NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Iscove, this is notice that the Discipline Committee ordered a ban on the publication, including broadcasting, of the name of the witnesses and any information that could identify the witnesses whose testimony is in relation to allegations of misconduct of a sexual nature involving the witnesses, under subsection 47(1) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

This is also notice that the Discipline Committee ordered a ban on the publication of the name and any information that could disclose the identity of the patients who are referred to orally at the hearing or in written exhibits filed at the hearing under subsection 45(3) of the Code.

> Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:
>
> Every person who contravenes an order made under … section 45 and 47… is guilty of an offence and on conviction is liable,
>
> (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
>
> (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Iscove, 2018 ONCPSD 9

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) f 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. MELVYN LAWRENCE ISCOVE

PANEL MEMBERS:

DR. E. STANTON (CHAIR)
MR. P. GIROUX
DR. J. WATTS
MS D. GIAMPIETRI
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS B. DAVIES
MS S. SULEVANI

COUNSEL FOR DR. ISCOVE:

MR. A. KWINTER
MS V. MARSON

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. MCALEER

Hearing Dates:	June 12, 13, 26-30 and September 5, 2017
Finding Decision Date:	March 8, 2018
Release of Written Reasons:	March 8, 2018

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 June 12, 13, 26 to 30, and September 5, 2017. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

The Notice of Hearing alleges that Dr. Melvyn Lawrence Iscove committed an act of professional misconduct:

1. under clause 51(1)(b. l) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18, in that he has engaged in the sexual abuse of patients; and

2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO ALLEGATIONS

Dr. Iscove denied the allegations in the Notice of Hearing.

SUMMARY OF THE CASE

Dr. Iscove is a psychiatrist who practises psycho-analysis in Toronto. He has a special interest in the treatment of patients with problems related to homosexuality, to which he applies the theories of Dr. Edmund Bergler; these theories treat homosexuality as a condition dating to infancy, which is amenable to therapy.

It is important to note at the outset that this case is not about the standard of practice of the profession. Although Dr. Bergler's theories and Dr. Iscove's use of these theories in his practice are controversial, there was no allegation in this case that Dr. Iscove failed to maintain the standard of practice of the profession, and the Committee's findings in this case are in no way related to any views that members of the Committee may have with respect Dr. Bergler's teachings. The Committee refers to these theories and their use by Dr. Iscove in his treatment of each complainant as it was part of the context in which the alleged sexual abuse occurred and the dynamics that were present in the relationship between Dr. Iscove and each of the complainants.

Allegations of sexual abuse arose from the complaints of two men, Patient A and Patient B, who had each been patients of Dr. Iscove for 18 and 23 years, respectively. Both had presented as young adults with concerns that included homosexual fantasies. Each alleged that after several years of analysis, Dr. Iscove engaged them in mutual masturbation and oral sex during their appointments for therapy. Both patients continued to see Dr. Iscove after the sexual activity ended and did not bring their complaints until several years after their doctor-patient relationships ended.

In addition to the allegation of sexual abuse, it is alleged that Dr. Iscove engaged in non-sexual boundary violations, of a financial and social nature, with each of the complainants.

THE ISSUES

A. Allegations with respect to Patient A:

1) Did the events, specifically the sexual acts, alleged by Patient A occur as described, and if so, did they constitute sexual abuse?

2) Did Dr. Iscove engage in disgraceful, dishonourable or unprofessional conduct in his boundaries, his communications and his relationship with Patient A?

B. Allegations with respect to Patient B:

1) Did the events, specifically the sexual acts, alleged by Patient B occur as described, and if so did they constitute sexual abuse?

2) Did Dr. Iscove engage in disgraceful, dishonourable or unprofessional conduct in his boundaries, his communications and his relationship with Patient B?

THE EVIDENCE

Patient A

Patient A was in his forties at the time of the hearing. He first became a patient of Dr. Iscove when he was in his early twenties. He was referred to Dr. Iscove by a psychologist to whom he had presented with depression and anxiety associated with fears that he was gay. From the outset of treatment, he was introduced by Dr. Iscove to the concepts propounded by Dr. Edmund Bergler, starting with a book entitled "Homosexuality: Disease or Way of Life." Dr. Iscove provided Patient A with many other books and papers by Dr. Bergler over the course of years. In a list of 23 books written by Dr. Bergler, Patient A was able to identify 16, which he had been given or loaned by Dr. Iscove; he had read all or much of these books.

From these resources, Patient A understood that Dr. Bergler (and Dr. Iscove) believed that "a male homosexual is a person who predominantly uses the unconsciously based defence mechanism of man-man relationships to escape his repressed masochistic attachment to his mother, and who shows in his personality the mechanism of the injustice collector" (p.194 of Counterfeit Sex; homosexuality, impotence, Frigidity E Bergler 1958; Exhibit 5). In the same source, Dr. Bergler describes 20 tell-tale indices of homosexuality, virtually all of which are negative traits such as "provocation," "pseudo-aggression," "constant dissatisfaction," "megalomaniacal conviction of being special," "hyper-narcissism," and hyper-superciliousness." Patient A testified that these phrases

formed a repeated component of his therapy as did the phrase "there is no such thing as a happy homosexual." Patient A understood that homosexuality, according to Dr. Bergler, was a "clinically curable condition through psychoanalytic treatment, with excellent chances of cure." When he initially engaged in therapy with Dr. Iscove, he was very interested in the idea that he could be cured of his homosexual thoughts and feelings.

Patient A's appointments were initially two or sometimes three times per week, and at each appointment, he would discuss major events in his life, and feelings about other people and about Dr. Iscove. At almost every appointment, there were discussions about Patient A's dreams and fantasies, including any fantasies that he might have had about Dr. Iscove. Even if Patient A did not spontaneously refer to fantasies about Dr. Iscove, Dr. Iscove would ask directly about fantasies specifically involving the doctor.

Patient A understood from Dr. Iscove that he was the only psychiatrist who was available to discuss and treat these fantasies and that Dr. Iscove was the only available source for this sort of help. Dr. Iscove told Patient A that for this reason, he was very fortunate to have the availability of Dr. Iscove's help. Dr. Iscove also cautioned Patient A that he should not talk to other people about the therapy, because they would be unable to understand the basis for it.

Patient A was able to describe the physical lay-out of Dr. Iscove's office. In particular, he described the precautions that Dr. Iscove took to maintain confidentiality; there was no reception area or receptionist. The main entrance led into a corridor on one side of which was the waiting room, which Patient A was instructed to enter and ensure the door was closed. On the opposite side of the corridor was Dr. Iscove's office from which Dr. Iscove would come to invite Patient A into his office.

Patient A testified that on only about five occasions in 16 years did he see either the previous patient or someone whom he believed to be the next patient. He had no memory of meeting Patient B and did not speak to any of the small number of patients that he saw. He denied any meeting or communication of any sort with Patient B either when he was a patient of Dr. Iscove, or subsequent to the cessation of his attendance for therapy. He was unaware of the nature of Patient B's complaint, although he had been told his name by

counsel on the day before the start of the hearing. Patient A also stated that he had not spoken to or communicated with other patients of Dr. Iscove.

Patient A testified that during their doctor-patient relationship, he admired Dr. Iscove and considered him as a father figure. He testified that he felt free to call him at any point and felt he could rely on Dr. Iscove's advice about almost every aspect of his life. However, he also said that some of Dr. Iscove's enquiries about his fantasies about the doctor made him feel uncomfortable, and that talking about his sexual fantasies was associated with a lot of shame. His understanding was that these were important disclosures for the purposes of therapy. Patient A testified that at times, he felt pressure to respond in a way that he thought Dr. Iscove expected and would say what he thought Dr. Iscove wanted to hear. Patient A denied that these were romantic fantasies but said that he loved Dr. Iscove as a father.

Patient A testified that on a date between the end of 2001 and the beginning of 2002, Dr. Iscove offered Patient A a hug at the end of an appointment. Patient A accepted and Dr. Iscove walked round his desk and they embraced. According to Patient A, this recurred on two or three appointments, during which Dr. Iscove would ask "what are you thinking you want to do?" and subsequently said "you may touch me if you like." Patient A then touched Dr. Iscove's erect penis through Dr. Iscove's trousers. The sexual activity subsequently progressed to Dr. Iscove removing his penis from his trousers, then Patient A doing the same. This progressed on later occasions to mutual masturbation and oral sex. Patient A estimated that such activity occurred on between 10 and 20 occasions with oral sex occurring on one-third of the episodes. On one occasion only, he remembered removing his clothes. Patient A admitted that he had not mentioned this in his statement to the College but said that the memory had come to him only recently and was prompted by his remembering that he had felt nervous about displaying his appendectomy scar.

Patient A was married at that time and he recounted feeling a mixture of shame, guilt and arousal. Neither he nor Dr. Iscove discussed the sexual activity directly, nor was the subject of how it related to the analytic process or theory addressed by either of them.

Patient A was uncertain about the date on which the sexual activity ended, although he thought it was in 2005; he was unable to say how the cessation came about. He testified he believed he said to Dr. Iscove that he did not want it to continue and that the sexual activity stopped after this. He did not remember discussing stopping in any greater detail and said, "It just stopped." Patient A was clear that he continued to see Dr. Iscove after the sexual activity had ended.

Patient A explained that he had never committed anything about the sexual activity to paper or to an e-mail at the time of the experience because he was simply not willing or too ashamed to do so.

Patient A gave evidence of a number of activities and interactions with Dr. Iscove which appeared to extend beyond the conventional physician-patient psycho-therapeutic relationship. He testified that in 2004, he awoke with pain. He called Dr. Iscove, who took him to Hospital where he had a surgery. In Patient A 's earlier statement to a College investigator, he had said that he had called Dr. Iscove from the hospital and that Dr. Iscove had come in to the hospital to see him. Patient A said that he felt free to discuss medical issues that were outside the usual realm of psycho-analysis and referred to e-mails from Dr. Iscove that addressed issues of depression and the use of anti-depressants, the role of diet, specifically salt, and general health and talks on the "role of magnetic resonance stimulation and wellness." A volume of e-mails between Dr. Iscove and Patient A from 2007 to 2010 was entered as an exhibit. In addition to the health-related e-mails referred to above, these e-mails referred to several other subjects, including:

- photographs of a trundle bed owned by Dr. Iscove, sent at a time when Patient A needed to buy a bed for his family member. It was unclear whether this was sent as an example of such a bed (as testified by Dr. Iscove) or was an offer to sell or give the item to Patient A. There was no evidence of a price in the e-mails and Patient A did not recall receiving such a bed from Dr. Iscove.

- a rabbinical sermon on "Forgiveness".

- a series of photographs of "Oriental" rugs. These are accompanied by comments from Dr. Iscove such as "Let me know if the colours suit your tastes" and "Does this sort of size and pattern suit your purposes? I would need to know the width of your space." The e-mails were sent at a time when Patient A needed a rug, although he did not receive one from Dr. Iscove.

- Several e-mails from Dr. Iscove in Israel with photographs of Dr. Iscove's newborn grandchildren and family members.

- e-mails regarding Dr. Iscove's Google search for the subject "Mr. C homosexual" at a time when Patient A had separated from his wife. Patient A had told Dr. Iscove that she was going out with a man of this name. In the e-mails, Dr. Iscove asks: "What do you make of the body language, speech pattern, gestures etc?"

- an e-mail from the late 2000s, in which Patient A asks about the availability of an apartment in another city. Patient A testified that this referred to an apartment owned by the Bergler Foundation, at which Patient A and a friend stayed for a weekend. This was arranged by Dr. Iscove in his role on the board of the foundation.

- A series of e-mails about operatic productions. In one of these e-mails in the late 2000s, Dr. Iscove invited Patient A and a friend to a working rehearsal of the opera as Dr. Iscove's guest as a President's Council member. Patient A attended the rehearsal, sitting with several other guests of Dr. Iscove, including another psychiatrist. When Patient A expressed concern about disclosing that he was a patient of Dr. Iscove, Dr. Iscove suggested that he could lie about that fact.

In addition, Patient A testified that he undertook research on behalf of Dr. Iscove. The research consisted of searching in journals and books for evidence of articles or reviews that were or may have been written anonymously by Dr. Bergler. Patient A testified that this was done to support Dr. Iscove's interest in ensuring the optimization of Dr. Bergler's bibliography and thereby the recognition of Dr. Bergler's theories. Dr. Iscove denied that he had ever asked Patient A to do this and suggested that it was done spontaneously by

Patient A. Patient A was uncertain if he had been asked directly by Dr. Iscove but was clear that Dr. Iscove never dissuaded him from doing the research.

Patient A reported the sexual relationship to the College after disclosing it to a psychiatrist to whom he had been referred by an earlier therapist. Although he had disclosed the sexual relationship to the first therapist, he had declined to name Dr. Iscove because he was aware of her [the therapist's] reporting obligations and did not want to get Dr. Iscove into trouble. At that time, he viewed the sexual interactions with Dr. Iscove as a mistake by an otherwise supportive and admired person. Patient A did not initially disclose the name to the second therapist (the psychiatrist) but did so after working through his feelings during the process of therapy.

Patient A denied that the disclosure was prompted by anger towards Dr. Iscove. He stated it was prompted by a concern that other patients might be similarly affected. He admitted to having feelings of anger toward Dr. Iscove, but also said that he still has feelings of admiration and gratitude for Dr. Iscove's help. Patient A also said that he had feelings of disappointment both at the events themselves and by Dr. Iscove's denial. Patient A also had conflicted feelings about Dr. Iscove's attempts to cure him of homosexuality (which he now openly admits is his accepted sexual identity). He described some feelings of anger, but also said that he understood that in 1991, it was a more acceptable view for therapy than it might be today, that the process allowed him to maintain a heterosexual marriage for a period of time and allowed him the benefit of having children.

Patient B

Patient B is in his forties. He became a patient of Dr. Iscove at about the age of 18 and continued to see him from late 1980s to 2011. His parents had recommended that he see Dr. Iscove for his feelings of depression and anxiety. He was initially hesitant to do so for reasons which he did not describe, but eventually agreed to see Dr. Iscove in order to help in his transition to university. Patient B denied that he had any concerns about his own sexuality before seeing Dr. Iscove. He said his relationships had been entirely heterosexual in nature at that time.

Patient B described Dr. Iscove's office in much the same detail as did Patient A and described Dr. Iscove paying particular attention to explaining the importance of privacy and the way in which this was maintained by keeping the waiting room door closed until Dr. Iscove invited him as the next patient into the office. He remembered seeing other patients on one or two occasions in the entire 23 years that he was Dr. Iscove's patient. Patient B said that he knew three other patients of Dr. Iscove, as a result of being friendly with their families. However, he was unaware of the name of the other complainant and had not met or talked to him.

Patient B confirmed that throughout his therapy with Dr. Iscove, he was encouraged to read material by Dr. Bergler and was aware that this was the basis for his treatment by Dr. Iscove. Patient B testified that Dr. Iscove raised the issue of Patient B 's feelings about homosexuality at every appointment, even though he did not think of himself as gay and had no physical relationships with other men. Despite this apparent conflict in their underlying beliefs, Patient B testified that he developed a trusting relationship with Dr. Iscove. He relied on Dr. Iscove to make decisions for him and found Dr. Iscove to be helpful in advising him, for example, in avoiding self-destructive behavior with alcohol. Patient B also felt that Dr. Iscove was supportive and helpful in his desire to further his career. As a consequence, he said he believed that he wanted to impress Dr. Iscove and show himself to be a "good patient."

Patient B testified that at every appointment, Patient B was encouraged to describe his fantasies and dreams, especially with respect to homosexual feelings. He said that although he was reluctant to disclose details at first, he concluded that it was easier to respond to these requests from Dr. Iscove and fully engaged in analysis of his fantasies. He testified this usually took the form of identifying any homosexual fantasies as being masochistic elaborations of his masochistic parental relationships. Fantasies that involved heterosexual relationships were identified by Dr. Iscove as being a way of denying his homosexuality. Patient B firmly believed that Dr. Iscove was attempting to "cure" his homosexuality. When Patient B was describing his fantasies, Dr. Iscove would frequently ask "what are you not telling me" and would ask about penis-sucking fantasies and masturbation if Patient B did not volunteer them. Patient B testified that Dr. Iscove would

ask at almost every appointment whether Patient B was having fantasies about Dr. Iscove himself; Patient B said that he did have sexual fantasies about Dr. Iscove, and that these made him feel uncomfortable. He expressed this discomfort to Dr. Iscove without taking any other action. He said he felt that he needed to continue to see Dr. Iscove because of an emotional dependence on Dr. Iscove as his therapist.

Patient B testified that at some point in approximately 2007, he and Dr. Iscove began engaging in sexual activity; there were about 12 episodes of sexual contact. He had been engaged in an extra-marital affair, and on ceasing this, he began to wonder if he was indeed homosexual. He considered beginning a homosexual affair with an unspecified male. After discussing this with Dr. Iscove, who persuaded him that a random partner was undesirable, Dr. Iscove made it known that he, himself, would be available. Patient B described Dr. Iscove coming around his desk to the patient's side and initiating mutual handling of each other's penis through their clothes. On subsequent occasions, the contact progressed to mutual oral sex with both parties ejaculating. They did not completely undress, but Patient B said that they removed their shirts on one or two occasions. On one visit, Patient B brought a condom with him, and asked Dr. Iscove to penetrate him anally, which Dr. Iscove did. Patient B testified that this only happened once.

The final three episodes occurred at Dr. Iscove's house, after Dr. Iscove suggested that they meet there. Patient B testified that on the last occasion, he saw his own reflection in a mirror in Dr. Iscove’s bedroom. He said he felt that "he did not belong there" (i.e., in that relationship) and this prompted him to decide to end the sexual activity. There was a gap in the doctor-patient relationship after January 2008, but Patient B went back again to Dr. Iscove in 2011, with concerns about his response to the death of a family member.

Patient B described his reaction to the sexual activity as conflicted. On occasion, he enjoyed the sexual aspect, but on others, such as when they were kissing, he did not enjoy the activity. His main concern was to maintain the therapeutic relationship because of Dr. Iscove's role as a father figure to him. However, part of the impetus to end the sexual activity was that the therapeutic component of the relationship was declining.

Patient B first disclosed the sexual activity with Dr. Iscove to a life coach after an encounter in a course with an individual whose condescending manner, he felt, reminded him of Dr. Iscove. The coach advised him to contact the College, but he did not wish to do so. He still felt that Dr. Iscove had tried to help him and still felt loyal to him, although he admitted that there were times he also felt angry about Dr. Iscove. Patient B later told his relative, who was angry about the events. Finally, in 2012, he disclosed the episodes to a psychiatrist whom he was seeing for depression. This psychiatrist reported the disclosure to the College, much to Patient B's distress. He did not wish to proceed with a complaint at that time out of concern for his own privacy. It was only after hearing later from the psychiatrist that there had been another complaint made about Dr. Iscove that he was willing to allow his own complaint to go forward.

Patient B testified that he remains conflicted by his feelings about Dr. Iscove, and by the contrast between viewing him as a helper versus having been taken advantage of by Dr. Iscove. He described feelings of sympathy for Dr. Iscove and his family, but also said "it happened and it's time for him to come clean about it." Patient B admitted to feelings of anger about having "wasted time on treatment for a condition that I don't have" and having opted for psychotherapy now that he knows that anti-depressant pharmacotherapy has produced such an improvement in his state of mind. However, it was clear to the Committee from his testimony that this anger is directed as much at himself as at Dr. Iscove.

Patient B provided e-mails, as had Patient A, referring to activities of a non-sexual nature that involved Dr. Iscove to a degree that appeared to extend beyond an appropriate physician patient relationship. These included:

- e-mails regarding an apartment in another city owned by the Bergler Foundation and administered by Dr. Iscove, at which Patient B had stayed for a small amount of money.

- e-mails regarding the treatment of a medical condition at a time when Patient B 's family member was ill. These included complimentary medicine therapy for the medical condition, the removal of dental amalgams for ameliorating the condition,

and referral of Patient B 's family member to an experimental treatment centre. Patient B testified that Dr. Iscove sold him an electromagnetic device for the treatment of his family member's medical condition for $4000. Dr. Iscove also sold him a juicer when Patient B was trying a raw food diet (the rationale for this was not the subject of testimony).

- e-mails with photographs of Dr. Iscove's grandchild.

- There were also e-mails from Patient B to Dr. Iscove detailing Patient B 's various experiences when on holiday, including details of sexual activities and fantasies. Patient B described these as alternatives to his regular therapy appointments during his absence.

Patient B admitted that none of the e-mails contained any reference to the alleged sexual activities. Moreover, he said there had never been any written documentation such as a diary, personal annotations or letters to other people that mentioned the allegations. Patient B testified that these were not the sort of activities that he would commit to paper, particularly in the light of Dr. Iscove's admonitions not to disclose material that was discussed in therapy to others, even his own family. Patient B also admitted that there were discrepancies in the dates he had given (or that others said he had given) about the sexual encounters. For example, he had told the psychiatrist who had informed the College that they occurred in 2009, but he had no appointments that year. His relative had written to the College that he was in his thirties at the time (which would put the events in 2000). In interviews with College investigators, he had said that sexual encounters occurred "a dozen to 20 times" and "a couple of dozen times," while in his oral testimony he used the phrase "several to a dozen times".

Dr. Iscove

Dr. Iscove is a 72-year-old psychiatrist. He received his MD from the University of Toronto in 1969. He completed a psychiatry residency in Albany, NY, and became a Fellow of the Royal College and a specialist in psychiatry in 1974.

Dr. Iscove testified that he first became interested in the analytic theories of Dr. Edmund Bergler during his pre-medical years, and was mentored by another follower of Dr. Bergler, Dr. Benjamin Winthrop. Dr. Iscove's practice has always focused on psycho-analysis; he said that he was using this approach even during his residency. He stated that although the basis of his analytic practice was Freudian, he "picked up where Freud left off," by focusing on events during infantile adjustment to the new extra-uterine environment. During this period, changes from the security of the womb to experiencing a broad range of unwanted negative emotions such as hunger, to which the infant may respond with anger particularly directed at the mother. This anger is manifested by making displeasure more pleasurable, a condition called psychic masochism. This making of self-damaging behaviour into a positive experience is, in the Berglerian view, the basis for all neurosis.

Dr. Iscove described his patient population as specifically excluding patients with psychosis, but otherwise consisting of a range of problems such as marital conflict, and “sexual disorders,” such as frigidity, over-sexuality and homosexuality. Dr. Iscove also sees a group of patients with academic problems, teaching them to overcome blockages in their learning. This group of patients he characterized as creative and artistic individuals, whom he finds particularly receptive to the analytic approach.

Dr. Iscove confirmed that he made significant use of books and papers by Dr. Bergler, which his patients are expected to read and discuss with him. (The books are owned by the Bergler Foundation, of which Dr. Iscove is the administrator. The Foundation also owns an apartment in another city, which was used by both complainants.) When he was cross-examined about the content of Dr. Bergler's writings, he was referred to a number of passages. These included the following:

> "All attempts to prove homosexuality to be anything but an illness had in my opinion failed...homosexuality is an unconscious and trouble-making defence mechanism and has to be viewed in the same way as other neurotic and troublemaking defences"

> "There are no happy homosexuals and there would not be even if the outer world left them in peace.... The amount of conflict of jealousy, for example, between homosexuals surpasses everything known even in bad heterosexual relationships"

Dr. Iscove's response to these and other examples from Dr. Bergler's works was discursive, and at times prevaricating. He generally tried to soften the effect of these passages but in the end, endorsed or at least accepted them. Dr. Iscove admitted that Dr. Bergler's works dated from several decades earlier and said that he and Dr Winthrop were the only practitioners who still used this approach with homosexual patients.

Dr. Iscove agreed that he played a role in influencing his patients, although he denied that this was a major role. He denied giving advice to his patients. Rather, he said that he made statements of fact that they might benefit from. For example, when asked by Patient B whether he should postpone a planned trip, Dr. Iscove's response was, "It would be better if you were not a homosexual when you go on that trip."

In discussing his treatment of patients with issues of homosexuality, Dr. Iscove was unwilling to agree with the College's suggestion to him that he characterized homosexuality as an illness and he would not agree that he characterized their treatment as being curative. He stated that these patients only became responsive to his therapy when they were ready to fight it (i.e., the homosexuality). He admitted that the majority of patients who came to him with issues of homosexuality did not stay the course; on the other hand, only a small proportion of patients who remained in long-term therapy and who showed clear evidence of wanting to fight their homosexual urges, subsequently went back to their homosexual lifestyles. He said that this was the case in one to two patients out of the 35 per month that he saw. Dr. Iscove felt that he had good relationships with his patients and commented that "only the paranoid complain about me."

Dr. Iscove was questioned at length about his own sexual experiences and denied any homosexual activity at any stage. He provided detailed evidence about all of his past heterosexual relationships.

When discussing his patient encounters with the two complainants, Dr. Iscove had the benefit of referring to his patient records, which were written in an abbreviated format at the time of the encounter. These patient records had been transcribed into a typed format (with abbreviations still intact) by Dr. Iscove over an 18-month period prior to the hearing.

With respect to Patient A, Dr. Iscove confirmed the testimony given by Patient A that at each appointment, there would be discussion of the patient's homosexual thoughts, feelings and specific fantasies, including the fantasies that the patient was having about Dr. Iscove. He confirmed that if Patient A denied fantasies, Dr. Iscove would commonly ask him what he was hiding from him or would react by saying, "Don't lie." The fantasies that were discussed would include any fantasies prior to the appointment, or those in the waiting room or during the therapy session itself. Dr. Iscove described Patient A as evasive in his disclosure during therapy. By this, he said he meant that he [Patient A] was deliberate in his lack of disclosure rather than simply unwilling to mention issues. Dr Iscove's explanation of this difference was not easy to understand and was accompanied by a series of examples of questionable relevance.

Much of Dr. Iscove's testimony about Patient A confirmed the account given by Patient A himself. Issues such as discussions about Patient A 's marriage, and their conversations about the birth of Patient A's child, were common to each, and although there were differences in nuance and timing of their conversations about Patient A 's variable unwillingness to accept that he was gay, both agreed that disagreements on this issue were a common component of their therapeutic discussions.

There was disagreement about the sequence of events at the time of Patient A 's admission to hospital. Dr. Iscove stated that he received a call from Patient A who was at home and drove him to the hospital where he ensured that Patient A was seen promptly; Patient A had testified that he telephoned Dr. Iscove from the hospital emergency room, and that Dr. Iscove arrived later. Dr. Iscove was also clear that he had not sold items such as carpets and a bed to Patient A and that the e-mails showing these items were examples only. Patient A was uncertain whether he had actually purchased any of them. Dr. Iscove

also denied that he had ever requested or suggested that Patient A do the research that Patient A had described, of looking for potential reviews by Dr. Bergler. He stated that Patient A had raised the subject initially, and that although they discussed the work at one point, this was because Dr. Iscove thought that Patient A was using the visits to the library as a means of meeting other homosexuals, a motive which Patient A denied.

Dr. Iscove also agreed that he had invited Patient A to the opera rehearsals described by Patient A, and that he had enabled Patient A to stay at the apartment in another city, although he described the costs as nominal.

Dr. Iscove and Patient A were in accord as to the descriptions of the office where appointments occurred, and the arrangements that were in place to maintain privacy. Dr Iscove described two occasions when Patient A described to him seeing another patient. Dr. Iscove suggested that Patient A could have been referring to Patient B. Over the course of eleven years from 1991 to 2002, there were 23 occasions in Dr. Iscove's appointment book when Patient B and Patient A had back to back appointments and could conceivably have met one another. All except two occasions were between 1991 and 1996, several years before the alleged sexual acts and many years prior to the complaints being made.

The records and Dr. Iscove's testimony with respect to Patient B were also predominantly consistent with Patient B 's testimony with respect to the frequent discussions of fantasies and analysis thereof. It was not until the eighth appointment in the late 1980s that Patient B acknowledged that he was relieved to be discussing issues of homosexuality. A pattern of denial and accepting homosexuality continued for several years thereafter. Dr. Iscove considered that Patient B was in denial about his homosexuality and used both his heterosexual fantasies and his heterosexual relationships as a camouflage for guilt about his homosexuality. In the late 1980s, Dr. Iscove noted the presence of lisping and drawling vowels which, together with increasing numbers of fantasies, he interpreted as evidence of homosexuality.

Dr. Iscove said on several occasions that the pattern of analysis was to identify self-destructive or self-harming behaviors and to bring these to the patient’s attention in a

direct fashion to allow the patient to develop ways of ceasing them. It was his belief that this process was what Patient B identified as being "beaten up" by the therapist.

Dr. Iscove stated that there was one occasion when he saw Patient B at his home rather than his office. He believes that this was on a Sunday. His explanation for this was that Patient B was unable to keep an appointment on the Friday before and that he offered to see Patient B on the Sunday, but that there was no air-conditioning in his office. There was no OHIP billing for the Sunday, but billing for the Friday, with no clinical notes from either date. The OHIP record showed that on at least four occasions in this two year period, billing for sessions with Patient B took place without there being a clinical record. Dr. Iscove was unable to locate his calendar for the first year of that two year period, although he produced his calendars for all other relevant years.

ONUS AND STANDARD OF PROOF

The College bears the burden of proof in a disciplinary hearing. The standard of proof that is required is the civil standard of a balance of probabilities, that is, that it is more likely than not that the alleged misconduct occurred. The standard was affirmed by the Supreme Court of Canada in *F.H. v. McDougall*; which also states that the evidence must be clear, cogent and convincing to satisfy the balance of probabilities. There is no obligation on Dr. Iscove to disprove the allegations.

SEXUAL ABUSE

Section 51(1) of the Code provides in part:

> 51.(1) A panel shall find that a member has committed an act of professional misconduct if,
>
> (b.1) the member has sexually abused a patient;

Section 1(3) of the Code defines "sexual abuse" of a patient by a member as:

> (a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
>
> (b) touching, of a sexual nature, of the patient by the member, or
>
> (c) behaviour or remarks of a sexual nature by the member towards the patient.

Section 1(4) of the Code states for the purposes of subsection (3),

> "Sexual nature" does not include touching, behaviour or remarks of a clinical; nature appropriate to the service provided.

There is no disagreement that the complainants were each long-term patients of Dr. Iscove during the time of the alleged abuse. There is also no doubt that the behavior that is alleged by each constitutes sexual abuse.

Consequently, the allegation of sexual abuse with respect to each complainant hinges on the Committee's assessment of the credibility and reliability of each of the witnesses.

DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL

Section 1.(1) of Ontario Regulation 856/93 provides in part:

> 1. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:
>
> […]
>
> 33. An act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

There is no statutory definition of disgraceful, dishonourable or unprofessional conduct. Whether conduct would be regarded by members as disgraceful, dishonourable or unprofessional is a matter within the specialized expertise of the Committee.

CREDIBILITY ASSESSMENT

Patient A

Patient A gave evidence in what the Committee viewed as a straight-forward manner. His narrative of the development of his therapy from Dr. Iscove, starting with unwillingness and confusion over his homosexuality and slowly developing to his acceptance of it, was consistent with the accounts contained in Dr. Iscove's charts. Patient A was reluctant to place blame on Dr. Iscove for the outcome of his treatment, frequently saying that he accepted some responsibility for failures, such as the breakdown of his marriage and the deterioration of his relationship with Dr. Iscove. Patient A 's accounts of the content of the therapeutic sessions, including the emphasis placed on homosexual fantasies, with Dr. Iscove and with others, were consistent with his patient chart. Similarly, the challenges made by Dr. Iscove to which he testified were reflected in the chart record.

Patient A admitted to being angry with Dr. Iscove, although he commented that his anger was the cause of his termination of treatment, rather than being the cause of his complaint. He was initially unwilling to bring a complaint forward, and even after doing so, he expressed disappointment at any harm resulting to Dr. Iscove. He also pointed out that part of his delay in reporting the alleged sexual abuse was an unwillingness to risk family, social or professional consequences that would be difficult for him.

The Committee did not identify any tendency by Patient A to exaggerate any elements of his testimony. There was no evidence of any direct benefit which would accrue to Patient A as a result of making the allegations.

Patient A was clear about the way in which the sexual encounters were initiated and the way in which they escalated through touching over clothing to under clothing, to mutual masturbation and then to oral sex. He was clear about the physical surroundings and the way in which Dr. Iscove came around the desk. He spoke clearly and calmly about his own conflicted feelings and Dr. Iscove's unwillingness to discuss the episodes.

Patient A 's credibility was challenged on a number of fronts during cross examination. It was put to him that he had told a social worker in 2009 that the sexual activity with Dr.

Iscove had started in 2001. He did not recall stating this to the social worker but stated that he did not take issue with the social worker's notes and accepted that he told her this. He agreed that he told College investigators that the sexual activity "started in late 2001 and early winter of 2002" and later that, "it could have been early 2002, rather than late 2001." In his testimony, he said that it started in late 2001 or early 2002 and continued until sometime in 2005. He also agreed that in 2014, he told a psychiatrist that it started in 2001 and continued until 2008/2009.

The Committee finds any discrepancy in Patient A's accounts regarding the start date of the sexual activity is minor and within the realm of what might be expected when one is asked to recall facts many years after the events. As he explained, he cannot recall the exact date that the sexual acts with Dr. Iscove began, but he does recall which office he was in at the time, and he knows that he was only in that office from the end of 2001 to the first part of 2002.

The discrepancy in timing with respect to when the sexual activity ended (2005 vs 2008/2009) is more pronounced. Counsel for Dr. Iscove submitted that this was a significant discrepancy that undermined Patient A's credibility. The Committee does not agree. Patient A testified that at the time he had spoken with the psychiatrist, he had not yet had the opportunity to review his clinical file. After he reviewed that file, it helped to refresh his memory with respect to the timeline of events.

It was clear to the Committee that Patient A had difficulty recalling the exact year when the sexual activity began and when it stopped. The Committee does not find this to be unreasonable, given the very lengthy doctor-patient relationship and the fact that Patient A was being asked to attribute dates to events many years after they occurred. Patient A had a clear recollection of the specific acts of sexual activity. The fact that he could not place those acts within a specific time period did not undermine his credibility with respect to whether or not the acts had in fact occurred.

Patient A's credibility was also challenged with respect to events unrelated to the alleged sexual abuse. Patient A told the College investigator that when he was admitted to Hospital, he had called Dr. Iscove from the hospital. Dr. Iscove testified that Patient A

had called him from home and that he had taken Patient A to hospital. Patient A admitted his error when he testified, saying that he may have confused the call with one that he made from the hospital after Dr. Iscove had left. The statement to the investigator was made in 2014, 11 years after Patient A's hospitalization. The fact that Patient A had forgotten that Dr. Iscove had driven him to the hospital does not affect the Committee's assessment of his credibility with respect to the allegations of sexual abuse.

Although Patient A had initially claimed to have done research into papers that might have been published anonymously by Dr. Bergler at the request of Dr. Iscove, he subsequently acknowledged that he was uncertain whether Dr. Iscove had actually initiated this activity, or whether he had done so himself. That he did the research and presented or discussed the results with Dr. Iscove is corroborated by chart entries in 1993. Particularly, given the time interval of more than 20 years, the fact that Patient A could not specifically recall who initiated the research was not a significant challenge to Patient A 's credibility.

It was also suggested that Patient A 's credibility suffered from his failure to tell his wife in the time period that they were married that he was gay. The Committee did not accept this argument. Both Dr. Iscove and Patient A testified that Patient A was confused or uncertain about his sexual orientation throughout most of this time, and the Committee did not find it surprising that he did not disclose this to his wife. The fact that he may not have been honest with his wife regarding his struggles with his homosexuality has no bearing on whether or not he is credible with respect to the allegations against Dr. Iscove.

Counsel for Dr. Iscove repeatedly pointed out that there was no documentary evidence to support the allegations of sexual abuse, and no evidence of specific dates on which the alleged abuse is to have occurred, although there is documentary evidence in the chart that Patient A was seeing Dr. Iscove for therapy and had one hour appointments at the relevant times, which is some evidence of opportunity.

The Committee notes that there is no requirement in either criminal or civil law for corroborating evidence to support allegations of sexual abuse. While corroborating evidence may be helpful to the trier of fact if it is present, there is no requirement that a

complainant provide independent corroborating evidence. As stated in *F.H. v. McDougall*, [2008], 3 S.C.R. 41 at para 80, sexual assault (or abuse) normally occurs in private, and corroborative evidence may simply not exist, especially if the events took place many years earlier.

When challenged as to why he had not made written notes or e-mails at the time referring to the alleged sexual abuse, Patient A indicated that he did not keep a journal or diary at the time and that the abuse occurred many years before he started communicating with Dr. Iscove by email.

Patient B

The Committee found Patient B to be forthright in his evidence about issues which he clearly found distressing and sensitive. He was detailed and specific about the initiation and the sequence of events and the specific sexual acts. His description of the nature and content of the therapeutic sessions was consistent with Dr. Iscove's chart. Differences between Dr. Iscove and Patient B regarding whether or not the latter was indeed homosexual were frequent topics of conversation during the therapeutic sessions and as acknowledged by both in their testimony and as reflected in Dr. Iscove’s notes.

Counsel for Dr. Iscove pointed out that, as with Patient A, there was a complete absence of corroborating documentary evidence of the sexual relationship between Dr. Iscove and Patient B. As the Committee has already noted above, corroborating evidence is not a requirement in cases of sexual abuse.

It was argued by Dr. Iscove’s lawyer that Patient B had, early in the therapeutic relationship, written graphically descriptive letters to Dr. Iscove about intimate details of his sex life with others, and about his dreams and fantasies while he was on vacation. Therefore, it was argued that it was unlikely that he would not have committed to paper (or electronically) similar details about the alleged sexual encounters with Dr. Iscove. The Committee noted that relating details of sexual activity and dreams or fantasies with others was a consistent part of therapeutic sessions with Dr. Iscove. It was understandable why Patient B, given the nature of the disclosure that Dr. Iscove had repeatedly insisted

upon, would write such letters to Dr. Iscove when Patient B was out of the country. To the contrary, Patient B testified that he and Dr. Iscove never discussed their sexual activities with one another. The alleged sexual abuse by Dr. Iscove occurred in 2007, and the letters from vacation were sent in 1992, 15 years earlier. Patient B was seeing Dr. Iscove for therapy at the time of the alleged sexual abuse. The circumstances were quite different. The Committee did not accept the argument that any negative inference could be drawn with respect to Patient B's credibility from the lack of correspondence between Patient B and Dr. Iscove referencing their sexual activity. There was no evidence that Patient B maintained a diary or a journal which could be an alternative source of documentation. He also explained why he did not write to Dr. Iscove about their sexual activity. He testified that "Mel was very private and secret and careful to -- about communications that would have implicated him in any way."

Patient B testified that the sexual activity started in 2007, although he acknowledged that he had told the psychiatrist, who reported to the College, that it began in 2009, a year in which he had no appointments with Dr. Iscove. Patient B testified that at the time that he saw the psychiatrist, he was vague and uncertain of the actual dates and was unaware that the issue would be reported to the College. He acknowledged that he had read the reporting letter from the psychiatrist prior to its being sent but that he had not noticed the dates recorded in the letter. When pressed in cross-examination on his inconsistency with respect to dates, he stated that he could remember the acts that were alleged ("I remember him putting his penis in my mouth") with much greater certainty and clarity than he could remember the dates on which they occurred.

The Committee found Patient B 's responses to be reasonable. A witness may recall specific details of a sexual encounter without recalling when it occurred. The fact that a witness cannot recall the date of the event, in itself, does not undermine his credibility with respect to whether or not the event occurred.

Counsel for Dr. Iscove also attempted to challenge Patient B 's credibility based on statements that were made by his relative in an anonymous letter to the College. Patient B testified that his relative did not show him the letter before it was sent and that he has

never seen the letter. The letter was not entered into evidence and Patient B testified that he could not recall what he told his relative about the timing of the events, other than that he had still been married to his wife at the time.

Patient B also used different phrases, under different circumstances and at different times, to describe the number of times that sexual contact occurred between him and Dr. Iscove. In his evidence at the hearing, he stated that it was several to a dozen times and "I don't believe it was more than a dozen times." However, in an interview with a College investigator in 2014, he said it was at least a dozen to 20 times, and in a second interview that it was "a couple of dozen."

The Committee finds that the estimates provided do not vary to such a degree so as to cause the Committee to question the veracity of Patient B's testimony that the specific acts occurred. The fact that Patient B could not recall how many times he and Dr. Iscove engaged in sexual acts is not unreasonable, given that there had been many such incidents and he had not recorded each event in any way. Further, the estimates were provided between seven and ten years after the events at issue, each time under different circumstances. Patient B was not precise in his accounting of how many times he and Dr. Iscove engaged in sexual contact. The Committee does not find, however, that this reflects negatively on his overall credibility. The dates and number of times that these incidents occurred were not of significance to Patient B and for that reason he does not recall them. What was significant was the fact that he engaged in sexual acts with his psychiatrist, a point upon which he has been consistently clear.

Patient B provided additional details of the sexual acts during his testimony which he had not given in interviews with College investigators. For example, he testified that sex occurred in a "69" position and that Dr. Iscove played with his nipples and liked to have his prostate touched. The Committee did not find it surprising that a witness would recall further details after having thought about the facts for months in between the interview and the testimony at the hearing, which had not been disclosed during his College interviews. The Committee did not find that Patient B was trying to embellish or exaggerate his accounting of events. The alleged abuse occurred many years ago. It

occurred on several occasions. It is not unreasonable that a victim of such abuse would not recount all of the details with perfect clarity and consistency on every occasion.

Patient B readily admitted that he had been angry with Dr. Iscove particularly at the time that the patient relationship ended. However, he did not initially want to take any action against Dr. Iscove, and only disclosed the alleged abuse to a psychiatrist in the mistaken belief that it would be kept confidential. Even then, he did not pursue the complaint until he was made aware of another patient having made a complaint. At the time of the hearing, he testified that he did not want to hurt Dr. Iscove or his family, but simply that "it was time for him (Dr. Iscove) to come clean about it".

Dr. Iscove's counsel also challenged Patient B's credibility on the basis of his failure to remember a specific painting that Dr. Iscove testified was in his bedroom. Dr. Iscove's counsel argued that if Patient B had actually been in Dr. Iscove's bedroom, as he claimed, Patient B would have recalled this particular painting, as it was sufficiently unusual to have been particularly memorable and unlikely to have been forgotten. Patient B, however, was not shown a photo of the painting during cross-examination (a photograph of the painting was only entered during Dr. Iscove's testimony; after Patient B had completed his testimony), nor was he specifically asked about this painting or a painting in Dr. Iscove's bedroom during his cross-examination. Patient B simply stated that he had seen several paintings in Dr. Iscove's home. The Committee found that it was unfair to assert that Patient B must be lying about having been in Dr. Iscove's bedroom, because he did not remember a particular painting when that had never been put to him in cross-examination.

Counsel for Dr. Iscove submitted that Patient B was not a credible witness because he had lied to his wife about an extra-marital affair. Patient B was forthright in his testimony about the affair, its termination, and the fact that he had lied to his wife. The Committee can draw no parallel between lying to one's wife about an extra marital affair and fabricating allegations of sexual abuse by one's psychiatrist.

The Committee found Patient B to be a credible witness. He testified with specific and sometimes graphic detail about the incidents of sexual contact with Dr. Iscove. There was

no inconsistency in his description of these sexual acts. Although he disclosed details in his testimony that he had not previously disclosed to College investigators, this did not detract from his credibility. Although he had a poor memory with respect to the number of incidents and the dates upon which they occurred, he was very clear in his account of the sexual acts in which he and Dr. Iscove engaged.

Dr. Iscove

Dr. Iscove categorically denied the allegations of sexual abuse by each of the complainants. It is difficult to assess the credibility of a witness who flatly denies that the incidents occurred. The Committee strongly disagrees, however, with the submission of Dr. Iscove's counsel that Dr. Iscove was placed in a position where he had to "prove the negative." This would be a reversal of the applicable burden. Dr. Iscove did not have to prove that he did not sexually abuse either complainant.

There were aspects of Dr. Iscove's testimony that the Committee found troubling with respect to his credibility. Dr. Iscove testified that he saw Patient B at his own home on a Sunday, because the air-conditioning in his office building was turned off on the weekends, and Patient B had an urgent need to see him. There are no notes in the chart for that date, and no billing of OHIP. There is, however, an OHIP billing for an appointment with Patient B on the Friday before, but again no notes. Dr. Iscove had no explanation for why he had no clinical notes for the appointment and why the OHIP billing was dated for a Friday. The Committee did not believe Dr. Iscove's explanation for inviting Patient B to his home.

More troubling is that during 2007 and 2008 when Patient B alleges that the sexual abuse took place, there are at least four appointments when OHIP billing occurred, but no notes were present in the chart. On some other occasions, the notes of appointments with Patient B are very brief. This was out of keeping with Dr. Iscove's normal practice of keeping very detailed notes of his sessions, including sessions with Patient B. Dr. Iscove joked that he was like a stenographer in his appointments, keeping very detailed notes of his conversations with his patients. The Committee could see evidence of this practice in Dr. Iscove's clinical notes for both Patient A and Patient B, which is why the incidents of

missing or abbreviated records were particularly noteworthy. Further, Dr. Iscove provided the College with all of his day timers, except the one for 2007.

The Committee found the lack of charting for some appointments to be troubling as it was inconsistent with Dr. Iscove's regular practice and consistent with the inference that the reason there were no notes was because he was engaged in sexual activity with Patient B, as alleged. The absence of clinical notes, however, was far from conclusive evidence that the abuse as alleged occurred on these dates. Dr. Iscove, however, could not provide any explanation for why there were no notes on these dates.

There were other aspects of Dr. Iscove's testimony which also called into question his overall credibility. In his testimony about the nature and style of his therapy, Dr. Iscove repeatedly claimed that he did not give advice to his patients. He did so despite admitting that he suggested that Patient A's wife should come to him for therapy, and he provided Patient A with advice over the telephone during Patient A's wife's labour and delivery. He attempted to draw distinctions between "advice" and "recommendations" or "matters of fact" in a way that the Committee found evasive. It was clear to the Committee that despite stating that he did not give advice to his patients, he clearly did so. The Committee did not understand why this was a point that Dr. Iscove would not concede.

Dr. Iscove also became evasive in responding to questions as to whether homosexuality should be considered an illness, and whether it was capable of being "cured," despite that these views were clearly held by Dr. Bergler. Given that Dr. Iscove had admittedly devoted his professional life to studying and applying the theories of Dr. Bergler, it was not clear to the Committee why Dr. Iscove refused to acknowledge that he agreed with Dr. Bergler on these points.

Dr. Iscove denied that he used words reasonably considered derogatory when he described his patients to their face, even when he was shown his clinical record which indicated that he had called Patient A "a liar." He argued that he did so with a big smile on his face and was not being insulting. However, the context in which the remarks were made did not suggest to the Committee that they were intended to be humorous.

Dr. Iscove denied that the e-mails from himself to Patient A were in any way attempts to sell items to his patient, and that they were simply indications of the sorts of things that Patient A might wish to obtain from other sources. However, the e-mail about the trundle bed contained the comment "here are the pictures. It is a regular twin bed size. The second bed slides in underneath...you would probably want to start off with new mattresses." There was no doubt to the Committee that the e-mails referred to a specific bed and not simply an example of the type of bed, as purported by Dr. Iscove. The e-mails of pictures of carpets are accompanied by the remark, "can you call me today to give me some idea if any of the patterns or colours would work for you. There are more to choose from." Again, this does not sound to the reasonable reader that the implication was simply that they were examples of carpets that Patient A could look for elsewhere. The Committee concluded that Dr. Iscove was offering the trundle bed and the carpets for sale to Patient A.

FINDINGS

The Committee considered the allegations of each patient individually in order to determine whether or not the allegations with respect that patient had been proved by the College.

A. Allegations regarding Patient A

(i) Sexual Abuse

The Committee finds that the incidents of sexual abuse occurred as described by Patient A. For the reasons described above, the Committee believes Patient A and finds he is a credible witness and that his evidence is reliable. The inconsistencies in Patient A’s evidence were consistent with the nature of human memory, the passage of time and the variation of expression that occurs when accounts are given by one person at different times. The inconsistencies were minor and did not relate to the core issue of whether or not the alleged sexual acts took place.

Patient A's evidence with respect to the sexual abuse was irreconcilable with Dr. Iscove's blanket denial that the abuse did not occur. As stated by the Supreme Court of Canada in *F.H. v. McDougall*, in civil cases:

> "provided the judge has not ignored evidence, finding the evidence of one party credible may well be conclusive of the result because that evidence is inconsistent with that of the other party. In such cases, believing one party will mean explicitly or implicitly that the other party was not believed on the important issue in the case. That may be especially true where a plaintiff makes allegations that are altogether denied by the defendant." (para 86)

The Committee finds that Dr. Iscove committed an act of professional misconduct in that he sexually abused Patient A in the manner described by Patient A in his evidence, by inviting Patient A to touch his penis over his clothing, mutual masturbation and oral sex.

(ii) Disgraceful, Dishonourable or Unprofessional Conduct

The Committee's finding with respect to the allegation of sexual abuse is a sufficient basis upon which to find that Dr. Iscove engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional. Engaging in sexual acts with a patient in the context of a psychotherapeutic relationship is an egregious violation of the trust Patient A placed in Dr. Iscove as his psychiatrist. Through the therapeutic relationship, Patient A became dependent on Dr. Iscove and relied on him like a father figure. To take advantage of this vulnerability to satisfy one's own sexual gratification is truly disgraceful, dishonourable and unprofessional.

In addition, however, it is alleged that Dr. Iscove engaged in boundary violations that would also constitute disgraceful, dishonourable or unprofessional conduct.

Apart from the alleged sexual abuse, Dr. Iscove's conduct with Patient A extended beyond the boundaries normally expected to be part of a physician-patient relationship. Much of this was recorded in e-mail correspondence between Dr. Iscove and Patient A. Examples of such email included the following:

- sending Patient A information about a trundle bed and information about Oriental carpets;

- sending Patient A an invitation to opera rehearsals, which included advice not to disclose his patient status to other invitees;
- sending other information about opera productions;
- sending information and photographs of his grandchild to Patient A.

Other examples of communications expanding beyond an appropriate doctor-patient relationship include:

- enabling Patient A to rent an apartment in another city owned by the Bergler Foundation; and
- taking Patient A to hospital.

It is evident that Dr. Iscove had a limited understanding of what constitutes a reasonable range of activities and boundaries in an appropriate doctor-patient relationship.

The Committee recognizes that boundaries may on occasion be grey, and that not all boundary crossings necessarily constitute professional misconduct. Boundaries may be crossed unintentionally or have minimal consequences.

The Committee determined that in this particular case, the following fell into the category of boundary crossings, but would not be reasonably regarded by members of the professions as disgraceful, dishonourable or unprofessional:

- Sharing of photographs of grandchildren with a patient; or
- Sending information about operatic or artistic productions to a patient.

The Committee did not find that these boundary crossings constituted disgraceful, dishonorable or unprofessional conduct in the circumstances of this long term psychotherapeutic relationship. The Committee notes, however, that when boundary crossings are present in significant numbers, as they are in this instance, such boundary crossings carry the risk of increasing patient dependence and vulnerability, as well as misinterpretation. The Committee regards them as unwise practices.

The remaining incidents are more troubling. With respect to the occasion on which Dr. Iscove drove Patient A to the hospital because he had an acute medical condition, the Committee does not want to suggest that there is anything wrong in coming to the aid of a patient requiring medical assistance. The Committee notes, however, that Dr. Iscove is a psychiatrist and this was not a psychiatric issue. The fact that Patient A chose to call Dr. Iscove when he had an acute physical condition and the fact that Dr. Iscove responded by driving Patient A to the hospital is reflective of the extent to which Patient A had come to rely on Dr. Iscove and that the boundaries within this doctor-patient relationship were significantly eroded.

The rental of the apartment in another city was claimed to be at a low rate which went to the Foundation rather than directly to Dr. Iscove; however, Dr. Iscove's position on the Foundation board placed him in a clear conflict of interest with respect to financial dealings of this nature and must be considered unprofessional.

The invitations to opera rehearsals not only violated social boundaries but placed Patient A in a position of dependency to Dr. Iscove and created the potential for violation of Patient A's confidentiality, demonstrated by Dr. Iscove's caution that not only should Patient A not disclose that he was a patient of Dr. Iscove, but that Dr. Iscove would deny the doctor-patient relationship if needed.

Finally, the Committee concluded that the e-mails regarding the trundle bed and the carpets must be viewed as offers to sell these items to Patient A. The fact that Patient A may not have actually purchased any of the items does not mean that this was not a boundary violation. Attempting to sell personal items to your patients is unprofessional.

The Committee found that Dr. Iscove engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional in that he:

1. tried to sell Patient A personal items;

2. invited Patient A to attend the opera as his guest;

3. arranged for him to rent the Bergler Foundation's apartment in another city.

B. Allegations regarding Patient B

(i) Sexual Abuse

The Committee believed Patient B that the sexual acts with Dr. Iscove occurred as he described. The Committee found him to be credible and his evidence reliable for the reasons above. He provided very detailed and persuasive evidence about the incidents of sexual abuse by Dr. Iscove. Although he could not recall the specific number of incidents or the dates upon which they occurred, this did not detract from his credibility or the reliability of his evidence with respect to the core issue of whether or not the alleged incidents occurred. Again, Patient B's evidence was simply irreconcilable with Dr. Iscove's denial. The Committee finds that the College has discharged its burden and the Committee finds that Dr. Iscove sexually abused Patient B in the manner described by Patient B, which included mutual touching of genitalia over clothing, masturbation, oral sex and one incident of anal intercourse.

(ii) Disgraceful, Dishonourable or Unprofessional

The Committee's finding with respect to the allegation of sexual abuse is a sufficient basis upon which to find that Dr. Iscove also engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional. Again, Dr. Iscove took advantage of a very vulnerable patient, who trusted him implicitly and who described him as a father figure, to satisfy his own sexual desires. This was disgraceful, dishonourable and unprofessional.

In addition, it is alleged that Dr. Iscove engaged in boundary violations with Patient B that would also constitute disgraceful, dishonourable or unprofessional conduct. These alleged boundary violations included sending information and photographs of his grandchild to Patient B; sending to Patient B information about various complementary medicine articles not relevant to his therapy; enabling Patient B to rent an apartment in another city owned by the Bergler Foundation; selling to Patient B, for $4000, an ~~e~~device

for the treatment of his family member's medical condition, and providing advice about treatment of the family member's medical condition; and selling a juicer to Patient B.

The Committee did not find that sending Patient B pictures of his grandchildren, or sending Patient B information about complimentary medicine, in the circumstances of this long-term doctor-patient relationship, is conduct that members of the profession would regard as disgraceful, dishonourable or unprofessional.

The Committee finds, however, that Dr. Iscove engaged in boundary violations that members of the profession would find disgraceful, dishonourable or unprofessional, in that he:

1. sold equipment to Patient B, for the use of Patient B's family member, in an area of medicine in which Dr. Iscove had no expertise;

2. arranged for Patient B to rent the Bergler foundation's apartment in another city; and

3. sold a juicer to Patient B.

These boundary violations further eroded the appropriate professional boundaries in a doctor-patient relationship. Given the level of dependence that Patient B had on him, Dr. Iscove should not have engaged in any commercial transactions with Patient B.

SIMILAR FACT EVIDENCE

Because the Committee found the evidence of each complainant credible and sufficient to find that sexual abuse had occurred as each alleged, there was no necessity to rely on similar fact evidence to make a finding with respect to either complainant. The Committee finds, however, that the test for similar fact evidence would have been satisfied in this case.

Similar fact evidence is presumptively inadmissible. The evidence of misconduct in respect of one complainant is not admissible to support the allegation of professional misconduct in respect of another complainant. Evidence from one complainant cannot be

used to support a belief that Dr. Iscove is the sort of person or character that would be likely to engage in misconduct with respect to another complainant.

Similar fact evidence only becomes admissible when its probative value outweighs its prejudicial effect. In these circumstances, the evidence is not offered to support the inference that the physician committed acts of professional misconduct because he is "a bad person" or the "type of person" who would do such a thing. Rather, the evidence is offered on the basis that the similarities between the complainants make it highly unlikely that they are lying or mistaken about what happened to them. As stated in the case of *R. v. Handy*, 2002 SCC 56, this occurs when the "the force of similar circumstances defies coincidence or other innocent explanation."

To determine if similar fact evidence can be used, the Committee must determine:

1. the probative value of the evidence;

2. the potential prejudice that could be caused by admitting the evidence;

3. balance the two to determine which outweighs the other.

The onus is on the College to satisfy the Panel, on a balance of probabilities, that in the context of a particular case, the probative value of the evidence in relation to a particular issue outweighs its potential prejudice and thereby justifies its reception.

(i) probative value of the evidence

In *R v. Handy*, the Supreme Court noted that "the utility of the [similar fact] evidence lies precisely in its ability to advance or refuse a live issue pending before the trier of fact." (at para 73). The College submits that the issue is whether the misconduct has occurred.

The listing of similarities between the two patients is exhaustive. Both complainants were in early adulthood when they began to see Dr. Iscove (18 and 20 yrs) and both remained his patients for approximately two decades. Both described sexual abuse occurring after many years of therapy, when they were in heterosexual marriages which were increasingly unhappy at the time. Both were uncertain (at best), confused, conflicted, felt

vulnerable and were defensive about the possibility of their homosexuality, according to each complainant's testimony and that of Dr. Iscove. The fact that they (and Dr. Iscove) described many common features about the content and the process of their therapy, including many hours spent on the discussion of their fantasies and dreams can be accepted as a consequence of the style and theories followed by Dr. Iscove. However, the frequency of questioning by Dr. Iscove of their sexual fantasies specifically about Dr. Iscove himself is less easily explained.

Both complainants independently described a virtually identical progression of sexual activities, starting with sexual touching and progressing to mutual masturbation and oral sex. Both described these activities occurring usually when both were partially undressed and both described their discomfort and unwillingness to engage in kissing. Neither complainant described any emotional or romantic aspects of the sexual activity with Dr. Iscove, and both said that at some point, they thought that the sexual activity was part of the therapy and an attempt to cure them of homosexuality by engaging in the acts, rather than fantasizing about them. They both described Dr. Iscove as a father figure, to whom they were grateful in some ways, who they were reluctant to criticize and initially, uncomfortable to complain about. The complainants both delayed disclosure of the abuse for several years, and initially did not name him, and did not complain to the College when they were initially urged to do so by others. They both described Dr. Iscove as being unwilling to engage in any discussion of the sexual activity. Finally, they were both engaged in, or were the subject of, a series of actions which lay outside the boundaries of an appropriate physician-patient relationship; these included the use of the apartment in another city, the sale, or attempts at sale, of items that were not relevant to their treatment, attendance at opera rehearsals, and sharing of family information by Dr. Iscove.

There were also dissimilarities. Patient A was a professional man with a relatively conventional lifestyle. Patient B was creative, and as described by Dr. Iscove, an artistic individual with a more varied career path and inconsistent employment. There were only minimal differences in their descriptions of the sexual activity with Dr. Iscove. Patient B

described a single episode of sex in a "69" position, and a single episode of anal penetration.

The similarities between the two stories caused the Committee to give careful consideration to the issue of potential collusion. At no point, however, was the Committee presented with any evidence of collusion. The complainants denied knowing each other, or meeting one another accidentally or otherwise. They were not alleged to have friends or acquaintances in common, from whom they could have learned details of the other's story, and there were no elements of their evidence that they could have learned only from the other or from a mutual third party.

The Committee finds that there is no “air of reality” to the allegation of collusion. Therefore the burden did not shift to the College to show on a balance of probabilities that the similar fact evidence was not tainted by collusion. (*R. v. Handy*, at para 112). Dr. Iscove suggested that the two complainants might have met while attending Dr. Iscove's office. Dr. Iscove and the complainants all testified, however, that Dr. Iscove took careful steps to avoid patients meeting each other by the use of separate entrance doors, waiting room door and office door. Patients were instructed that they should wait only in the waiting room and keep the waiting room door closed until they were invited in to the office by Dr. Iscove. In addition, both patients testified that Dr. Iscove was insistent that they not disclose the contents of therapy sessions to others. There were 22 days during the 18 years when the two complainants had back to back appointments. The last happened in 2002, some 10 or more years before each complained to the College.

The patient chart records that Patient A stated that he had seen another "good-looking patient" in the waiting room in 1992. This could have been Patient B but there is no evidence to support this; the date of the occurrence is not recorded and the possibility is purely speculative.

The passage of time since the last possible meeting between the two complainants at back-to back appointments, and the fact that the complaints were made to the College years after each had discontinued seeing Dr. Iscove, simply does not support the allegation of collusion.

The Committee also considered the possibility that each of the two complainants was being truthful in his account, but that they each suffered from a delusional belief that the abuse had occurred. Not only did the Committee believe that it was most unlikely that two patients would have virtually identical delusions, but that two patients undergoing two decades of therapy from a psychiatrist without the presence of such delusions being detected is most improbable.

(ii) potential prejudice

Prejudice in this context relates solely to the concern that the Committee will use the similar fact evidence improperly to conclude that Dr. Iscove is the type of person to have committed the misconduct.

(iii) weighing the probative value against the potential prejudice

The Committee finds that the similarities between the testimony of the two complainants supports the finding that the acts alleged by each occurred as described. With both, Dr. Iscove misused his position of trust and authority to foster a relationship of trust which he subsequently abused for his own sexual gratification. The probative value exceeds any potential prejudice.

CONCLUSION

The Committee finds that Dr. Iscove committed an act of professional misconduct in that:

1. he has engaged in the sexual abuse of two patients; and

2. he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. In particular:
    a. he sexually abused two patients;
    b. he sold equipment to Patient B for the use of Patient B 's family member in an area of medicine in which he had no expertise;

c. he arranged for Patient B and Patient A to each rent the Bergler Foundation's apartment in another city;
d. he sold a juicer to Patient B;
e. he tried to sell Patient A personal items; and
f. he invited Patient A to attend a working rehearsal of the opera as his guest.

IMMEDIATE INTERIM SUSPENSION

Section 51(4.2) of the Code provides:

> Interim suspension of certificate
> (4.2) The panel shall immediately make an interim order suspending a member's certificate of registration until such time as the panel makes an order under subsection (5) or (5.2) if the panel finds that the member has committed an act of professional misconduct,
> (a) under clause (1) (a) and the offence is prescribed for the purposes of clause (5.2) (a) in a regulation made under clause 43 (1) (v) of the *Regulated Health Professions Act, 1991*;
> (b) under clause (1) (b) and the misconduct includes or consists of any of the conduct listed in paragraph 3 of subsection (5); or
> (c) by sexually abusing a patient and the sexual abuse involves conduct listed under subparagraphs 3 i to vii of subsection (5). 2017, c. 11, Sched. 5, s. 19 (2). [emphasis added]

Subparagraphs 3 i to vii of subsection 51(5) state:

3. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:

> i. Sexual intercourse.
> ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
> iii. Masturbation of the member by, or in the presence of, the patient.
> iv. Masturbation of the patient by the member.
> v. Encouraging the patient to masturbate in the presence of the member.
> vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.
> vii. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 19 (3).

Given the Committee's findings, the Committee makes an immediate interim order suspending Dr. Iscove's certificate of registration, until such time as the Committee makes an order under subsection 5 or 5.2 of the Code. The Committee requests that the Hearings Office fix a date for the penalty hearing in this matter.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Iscove, 2018 ONCPSD 53

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. MELVYN LAWRENCE ISCOVE

PANEL MEMBERS:

DR. E. STANTON (CHAIR)
MR. P. GIROUX
DR. J. WATTS
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS B. DAVIES
MS S. SULEVANI

COUNSEL FOR DR. ISCOVE:

MR. A. KWINTER
MS V. MARSON

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. McALEER

Penalty Hearing Date: April 16, 2018
Penalty Decision Date: October 5, 2018
Release of Written Reasons: October 5, 2018

PUBLICATION BAN

PENALTY DECISION AND REASONS FOR DECISION

On March 8, 2018, the Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario found that Dr. Iscove committed an act of professional misconduct, in that he has engaged in the sexual abuse of two patients, and in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

Given the Committee's findings, on March 8, 2018, the Committee made an immediate interim order suspending Dr. Iscove's certificate of registration, pursuant to s.51(4.2) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991,* until such time it made its order on penalty.

On April 16, 2018, the Committee heard evidence and submissions on penalty and costs. The Committee reserved its decision on penalty and costs.

SUBMISSIONS ON PENALTY AND COSTS

Counsel for the College and counsel for Dr. Iscove both submitted that revocation of Dr. Iscove's certificate of registration and a reprimand are mandatory for the findings of sexual abuse in this case. The parties disagreed regarding other aspects of penalty and the quantum of costs.

Counsel for the College submitted that Dr. Iscove should be required to reimburse the College fund for two patients in the amount of $32,120.00, under the program for therapy and counseling required under s. 85.7 of the Code, and to post security, such as an irrevocable letter of credit, to guarantee payment of that amount.

Counsel for Dr. Iscove submitted that both patients had already received therapy and showed no evidence of requiring further therapy. Consequently, counsel for Dr. Iscove

maintained that an order requiring payment and security for payment for funding for therapy and counseling was not necessary.

Regarding the issue of costs, counsel for the College submitted that Dr. Iscove be required to pay costs to the College for nine days of hearing at the current tariff of $10,180.00 per day of hearing, for a total of $91,620.00.

Counsel for Dr. Iscove submitted that the hearing had adjourned due to a change in Dr. Iscove's counsel, which was beyond Dr. Iscove's control, and that if this adjournment had not taken place, the hearing would have completed prior to the increase in the tariff on February 23, 2018, from $5.500 to $10,180 per day of hearing. Also, counsel for Dr. Iscove submitted that eight out of the nine hearing days took place prior to the change in the tariff and therefore, costs should be calculated on the basis of the tariff in effect at the time of the hearing dates.

EVIDENCE ON PENALTY

Patient Impact Statements

The College proposed to introduce two patient impact statements: one by Patient A, to be read by College counsel (on consent); and one by Patient B, to be read by Patient B's relative.

Patient B's Representative and Admissibility of Patient B's Statement

Counsel for Dr. Iscove objected to Patient B's relative reading Patient B's statement and objected to certain content of Patient B's statement that was critical of Dr. Iscove to the extent that, in counsel's submission, the entire statement was inadmissible.

Section 51(5) of the Code states:

Orders relating to sexual abuse

(5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Suspend the member's certificate of registration if the sexual abuse does not consist of or include conduct listed in paragraph 3 and the panel has not otherwise made an order revoking the member's certificate of registration under subsection (2).
3. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:
    i. Sexual intercourse.
    ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
    iii. Masturbation of the member by, or in the presence of, the patient.
    iv. Masturbation of the patient by the member.
    v. Encouraging the patient to masturbate in the presence of the member.
    vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.
    vii. Other conduct of a sexual nature prescribed in regulations made pursuant to clause 43 (1) (u) of the *Regulated Health Professions Act, 1991*. 2017, c. 11, Sched. 5, s. 19 (3).

Section 51 (6) and (7) of the Code state:

Statement re impact of sexual abuse

(6) Before making an order under subsection (5), the panel shall consider any written statement that has been filed, and any oral statement that has been made to

> the panel, describing the impact of the sexual abuse on the patient. 1993, c. 37, s. 14 (3).
>
> **Same**
>
> (7) The statement may be made by the patient or by his or her representative. 1993, c. 37, s. 14 (3).

Section 51(6) of the Code requires the Committee to consider any patient impact statements before making an order in relation to sexual abuse. Section 51(7) states that the statement may be made by the patient or the patient's representative.

Counsel for Dr. Iscove objected to Patient B's relative reading the statement and submitted that the term "representative" in s.51(7) of the Code should be construed to mean College counsel. Counsel for the College submitted that College counsel is not counsel for the patient and that the term "representative" should be interpreted as an individual who is approved by, and has the confidence of, the patient.

In the absence of legal authorities on this issue, the Committee found that the term "representative" in s.51(7) is sufficiently broad to encompass a person of the patient's own choosing, and therefore, permitted Patient B's relative to read Patient B's statement.

Counsel for Dr. Iscove also objected to certain content of Patient B's statement which was critical of Dr. Iscove to the extent that counsel submitted the entire statement was inadmissible. The Committee considered the content of Patient B's impact statement. In relation to the portions of the statement that could be considered critical of Dr. Iscove, a number were repetitive of what was heard in Patient B's testimony at the hearing. The Committee could see no justification for redacting or excluding information that was already accepted in evidence. Some information in the statement was not previously in evidence and contained statements that could be considered hearsay. One portion of Patient B's statement was redacted on consent. The Committee ordered that some other portions of Patient B's statement be redacted to address the hearsay problem. The

Committee would like to stress that it is very rare to redact a patient impact statement and the Committee's decision to do so in this case should not be taken to establish any precedent for doing so. These were unique circumstances. The Committee admitted approximately 75% of the content of the original impact statement.

Patient A's Statement

Patient A described his confusion and his feeling of harm arising from the abuse and coming from someone who had previously described homosexuals as "self-damaging, unreliable frauds." He also described his feelings of guilt and worthlessness, and that he would never be able to fully recover, despite the progress that he has made to date. He spoke about the resulting loss of trust and the consequent challenge of establishing healthy relationships.

Patient B's Statement

Patient B emphasized the harm that arose at the time of his therapy with Dr. Iscove, as well as the challenges that arose from his subsequent disclosure of the abuse. Like Patient A, he described shame and confusion during his therapy and abuse, and the effects on his relationships with family and partners. Patient B stated that he felt particularly disturbed by the effect on his family and friends, because, as those indirectly impacted, they lacked the opportunities for counseling funded by the College's program for patient therapy and counseling, and closure.

Letters of Support

Counsel for Dr. Iscove sought to introduce into evidence five letters of support, four of which were from clients/patients of Dr. Iscove.

Counsel for the College objected to the admissibility of these letters. College counsel submitted that the only contested issues in this penalty hearing are payment and security

for payment to the fund for patient therapy and counseling, and the quantum of costs. The letters of support do not address these issues. Furthermore, the College maintained that the letters included hearsay statements.

The letters, generally speaking, expressed the authors' complete satisfaction with the treatment provided by Dr. Iscove and their admiration of him as therapist and as an individual.

The Committee decided to admit the letters into evidence and reserve its decision on what, if any, weight to afford them.

PENALTY AND REASONS FOR PENALTY

The Committee found that Dr. Iscove engaged in sexual abuse of two very vulnerable patients. The abuse included mutual masturbation and oral sex. Thus, revocation of Dr. Iscove's certificate of registration and a reprimand are mandatory under the legislation. The Committee would have had no hesitation in ordering the revocation of Dr. Iscove's certificate of registration, even if it was not so mandated.

Dr. Iscove is an experienced psychoanalyst. Patients A and B were Dr. Iscove’s patients of long-standing, and both described how completely dependent they were upon Dr. Iscove's continuing care and approval. Both patients described how highly they regarded Dr. Iscove, looking upon him as a father figure. Dr. Iscove would have been more than aware of the risks of transference and counter-transference in such a relationship.

In addition to sexual abuse, the Committee found that Dr. Iscove had engaged in disgraceful, dishonourable or unprofessional conduct in relation to various boundary violations with both patients. His repeated violations of patient boundaries contributed to the exploitation of these highly vulnerable patients, which culminated in the sexual abuse. In their testimony and in their patient impact statements, they described the gravity of the effects of the abuse.

In the circumstances of this case, revocation is the only penalty which upholds the principles of protecting the public, maintaining public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest, as well as expressing the profession's and the public's denunciation of such conduct. Revocation is entirely proportionate to the misconduct and is the only adequate deterrent to the profession as a whole and to the member for such misconduct.

Counsel for Dr. Iscove submitted that the Committee should consider as mitigating the fact that Dr. Iscove had no prior history of complaints or professional misconduct, and that he is highly regarded by patients and in his community, particularly the music and artistic communities, as demonstrated by the letters of support. Given the intensely private nature of Dr. Iscove's sexual abuse of two vulnerable patients, the Committee did not consider his reputation in the community to be mitigating in the circumstances of this case. An absence of any disciplinary history can be a mitigating factor, but given the facts of this case, it was not a mitigating factor that would result in any lesser penalty, even if revocation was not mandatory.

Payment and Security for Payment to the Fund for Patient Therapy and Counseling

If the act of professional misconduct was the sexual abuse of a patient, s. 51 (2) (5.1) and (5.2) of the Code provides the Committee with the discretion to make an order requiring the member to reimburse the College for the program for therapy and counseling for persons alleging sexual abuse by a member under s. 85.7, and to do so by requiring the member to post security to guarantee payment.

Counsel for Dr. Iscove submitted that both patients had already received counseling. This may be true, but each of these patients has demonstrated a commitment to counseling in the past and each made it clear in his patient impact statement that each continues to struggle with the impact of this abuse.

Furthermore, Dr. Iscove has been severely restricted in his practice (and is now no longer able to practise), and at the age of 73 is unlikely to successfully regain his certificate of registration to practice in five years' time. Therefore, counsel for Dr. Iscove submitted that such an order would result in unnecessary financial hardship to Dr. Iscove.

There was no evidence before the Committee with respect to Dr. Iscove's financial situation. The Committee considered the decision of the Discipline Committee in *CPSO v. Brown*, 2015 ONCPSD 34, in which Dr. Brown had also made submissions with respect to his financial means. The Committee found at paragraph 19:

> "There was no evidence, however, before the Committee to support the submission with respect to Dr. Brown's financial circumstances. In any event, given the policy considerations that underlie section 51(2) and the importance that counseling be available for the patient should she pursue that option, the Committee is not inclined to agree with Dr. Brown's position".

Although not bound by this prior decision of the Discipline Committee, this Panel agrees with the principle set out in the *Brown* decision. The Patient Relations Committee, not the Discipline Committee, determines whether to provide reimbursement for the costs of therapy. It is, however, important and in the public interest that such funds are available if required. It was clear from the evidence and from the patient impact statements that Dr. Iscove's actions have resulted in severe and long-standing distress for both patients. The Committee, therefore, makes an order that Dr. Iscove reimburse the College for funding for therapy and counseling for two patients, in the amount of $16, 060.00 per patient, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty (30) days of this order, in the amount of $32,120.00.

COSTS

The College sought costs for eight days of the hearing with respect to the allegations and one day of the penalty hearing, all at the current tariff rate of $10,180.00 per diem. The Committee has the authority to order costs as outlined in s. 53.1 of the Code, in "an appropriate case" and in a fair and reasonable amount. The Committee reviewed the circumstances of the case and concluded that this was an appropriate case to in which to order that Dr. Iscove pay costs to the College and that the amount sought by the College was fair and reasonable.

The College was successful in proving the allegations of sexual abuse and disgraceful, dishonourable and unprofessional conduct with respect to both patients. It did so through the evidence of each of the complainants and through cross-examination of Dr. Iscove. It is the Committee's view that College counsel was efficient in her prosecution of the case. Dr. Iscove had every right to defend himself in response to the allegations, but the College clearly proved its case. Further, Dr. Iscove was evasive in his testimony and his manner of responding to questions by College counsel prolonged the length of the hearing.

The Committee's order that Dr. Iscove pay hearing costs to the College is not intended in any way to penalize Dr. Iscove for having defended the allegations. The Committee acknowledges that a cost order is not meant to be a penalty.

Counsel for Dr. Iscove submitted that costs should be calculated on the basis of the tariff that was in place on the hearing dates at issue and that the increased tariff, which came into effect on February 23, 2018, should not be imposed retrospectively.

The issue of retrospective application of statutory changes regarding costs was considered in *Canadian Broadcasting Corp. Pension Plan v. BF Realty Holdings*, 2002 CanLII 15157 (ON CA). The Court of Appeal stated as follows:

> [12] As a general rule, enactments are not to be given retrospective effect in the absence of a clear expression of a contrary legislative intent. That general rule, however, is subject to the established exception that procedural enactments are presumed to have a retrospective effect. This court has recognized that litigation costs are procedural in nature: see *Shea v. Miller*, 1970 CanLII 250 (ON CA), [1971] 1 O.R. 199 (C.A.) and *Somers v. Fournier* (2002), 2002 CanLII 45001 (ON CA), 214 D.L.R. (4th) 611 (Ont. C.A.).
>
> [13] The consequences of a retrospective application of the new costs grid can be serious and, in some cases, highly prejudicial to the affected parties. In those circumstances, justice between the parties may require a court, in the exercise of its discretion concerning costs, to deviate from the strict requirements of the costs regime envisaged by O. Reg. 284/01. In our view, however, those cases will be rare and will normally depend on evidence of actual prejudice beyond the fact that the legal services at issue were rendered prior to January 1, 2002.
>
> [14] In this case, no demonstration of such prejudice has been advanced or established. There is no basis, therefore, to depart from the traditional approach of retrospective application of enactments in the nature of O. Reg. 284/01. This court's award of costs was made after O. Reg. 284/01 came into force. Accordingly, the scale of costs applicable to the costs award made in favour of the respondents is governed by O. Reg. 284/01. Thus, costs are to be calculated on a partial indemnity, rather than a party and party, basis.

The Discipline Committee understands that costs are procedural in nature and therefore, based on the principles set out above from the Court of Appeal, there is a presumption that amendments to the cost tariff are to have retrospective effect. Only if significant prejudice to the affected parties has been demonstrated, is there a basis to depart from the approach of retrospective application with respect to procedural changes. The Discipline Committee in *Re Redhead*, 2013 CarswellOnt 18632 was satisfied that the change in the

tariff was presumed to have retrospective effect and that the Committee should deviate from it only in rare cases and based on evidence of actual prejudice, of which there was none in that case. In a more recent decision of this Committee, *CPSO v. Kunynetz*, 2018 ONCPSD 5 (CanLII), the Discipline Committee did not apply the increased tariff retrospectively; however neither the Committee's decision in *Re Redhead* (2013), nor the Court of Appeal's decision in *CBC Pension Plan* (2002) were considered in the Committee's reasons in that case. Further, there were other factors at issue in *Kunynetz,* which resulted in a lesser costs award, including the fact that the College was not successful in proving all of the allegations in that case.

The Committee found no evidence of significant prejudice to Dr. Iscove resulting from the retrospective application of the current tariff and ordered that Dr. Iscove pay hearing costs to the College for nine days of hearing, at the tariff rate of $10,180.00 per day of hearing, for a total amount of $91,620.00.

ORDER

Therefore, the Committee orders and directs on the matter of penalty and costs that:

1. The Registrar revoke Dr. Iscove's certificate of registration, effective immediately.
2. Dr. Iscove reimburse the College for funding provided for patients under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty (30) days from the date of this Order, in the amount of $32,120.00.
3. Dr. Iscove appear before the panel to be reprimanded.
4. Dr. Iscove pay to the College its costs of this proceeding, in the amount of $91,620.00 within thirty (30) days from the date of this Order.