DISCIPLINE COMMITTEE OF THE COLLEGE OF CHIROPRACTORS OF ONTARIO

PANEL:

Chair	Ms Karoline Bourdeau	Public Member
	Mr. Doug Cressman	Public Member
	Dr. Colin Goudreau	Professional Member
	Dr. Colleen Pattrick	Professional Member
	Dr. Brian Budgell	Professional Member

BETWEEN:	)	Appearances:
	)	
COLLEGE OF CHIROPRACTORS OF ONTARIO	)	Mr. Chris Paliare and Ms. Karen Jones for the College of Chiropractors of Ontario
	)	
- and -	)	
	)	
DR. SHAUN LAMBROU	)	Brendan Farrer for Dr. Shaun Lambrou
	)	
	)	Heard: March 6, 2019

Also present at the hearing were:

Mr. Colin Stevenson
Independent Legal Counsel to the Panel

Ms. Jo-Ann Willson
Registrar and General Counsel CCO

Ms. Lydia Pak
Court Reporter

DECISION AND REASONS

INTRODUCTION

A hearing into allegations of professional misconduct against Dr. Shaun Lambrou took place before a panel of the Discipline Committee (the "Panel") of the College of Chiropractors of Ontario (the "College" or "CCO") on March 6, 2019. The College has a mandate to regulate the practice of the chiropractic profession and to govern its members and, in so doing, serve and protect the public interest.

The Panel found that the Member engaged in professional misconduct by breaching subsections 51(1)(c) of the Health Professions Procedural Code of the Chiropractic Act, 1991, S.O. 1991, c. 21, as amended, and paragraphs 1(2) and 1(33), of Ontario Regulation 852/93. Below we explain that decision.

THE ALLEGATIONS

The allegations against Dr. Shaun Lambrou (the "Member"), were stated in a Notice of Hearing, dated October 12, 2018 which was filed as Exhibit 1. The original allegations were:

(a) you have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the *Health Professions Procedural Code* of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, in that in December 2017 you sexually abused a patient known as Patient A;

(b) you have committed an act of professional misconduct as provided by subsection 51 (l)(c) of the *Health Professions Procedural Code* of the *Chiropractic Act,*

1991, S.O. 1991, c. 21, as amended, and paragraph 1(2) of Ontario Regulation 852/93, in that in December 2017, you contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession with respect to your treatment of and/or conduct towards a patient known as Patient A;

(c) you have committed an act of professional misconduct as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Chiropractic Act, 1991*, S.O. 1991, c. 21 (1) as amended, and paragraph 1(5) of Ontario Regulation 852/93, in that in December 2017, you abused a patient known as Patient A verbally and/or physically and/or psychologically and/or emotionally; and

(d) you have committed an act of professional misconduct as provided by subsection 51 (l)(c) of the *Health Professions Procedural Code* of the *Chiropractic Act, 1991*, S.O. 1991, c. 21, as amended, and paragraph 1(33) of Ontario Regulation 852/93, in that in December 2017, you engaged in conduct or performed an act, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to your treatment of and/or conduct towards a patient known as Patient A.

The CCO, however, as part of a Resolution Agreement, withdrew allegations (a), (c) and the claims of disgraceful and dishonourable conduct in (d).

THE EVIDENCE

An Agreed Statement of Facts (Exhibit 2) was filed. This provided that:

1. Dr. Shaun Lambrou ("Member") became a member of the College of Chiropractors of Ontario ("CCO") in 2010. The Member has not been the subject of a previous Discipline Committee hearing.

2. During the relevant time, the Member was a practitioner at Massage Matters ("Clinic") in Toronto, Ontario.

Patient A

3. In December 2017, Patient A was experiencing neck pain caused by stress. She had been receiving chiropractic treatment and massage for the pain. However, her usual chiropractor moved and she found massage alone was no longer effective. Patient A decided to obtain treatment from a new chiropractor.

4. On December 14, 2017, Patient A attended at the Clinic and completed patient intake forms. The Member greeted her in the reception area of the Clinic and took her into a treatment room. He asked Patient A questions, assessed her and diagnosed her as having mechanical neck strain caused by stress and posture. The Member proposed treating her with adjustments, soft tissue work and possibly acupuncture in the future. Patient A agreed to the proposal.

5. The Member provided Patient A with a treatment on December 14, 2017. She was wearing street clothes, including a shirt and sweater. According to Patient A, the Member asked her to remove her sweater and she did so. The Member put cream on his hands and did soft tissue

work on the back of her neck and clavicle area. During the soft tissue work, the Member leaned his body against Patient A's back. Had he testified, the Member would have said that he needed to position himself in that manner so he could generate the appropriate amount of force required to do the soft tissue work.

6. The pressure from the Member's body against her back made Patient A uncomfortable, but, she did not say anything. Following the soft tissue work, Patient A lay down prone on the treatment table and the Member did soft tissue work on her back, putting his hands under her shirt from the bottom to do so. This also made her feel uncomfortable, but she didn't say anything. The Member then had Patient A lie supine on the treatment table and he adjusted her neck and back.

7. Following the treatment, the Member escorted Patient A to the reception area. He encouraged her to book three more appointments, and she booked two: one on December 20, 2017 and one on December 23, 2017.

8. On December 20, 2017, Patient A returned to the Clinic for a second treatment. She was no longer having neck pain and reported that her tension was much lesser but not completely gone. Similar to the first treatment, the Member asked her to remove her sweater, and began to do soft tissue work on her neck and clavicle area. Similar to the first treatment, he leaned his body against her back during the soft tissue work.

9. Had Patient A testified, she would have said that when the Member leaned his body against her, she believed she felt his penis against her back. Had he testified, the Member

would have denied his penis ever touched Patient A, and that what she felt was the side of his leg and his hip.

10. Following the soft tissue work, the Member asked Patient A to lie supine on the treatment table. She did so and he did soft tissue work on her neck. During the soft tissue work on her neck, Patient A sat up and asked him to stop. She told the Member that she had just finished reporting a situation that involved years of sexual harassment from a fellow employee at her workplace. She told him that when he massaged her and leaned against her, she had felt his private parts rubbing up against her and that it was not Ok. The Member told her that he was sorry.

11. Had the Member testified, he would have said he was shocked and surprised by Patient A's comments and that he apologized because there had been a misunderstanding.

12. Patient A then ended the treatment early and left the room. She went to the reception area. She paid for the treatment and cancelled the next appointment. The same day Patient A made a complaint to the CCO.

13. In addition to documenting the assessment and treatment of Patient A on December 20, 2017, the Member also documented "Clinical Note Addendum: Patient left treatment early, was not feeling well."

14. Patient A was very upset by what she perceived happened to her on December 20, 2017. On December 28, 2017, Patient A saw a psychologist for treatment for her distress. The

psychologist made a mandatory report of sexual abuse of a patient to the CCO on December 29, 2017.

CCO Standards and Guidelines

15. CCO Standard of Practice S-001 Chiropractic Scope of Practice requires a member to provide relevant, safe, supportive patient-centered quality care and to document legible and accurate notes capturing any unique aspects of treatment.

16. CCO Standard of Practice S-002 Record Keeping requires a member to maintain accurate and complete patient records that contain comprehensive information about the initial examination and all assessments, the diagnosis or clinical impression, and a plan of care for the patient. The record must contain a copy of the patient's consent to any course of care, and reasonable information about advice and treatment given to the patient. The record should accurately recreate the doctor/patient interaction and should include reasonable information about a procedure that was commenced but not completed, including the reasons for non-completion.

17. CCO Standard of Practice S-013 Consent, requires a member to obtain consent to care or a plan of care that is fully informed, voluntarily given, related to the patient's conditions and circumstances and documented in the patient health record.

18. CCO Guideline G-001 Communication with Patient, requires a member to ensure that a patient, at all times, understands what is being done and why. The member has an

obligation to respect a patient's dignity and personal space and demonstrate particular awareness when touching a sensitive area of the body.

Admissions

19. The Member admits that he failed to adequately explain to Patient A the nature of the treatment he was proposing to provide to her and the reason for it. He, therefore, did not obtain informed consent for the treatment. The Member admits he did not adequately communicate with the patient throughout the treatment so that she understood what he was doing and did not take steps to ascertain her comfort with his treatment. He failed to document why the treatment on December 20, 2017 was not completed. He admits his documentation in the addendum on December 20, 2017 was misleading, inaccurate and incomplete.

20. The Member admits that, based on the facts set out above, he committed acts of professional misconduct as set out in the Notice of Hearing dated August 17, 2018 ("Notice of Hearing") because he:

(a) contravened a standard of practice of the profession or failed to maintain the standard of practice expected of members of the profession, as described in Allegation 2; and

(b) engaged in conduct or performed acts that, having regard to all the circumstances would reasonably be regarded by members as unprofessional as described in Allegation 4.

Other

The Member also acknowledged that he had received legal advice from his counsel, Valerie Wise, prior to signing the Resolution Agreement and that he had signed the Agreed Statement of Facts freely and voluntarily.

DECISION

After a brief recess to consider our decision the Panel accepted the submission from the parties and found Dr. Lambrou to have committed professional misconduct as alleged in the outstanding allegations in the Notice of Hearing.

SUBMISSIONS ON PENALTY AND COSTS

The parties presented the Panel with a joint submission on penalty and costs which was filed on consent as Exhibit 3. This submission asked the Panel to make the following orders:

1. Requiring the Member to appear before the Panel to be reprimanded.

2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of four months ("Suspension") beginning on April 15, 2019.

3. Directing the Registrar to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:

(a) by July 15, 2019, the Member must:

(i) review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including, but, not limited to CCO Standard of Practice S-001 Chiropractic Scope of Practice; CCO Standard of Practice S002: Record Keeping; CCO Standard of Practice S-013 Consent, and CCO Guideline G-001: Communication with Patients; and

(ii) provide evidence that he has successfully completed, at his own expense, the Legislation and Ethics Examination and the Record Keeping Workshop;

(b) requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the suspension.

4. Directing the Registrar to suspend one month of the Suspension if the Member completes the Conditions set out in Paragraph 3(a), by July 15, 2019.

5. Requiring that the results of the proceeding be recorded in the public portion of the Register and published in the Annual Report or other publications at the discretion of the College of Chiropractors of Ontario.

The CCO and the Member also requested the Panel order the Member to pay $10,500.00 by December 31, 2019 to the CCO to partially pay for its costs of the investigation and the costs and

expenses of the hearing and of legal counsel, with the Member to provide post-dated cheques for the costs at the completion of the Discipline Committee hearing.

Dr. Lambrou again acknowledged that he had received advice from his counsel, Valerie Wise, prior to entering into this Resolution Agreement and affirmed that he had signed the Joint Submission on Penalty and on Costs freely and voluntarily. Dr. Lambrou also stated that he would not appeal or seek judicial review of the decision of the Discipline Committee regarding the allegations set out in the Notice of Hearing so long as the Panel accepted the Joint Submission on Penalty.

ORDERS

After retiring to consider the penalty the Panel accepted the recommendations from the parties and made the following orders:

1. Requiring the Member to appear before the Panel to be reprimanded.

2. Directing the Registrar and General Counsel ("Registrar") to suspend the Member's certificate of registration for a period of four months ("Suspension") beginning on April 15, 2019.

3. Directing the Registrar to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:

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(i) review, and undertake in writing to comply with, all CCO regulations, standards of practice, policies and guidelines, including, but not limited to, CCO Standard of Practice S-001 Chiropractic Scope of Practice, CCO Standard of Practice S002: Record Keeping, CCO Standard of Practice S-013 Consent, and CCO Guideline G-001: Communication with Patients and

(ii) provide evidence that he has successfully completed, at his own expense, the Legislation and Ethics Examination and the Record Keeping Workshop;

(b) requiring the Member to be peer assessed at his own expense within six months of returning to practice after the lifting of the suspension;

4. Directing the Registrar to suspend one month of the Suspension if the Member completes the Conditions set out in Paragraph 3(a), by July 15, 2019.

5. Requiring that the results of the proceeding be recorded in the public portion of the Register and published in the Annual Report or other publications at the discretion of the College of Chiropractors of Ontario.

6. Requiring the Member to pay $10,500.00 by December 31, 2019 to the CCO to partially pay for its costs of the investigation and the costs and expenses of the hearing and of legal counsel, with the Member to provide post-dated cheques for the costs at the completion of the Discipline Committee hearing.

The Panel concluded that the proposed penalty was both fair and reasonable, as it falls within the range of penalties appropriate based on the admissions and findings in this matter. We acknowledge that it was negotiated by counsel for both parties and we are satisfied that the review of CCO guidelines, regulations, standards of practice and policies as well as taking the record keeping workshop and legislation and ethics exam will be effective remediation tools. The Panel believes that by making this order, the public interest is served through a strong message of deterrence and a clear assurance of the College's commitment to the public protection.

REPRIMAND ADMINISTERED

7. As Dr. Lambrou had undertaken not to appeal or seek judicial review if we accepted the Joint Submission, at the conclusion of the hearing, the Panel administered the oral reprimand required by its penalty order.

I, Karoline Bourdeau, sign this decision and reasons as chair of this Discipline Panel and on behalf of the members of the Discipline Panel listed below:

April 2, 2019

Karoline Bourdeau

KAROLINE BOURDEAU, J.D., Chair

Panel Members: Mr. Doug Cressman
Dr. Colleen Pattrick
Dr Colin Goudreau
Dr. Brian Budgell