/93, made under the *Medicine Act, 1991*.

2. The Registrar impose the following terms, conditions and limitations on Dr. Gagnon's certificate of registration:

    a. Dr. Gagnon shall successfully complete, at his own expense and before the end of 2015, education approved by the College regarding boundaries in the doctor-patient relationship.

3. Dr. Gagnon appear before the panel to be reprimanded.

4. Dr. Gagnon to pay the College its costs of this proceeding in the amount of $4,460.00 within thirty (30) days of the date of this Order.

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