H160013

THE DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. ATHI KANAPATHY SOMASUNDARAM**, of the City of Scarborough in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation").

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Carol Janik
Dr. Sandy Venditti
Ram Chopra
Margaret Dunn

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Mr. Mark J. Sandler, Ms. Amanda
	)	Ross
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. ATHI SOMASUNDARAM	)	Mr. Harry Black, Mr. Earl Heiber
	)	For Dr. Athi Somasundaram

Hearing held on March 13, 14, May 11, 18, June 21, August 15, October 5, November 7, 2018.

REASONS FOR DECISION ON MOTION

This matter came on for a hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on March 13, 2018. The matter proceeded for eight days over the course of several months.

THE ALLEGATIONS

The allegations against Dr. Athi Somasundaram (the "Member") were contained in the Notice of Hearing, dated February 3, 2017. The allegations against the Member were as follows:

1. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991,* Statutes of Ontario, 1991, Chapter 18, in that, during the year 2015, you contravened a standard of practice or failed to maintain the standards of practice of the profession relative to one of your patients, namely N.L, contrary to paragraph 1 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

- In or about 2015, you provided orthodontic treatment for your patient, N.L, that was inadequate and failed to meet the standards of the profession
- On or about March 15, 2015, your case work-up was incomplete given the lack of intra-oral and extra-oral findings, a failure to take the necessary diagnostic radiographs, a lack of cephalometric analysis and a failure to obtain models.
- On or about March 15, 2015, you formed a diagnosis without first obtaining the necessary diagnostic information.
- On or about March 15, 2015, you failed to document and assess the patient's periodontal condition, form a periodontal diagnosis and/or evaluate the patient's periodontal condition prior to embarking on orthodontic treatment.

- On or about March 15, 2015, you failed to provide the patient with the available treatment options to address her malocclusion, including options for extraction versus non-extraction treatment.
- During the period March to October 2015, you failed to appropriately monitor your patient's orthodontic progress.
- On or about September 13, 2015, you extracted N.L's four bicuspid teeth (teeth 14, 24, 34 and 44) without taking pre-treatment radiographs.
- In or about 2015, you allowed your patient, N.L, to direct treatment decisions which compromised the treatment you provided.

2. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2015, you treated a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent relative to one of your patients, namely N.L., contrary to paragraph 7 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

   Particulars:

- You failed to obtain N.L.'s consent to treatment.
- You did not provide N.L. with a diagnosis, the nature and purpose of the proposed treatment along with the risks and benefits of such treatment, the treatment alternatives available along with the associated risks and benefits, the likely consequences of not having the treatment, and the cost of each treatment option.
- You did not provide the patient with a written treatment plan, a fee estimate or financial agreement.

3. You committed an act or acts of professional misconduct as provided by s.51(1)(b.1) of the *Health Professions Procedural Code*, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18, and as provided by s.51(1)(c) of the *Health Professions Procedural Code* and paragraph 8 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended, in that, during the year 2015, you sexually abused a patient, namely N.L.

Particulars:

- On or about September 13, 2015, you sexually abused your patient, N.L., in that you hugged N.L. at the end of her appointment.
- In or about March to September 2015, you rubbed N.L.'s face and rubbed along the side of her face/cheek area for a non-dental purpose.
- On or about September 21, 2015, you sexually abused your patient, N.L, in that:
    - you hugged her;
    - you held onto her by grabbing her by her hips;
    - you nuzzled her neck and/or put your face next to her neck to "take a big smell" of her; and/or
    - you kissed and/or tried to kiss her.
- In or about March to October 2015, you made comments to N.L. about wanting to have a personal, social relationship with her outside the dental office.
- In or about March to October 2015, you sexually abused your patient, N.L., by making comments to her about her physical appearance which were of a sexual nature, inappropriate and/or a breach of dentist-patient boundaries.

4. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act*, *1991*, Statutes of Ontario, 1991, Chapter 18, in that, during the year 2015, you failed to keep records as required by the regulations, contrary to paragraph 25 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- In or about March 2015 to October 2015, you failed to keep records as required in that:
    - Your financial recordkeeping for N.L. was incomplete.
    - During the period March to October 2015, you failed to fully document the fees for treatment with the corresponding dental service.
    - In or about March to October 2015, you failed to provide the patient with receipts for the payments she made.
    - In or about March to October 2015, your clinical chart entries were inadequate and did not fully document the treatment you provided.

- On or about September 13, 2015, you failed to document your methodology during the extraction appointment.
- In or about March to October 2015, you failed to document the location, tooth numbers, materials and methods for the orthodontic treatment.
- Your patient medical history form was incomplete.
- There was no dental history documented.
- There was no odontogram.
- There was no periodontal charting, diagnosis, assessment and/or evaluation.
- There were no intra-oral and extra-oral findings.
- There was no cephalometric analysis.
- You did not document in your chart your interaction with N.L. that took place through text messaging and/or phone calls on your personal cell phone.

5. You committed an act or acts of professional misconduct as provided by s.51(1)(c) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 in that, during the year 2015, you engaged in conduct or performed an act or acts that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical relative to one of your patients, namely N.L., contrary to paragraph 59 of Section 2 of Ontario Regulation 853, Regulations of Ontario, 1993, as amended.

Particulars:

- In or about October 2015, your spouse, who is also your employee, Mrs. Dayanithi Somasundaram, attended at N.L's home unannounced and uninvited.
- In or about September 2015, you rubbed N.L.'s face and rubbed along the side of her face/cheek area for a non-dental purpose.
- On or about September 13, 2015, your conduct towards N.L. was disgraceful, dishonourable, unethical and unprofessional in that you hugged N.L.
- On or about September 21, 2015, your conduct towards N.L. was disgraceful, dishonourable, unethical and unprofessional in that you:
  - hugged her;
  - held onto her by grabbing her by her hips;

  - nuzzled her neck and/or put your face next to her neck to "take a big smell" of her; and/or
  - kissed and/or tried to kiss her.
- In or about March to October 2015, you made comments to N.L. about wanting to have a personal, social relationship with her outside the dental office.
- In or about March to October 2015, your conduct towards N.L. was disgraceful, dishonourable, unethical and unprofessional in that you made comments to N.L. about her physical appearance that were sexual in nature, inappropriate and/or a breach of dentist-patient boundaries.

THE MEMBER'S PLEA

The Member admitted the allegations of professional misconduct as set out in paragraphs 1, 2 and 4 of the Notice of Hearing. The Member denied the allegations set out at paragraphs 3 and 5.

THE UNCONTESTED EVIDENCE

On consent of the parties, College Counsel introduced into evidence an Agreed Statement of Facts, wherein the Member's admissions to allegations 1, 2 and 4 were confirmed, and where the College provided evidence substantiating same. The Agreed Statement of Facts is attached as Schedule "A" to the end of these Reasons for Decision.

BACKGROUND

The remaining allegations against Dr. Somasundaram set out at paragraphs 3 and 5 of the Notice of Hearing, relate to his treatment of and interaction with patient, N.L. including that on or about September 21, 2015 he sexually abused the patient.

The Member was initially trained as a dentist in Sri Lanka and India. He returned briefly to practise dentistry in Sri Lanka before coming to Canada. Since 1993, he has operated his own dental practice, which is currently located in the east end of Toronto, Ontario. The Member also taught in the prosthodontic department at the University of Toronto, and taught undergraduates until 2016. He has no prior disciplinary record.

ISSUES

This case raises four primary issues:

1. Did the Member engage in the sexual abuse of patient, N.L. in that on or about September 13, 2015 he hugged her at the end of her appointment?

2. Did the Member engage in the sexual abuse of patient, N.L. in that on or about March to September 2015, he rubbed her face and rubbed along the side of her face/cheek area for a non-dental purpose?

3. Did the Member engage in the sexual abuse of the patient, N.L. in that on or about September 21, 2015 he hugged her, held onto her by grabbing her by her hips, nuzzled her neck and/or put his face next to her neck to "take a big smell" of her, and/or kissed and/or tried to kiss her?

4. Did the Member engage in an act or omission that would be reasonably regarded by members of the profession as disgraceful, dishonourable, unprofessional or unethical by engaging in the conduct as set out above?

EVIDENCE CONSIDERED

The panel heard testimony from five witnesses: Patient, N.L., her sister and husband, the Member and the Member's assistant.

In addition, the panel was provided with a number of photographs of the Member's office, N.L.'s dental records, text messages exchanged between the Member and N.L., and payroll information for N.L.'s sister. The panel was also given the opportunity to visit the Member's office.

OVERVIEW OF THE ALLEGATION

Patient N.L. is married, with two children. She lives outside of Toronto, where she builds custom furniture and works part-time at a fastener centre. Starting in March 2015, the patient began to receive dental services from the Member. She came to the Member for braces on referral by her sister, who advised her that the Member was less expensive than other dentists in the area.

The Patient alleged that during her appointments with the Member, he would compliment the way she looked and told her how beautiful she was going to be

when she was done her treatment. The Patient further alleged that the Member would get really close to her face and rub or brush his hand on the side of her cheek. She testified that on at least one occasion, he gave her a hug goodbye when she was leaving his office.

The Patient testified that at the end of her appointment with the Member on September 21, 2015, the Member gave her a hug goodbye. She reciprocated the hug, but the Member would not let her go. She alleged that she tried to get away from him and told him to stop. She testified that the Member tried to kiss her and was putting his head into her neck, nuzzling or attempting to nuzzle her. At a certain point during this interaction, the patient alleged that she was able to get away from the Member, but he grabbed her again by the hips, pulled her into him and tried to kiss her. The Member stopped once he heard someone trying to turn the doorknob to get into the office.

The Patient could not recall anyone else in the office at the time of the incident. The Member and his office assistant testified that both she and the Member's wife were present, as well as an unknown Asian man, who was sitting in the Member's waiting room.

The Law and Legal Principles

Burden and Standard of Proof

The College bears the burden of proving the allegations against the Member. The College must do so on the civil standard of proof, which is proof on a balance of probabilities. *(F.H. v McDougall,* 2008 SCC 53). Put another way, the College must establish that it is more likely than not that the alleged conduct occurred.

The Court further provided that the burden of proof does not change depending on the seriousness of the case:

> In my view, the only practical way in which to reach a factual conclusion in a civil case is to decide whether it is more likely than not that the event occurred. To suggest that depending upon the seriousness, the evidence in the civil case must be scrutinized with greater care implies that in less serious cases the evidence need not be scrutinized with such care. I think it is inappropriate to say that there are legally recognized different levels of

> scrutiny of the evidence depending upon the seriousness of the case. There is only one legal rule and that is that in all cases, evidence must be scrutinized with care by the trial judge. Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. (*McDougall*, paragraphs 44-46, 48)

The Panel recognized that it is the College's burden to prove the allegations to the requisite standard. There is no obligation on the Member to disprove the allegations or to provide an explanation as to why the patient might have made up the allegations.

The Panel is aware that there is no legal requirement that a complainant's testimony be corroborated and, in any case, in a situation where there is an allegation of sexual abuse, it would be rare to have corroborating evidence since such acts typically occur in private. (*McDougall*, para 80)

Credibility and Reliability

In reaching its decision, the Panel considered both the credibility of each witness and the reliability of their testimony. The Panel is aware that these are two different concepts. Credibility refers to the witness's sincerity and willingness to speak the truth as he or she believes the truth to be. Reliability relates to the witness's ability to accurately observe, recall and recount the events in issue. That is, the witness's credibility must be assessed along with whether his or her evidence is reliable and can be counted on to be accurate.

The Panel considered the following factors or questions in assessing credibility and reliability:

- Did the witness seem honest?
- Did the witness have an interest in the outcome?
- Did the witness seem to make accurate and complete observations? What were the circumstances of the observations? Were they unusual or routine?
- Did the witness seem to have a good memory?
- Did the witness seem to be reporting or simply putting together an account put together from other sources?
- Was the testimony reasonable or consistent?

- Did they say something different on an earlier occasion?
- Did any inconsistencies make the evidence more or less reliable and believable? Was it an honest mistake? Is there an explanation for the inconsistency?
- What was the witness's demeanour?

The Panel also considered the following factors when assessing a witness' evidence:

- Opportunity to observe;
- Common sense
- Probability or improbability of the witness's story – Does the evidence make sense? Is it reasonable? Is it probable? Did the witness show a tendency to exaggerate testimony?
- Was the testimony of the witness contradicted by the testimony of another witness or witnesses whom we consider to be reliable?
- Whether there was anything confirming one version of events over another
- Whether witnesses were forthright in their evidence

(*Stefanov* v. *College of Massage Therapists of Ontario*, para.50 and *Re Pitts and Director of Family Benefits Branch of the Ministry of Community & Social Services)*

The Panel considered all of the evidence presented in light of the guidance provided by the case law.

The Panel's assessment of credibility of the witnesses played a significant role in the Panel's ultimate decision.

DECISION

Based on the Member's plea and the facts as set out in the Agreed Statement of Facts, the Panel finds that the Member engaged in professional misconduct as alleged in paragraphs 1, 2 and 4 of the Notice of Hearing.

Further, the Panel finds that the Member engaged in professional misconduct as set out in paragraphs 3 and 5 of the Notice of Hearing. With respect to the allegations at paragraphs 3 and 5 of the Notice of Hearing, the Panel finds that the Member engaged in professional misconduct in that he sexually abused a patient and having regard to the circumstances, that his conduct would

reasonably be regarded by other members of the profession as disgraceful, dishonourable, unprofessional or unethical.

Our reasons are as follows.

SUMMARY of FACTUAL FINDINGS

Evidence of Patient, (N.L.)

At the Patient's first appointment on March 8, 2015 she filled out an initial patient form. She attended the Member's office for the purposes of getting braces. N.L testified that at this first appointment she discussed financial terms with the Member and that they agreed to an approximate cost of $3500.00 payable by a $500.00 deposit, followed by $100.00 per visit. The costs were to include preparing and inserting braces and all follow-up appointments.

The Member's records show that N.L. attended the office eight times between March 8, 2015 and September 21, 2015. Their appointments were booked through text message exchanges between Dr. Somasundaram and the patient.

The Patient testified that Dr. Somasundaram had an assistant, who typically did not remain in the operatory during her appointments. Instead, it appeared to the patient that the assistant would attend to preparing the operatory, leave and then return at the end of the appointment for the purposes of cleaning the operatory. In one of the text messages filed in evidence, the patient asked the Member whether his assistant would be present, given the nature of the appointment. The Patient explained that she asked about the assistant, because in her experience the assistant did not stay for appointments.

The Patient testified that during her appointments, Dr. Somasundaram would tell her that they should go for coffee; he would compliment her on the way she looked, and would remark on how beautiful she was going to be when the dental work was complete. He told her that she looked like a model. She testified that he would get really close and rub his hands on the side of her cheek. Further, she testified that on at least once occasion (in addition to the September 21 incident) that he gave her a hug goodbye when she was leaving the office.

The Patient acknowledged that her husband and/or sister occasionally accompanied her to her appointments, but that she did attend the office alone on one or more occasions.

The Patient also admitted that on September 5, 2015, she asked the Member via text message if he could bill her insurer for extractions that he had to perform as a cleaning or scaling, so that she did not have to pay for the procedure directly. Dr. Somasundaram declined to do so. The Patient explained that she asked the Member to do this because she believed that he had done something similar for her sister in the past. She acknowledged that it was inappropriate for her to ask the Member to mislead her insurer.

On September 13, 2015, the Patient attended Dr. Somasundaram's office with her husband for extractions of her four bicuspids. By this point in her treatment, she had already paid the Member $1300.00

On September 21, 2015, the patient attended Dr. Somasundaram's office alone for a follow-up. She and Dr. Somasundaram exchanged text messages about her time of arrival. Originally, her appointment was scheduled for noon but at 9:18 am she texted Dr. Somasundaram to let him know that she should be arriving closer to 11:00 am. At 9:25 am. the Member replied "OK".

On cross examination, the Patient denied taking highway 407 to attend her appointment, because she was running late. It was suggested to her that she was upset about having to pay to travel on the 407 and then pay the Member for what ended up being a brief visit. The Patient said she did not use the 407 and that the suggestion did not make sense, since she was not running late for her appointment.

The Patient testified that once she arrived at the Member's office, she waited in her car for the Member to arrive. She saw his assistant open the front door, but continued to wait in her car until she saw the Member pull up in his vehicle. After Dr. Somasundaram arrived, the complainant came into his office. The Patient testified that there was no one else in the waiting room. The Member brought the patient into the operatory area, where she did see the assistant come in for a moment, but then leave. The Patient testified that she did not see the assistant again. After a relatively short examination, the Patient paid the Member another $100.00 and turned to leave the operatory area. She testified that as she was about to leave the operatory, Dr. Somasundaram gave her a hug goodbye and she reciprocated. She testified, however, that the Member did not let go of her. She told him to stop and tried to get away. The Patient testified that the Member then tried to kiss her, but that she was able to turn her head away. He then put his head into her neck and nuzzled her. She testified that she looked to see if someone was around but saw no one. Dr. Somasundaram

released her from the embrace and moved into the waiting room to shut off the lights. The Patient testified that at no time did she see anyone else in the office.

The Patient tried to get past Dr. Somasundaram, but he grabbed her by the hips and pulled her towards him to kiss her. She told him to stop. The Patient testified that she then heard someone turning the door handle on the outside door of the office. She described this as someone "jiggling the handle". She took this to mean that the door into the office must have been locked, but she did not understand why it would be since it was opened at the time she came in. She testified that she could not see who was at the door because of her position in the waiting room and so she assumed that the person at the door could not see her. The Patient testified that upon hearing the door handle, Dr. Somasundaram released her, turned to the door and opened it. The Patient testified that at that point, a tall, Asian man with dark hair came in and sat in the waiting room. The Patient explained that she took the opportunity to run out of the office, through the open door. She said that no one followed her out of the door.

The Patient testified that she was frazzled and disoriented when leaving the office. At 12:27 pm, the Member texted her "Where are you? N." He also tried to call her but she did not answer.

The Patient testified that she called her husband while she was driving. She felt fear, disbelief, distraught and said she was crying. She testified that instead of going home, she went to her sister's house.

It is uncontested that Dr. Somasundaram made multiple attempts to contact the Patient through text message in the days after the alleged incident.

The Patient did not return to the Member's office to complete her dental work. She found another dentist to do so. She also lodged a complaint with the College. Shortly after doing so, in or around October 12, 2015, the Patient testified that the Member's wife attended her home uninvited. The Patient testified that the Member's wife said that a complaint would ruin their future and asked the Patient to withdraw it. The Member's wife offered the Patient money to dismiss the complaint. N.L. testified that she told her that she would call her back. N.L. did not call the Member's wife back.

The Member's wife called the Patient repeatedly and two days later returned to her house, offering her an envelope which the patient refused to accept. The Patient testified that she never accepted money from the Member or his wife, never asked them for money and has no intention of doing so.

The Patient's Credibility and Reliability

Dr. Somasundaram's counsel contended that the Patient was not credible for two main reasons. First, counsel argued that the Patient had asked the Member to essentially mislead her insurer for her own financial gain. Second, counsel argued that the Patient's testimony about having attended her sister's home after the alleged incident was inconsistent with her sister's testimony and therefore not reliable.

As set out below, the panel did not accept the Member's arguments with respect to the Patient's credibility.

The Patient was forthright in admitting that she made a mistake in asking the Member to alter her insurance claim codes.

The Patient had no apparent motive to fabricate her complaint.

She rejected Mrs. Somasundaram's efforts to give her money in exchange for dropping her complaint.

She has had to pay substantially more money to have her orthodontic treatment completed by another practitioner.

The Panel rejects the argument that the Patient was motivated by money to fabricate her complaint.

The Panel accepted the Patient's evidence as credible and reliable. At no time did she substantially change her version of the events. The fact that she and her sister recalled their visit occurring on different dates does not undermine the patient's credibility. The timing of that visit is of little significance.

The Patient's evidence with respect to the Member's comments and inappropriate touching during the visits leading up to the September 21st visit was credible and reliable. Again, there appeared to be no reason why the Patient would have fabricated the information and much of it was consistent with the evidence her sister gave, as discussed below.

In summary, the Panel concluded that the patient provided it with credible and reliable evidence. She relayed a consistent version of the alleged events, in a straightforward fashion. Her testimony was not shaken on cross-examination and

where she was mistaken or could not recall a particular detail, she fairly conceded it.

Evidence of N.D. (Patient's Sister)

N.D. testified that she saw the Member as a patient and then at some point in 2009, she began working for him. She worked for him for a brief period of time. She indicated that in her experience as both a patient and a member of staff, the Member would sometimes work without an assistant.

N.D. testified that the Member would greet her with a hug at the start of and the end of each of her appointments. She also testified that he would place the palm of his hand against her face rubbing or caressing it slightly and that he would tell her that she was beautiful.

N.D. testified that her sister (the Patient) called her on September 21st, the day of the alleged incident and that she recalled seeing her sister within 24-hours of the incident, but did not believe she saw her the same day.

N.D. also testified that after September 21st, the Member attempted to contact her by telephone and text on several instances. She did not return any of his calls or text messages.

Credibility and Reliability of N.D.

The Panel considered N.D.'s evidence in light of the fact that she may have had an interest in supporting or bolstering her sister's complaint. In light of this potential concern, the Panel placed little weight on N.D.'s evidence with respect to the patient's apparent emotional state following her September 21st appointment.

With respect to the balance of N.D.'s testimony, the Panel found her credible. She presented her evidence in a clear and forthright manner. She had good recall of the events she was describing and where her memory was deficient, she freely acknowledged same. The Panel found N.D.'s description of the fact that the Member sometimes worked without an assistant to be reasonable and consistent with the other evidence presented. While there was some debate about the nature of and length of N.D.'s employment with the Member, it was not contested that she did spend some time there in an employment capacity and that she was a long-time patient.

The Panel also found N.D.'s testimony with respect to her interactions with the Member to be plausible. Again, her experience of the Member hugging her and complimenting her is consistent with her sister's experience

Finally, the Panel found N.D.'s evidence with respect to the Member's attempts to contact her after September 21st credible. The actions are consistent with the actions the Member took in relation to the Patient, which were in part corroborated by the text messages filed into evidence.

Evidence of D.L. (Patient's Husband)

D.L. testified that he attended at the Member's office with his wife on approximately 2 or 3 occasions. He also confirmed that in part he did this because his wife had previously mentioned to him how the Member had caressed her face on earlier visits.

D.L. testified that when he was present he did not see an assistant in the operatory during his wife's procedures, except for a minute or two at the outset of the appointment. He believed that he saw two different women working with the Member at the various visits.

D.L. testified that he was present with the patient on at least one occasion where Dr. Somasundaram hugged her. She withdrew and acted rigidly. Dr. Somasundaram ended the hug quickly.

D.L. testified that Dr. Somasundaram texted his wife on September 23rd , that she did not respond and that she subsequently blocked his phone number.

He also confirmed in his testimony that Dr. Somasundaram's wife came to their home on two occasions in mid-October. He testified that after introducing herself she told the patient and him that she had children and that she did not want the complaint to affect their family dynamics. She appeared distraught and was crying. She offered to pay for the completion of the patient's dental work and there would also be something extra for the family if the complaint was dropped. On the second visit, she handed him an envelope but he returned it to her unopened. He did not know what was inside it.

Credibilty and Reliability of D.L.

The Panel thought the witness was both credible and reliable. His testimony seemed reasonable and honest. The evidence he gave was internally consistent and was in large measure corroborated by the evidence his wife and sister-in-law provided. The Panel recognized that D.L. may have described his wife's emotional state in a manner that favoured her version of events. In that regard, the Panel elected not to give significant weight to the husband's testimony about his wife's emotional state.

Evidence of Dr. Athi Somasundaram

In 2015 the Member employed three people in his office: his wife Meena for payroll and two assistants, Gowry and Gupreet.

Dr. Somasundaram testified that he never saw patients without an assistant present. He had previously told a College investigator that he did not work with an assistant. When confronted with this inconsistency, he explained that he had been confused by the investigator's questions and that assistants are present when he is seeing patients.

The Member confirmed that N.D. (the Patient's sister) was a patient from approximately 2009. He denied that he ever employed her in his office, but he did acknowledge that she worked briefly for him on a voluntary basis. He also vigorously denied that he ever initiated a hug with N.D. or that he ever rubbed her cheek or complimented her.

Dr. Somasundaram first saw the Patient in March 2015 on a referral by N.D. He understood that the patient was told that he could do braces for a "good price" and that he had flexible hours. He informed the Patient that the total fee for braces would be $3500.00. Further, he explained to her that if she got her x-rays done elsewhere, he could reduce the fee to $3000.00. He also explained that extractions, fillings, and lab charges would be extra. She agreed to the terms.

Dr. Somasundaram denies ever initiating a hug with the Patient. Instead, the Member testified that on occasion, the Patient would initiate a hug with him. He testified that she would even do so in her husband's presence.

The Member testified that the Patient attended his office periodically between March and May 2015. During those visits, the Patient and the Member discussed the Patient's furniture business and their mutual interest in motorcycles. The

Member claimed that the Patient suggested he visit her business when he was passing through her area on his way to visit his children at university.

There was then a three month period in which the Patient did not attend the Member's office. He understood that she had lost her job and that she could not afford to return for treatment. He did not see the Patient from May until late August 2015.

In response to this complaint, the Member initially maintained that the Patient stopped seeing him because he refused to change her insurance claim codes so that she could collect from her insurer. He said that it was after his refusal to engage in this manner that she launched her complaint with the College. However, on cross-examination, it became clear the Member's recollection was incorrect. The Patient visited the Member on two other occasions following her request to change the insurance claim codes and that she did not file her complaint until approximately one month after that discussion took place. In fact, the evidence made clear that following this discussion (which took place over text message) the Patient returned to the office to have teeth extracted, for which she paid $400.00.

With respect to the appointment that took place on September 21st, the Member testified that the Patient was running late for the appointment and that she was upset about paying to drive on highway 407, as well as having to pay for her appointment. This evidence was contradicted by the text messages, which made clear that the Patient was in fact early for her appointment on September 21st.

The Member testified that during his appointment with the Patient on September 21st, there were two people in the office, in addition to himself, when the Patient arrived. He testified that his assistant Gowry was present, as was an Asian man, who was sitting in his reception area. The Member explained that the Asian man was there to make photocopies at the Member's photocopy business, which is found in the basement level of the same office building. The Member testified that he told Gowry to make the man wait until the Patient's appointment was finished.

The Member explained to the Panel that he had Gowry set up the operatory ahead of the Patient's appointment and that she was present during the whole appointment. This was inconsistent to what the Member told the College investigator initially about always working without an assistant.

The Member testified that it was only after the Patient left the office that Gowry took the Asian man down to the basement.

Dr. Somasundaram testified that the Patient was unhappy about paying him $100.00 for a short appointment. He reminded her about the fee arrangement she had initially agreed to. He testified that the Patient paid him, hugged him and left the office. He believed that when the Patient left the office that day, she left on good terms. This position was somewhat inconsistent with the Member's claim that the Patient was upset about the payments when she left and that explained why she decided to launch a complaint with the College.

Again, also inconsistent with the evidence that the Patient left on good terms, Dr. Somasundaram texted her multiple times to ask where she was and to ask her to call him back. The Member testified that he sent the Patient those texts following their appointment, because he was worried about her safety driving home.

In his written response to the College, the Member stated that he tried to contact the Patient following the September 21st appointment to inform her that she did not have to make the next payment or that he would refund the full amount of what she had already paid if she was unhappy. This offer does not appear to have been reduced to writing in any of the text messages the Member sent to the Patient.

On October 7, 2015, a College investigator attended the Member's office for the purposes of speaking with him about the complaint. The Member testified that he was not in the office that day and was not told about the visit. Coincidentally, however, the Member made a phone call to the Patient on the same day, but she did not respond. The investigator spoke to Gowry who assumed the investigator was a sales person. The investigator left a message on the office voicemail which Dr. Somasundaram said he never checked and did not pick up. He explained that he only checks missed calls and because the number from which the investigator called was blocked, he could not call her back.

The Member admitted that he did receive a letter from the investigator on October 13, 2015. On October 14, 2015, he tried to reach the Patient by text. He finally spoke with the College investigator on October 15th.

The College investigator asked Dr. Somasundaram for the Patient's file. At the time, the Member knew that he had lost the original patient information form filled out by N.L. He replaced it with one he filled out himself, but he did not

tell the College investigator about it. Instead, he told the investigator the Patient had never filled out the Patient Information Form. He later admitted that he misinformed the investigator, once he was advised that the Patient had reported to the College that she had filled one out. It was not clear to the Panel why the Member chose to invent a story about the missing Patient Information Form.

Dr. Somasundaram denied knowing of his wife's visits to the Patient's home. He testified that while his wife knew about the complaint, she did not know about the subject matter. He told his wife that the complaint was financial in nature.

Dr. Somasundaram acknowledged that neither the Patient nor her husband have ever asked him for any money and have never filed a lawsuit against him.

Dr. Somasundaram's Credibility and Reliability

The Panel found it difficult to accept the Member as a credible and reliable witness. The inconsistencies in his testimony were significant.

He initially told the College investigator that he did not work with an assistant. When that was no longer expedient, he changed his position to state that he always had an assistant present.

He misrepresented to the College investigator why he did not have an original Patient Information Form. He did not tell the investigator that he had simply misplaced the original form and had replaced it with one he completed himself. It was only when faced with the Patient's evidence that he changed his story.

The Member advised the ICR Committee that the Patient did not return to his office after her August 28th appointment because she was upset about the mounting fees and upset that he would not lie to her insurer. It is clear from the text messages exchanged between the Member and the Patient that she did not stop attending his office after September 5th, the day she asked about the insurance coverage. The incident in question took place on September 21st, a week after she had visited the office on September 13th for teeth extractions. There is nothing in the evidence to suggest that the Patient was angry about the Member's refusal to change the insurance codes or that she stopped attending the office after his refusal.

Before this Panel, the Member changed his story once again. He said that the Patient was upset about having to pay the $100.00 on September 21st for such a

short visit. He said that she had been running late and that ultimately she left the appointment unhappy with the cost of the visit and the travel costs incurred for attending. As summarized above, this is inconsistent with the text messages that make clear that the Patient was not running late that day and was in fact hours early for the appointment. This version of events is also inconsistent with Gowry's evidence (described below) that she did not see anyone leave the office upset that day, however she testified that she did see the Patient pay the Member for the visit. Had the Patient been upset, one would have expected that to be apparent to Gowry, who allegedly saw the financial transaction take place.

The Member explained that his urgent texts to the Patient after the September 21st appointment arose out of a concern over her safety and because he wanted to offer her a refund. The Panel does not accept this explanation. This is entirely inconsistent to all of the other text messages exchanged between the Member and the Patient He did not make any similar attempts to contact her after May 2015, when she did not return to his office for three months. The more likely reason for the urgent text messages was an attempt by the Member to ensure that the Patient would not complain or take any action with respect to his conduct.

The Panel does not accept the Member's evidence about an Asian man being present in the waiting room during the Patient's visit on September 21st. This is entirely inconsistent with the Patient's memory of the events. Had someone been present, the Patient clearly would not have been frightened or concerned about how to leave the office that day. Further, the Panel finds it difficult to accept that someone was present during the alleged incident, yet the Member made no efforts to identify him. The man was apparently a customer of the Member's copy business. The Member acknowledged that he did not check to see whether the man paid by way of credit card or whether there was some other way of identifying him.

Evidence of Gowry Umasanger ("Gowry")

Gowry worked as a dental assistant for Dr. Somasundaram from April 2015 to March 2017. She also worked in the grocery store in the basement when the dental office was closed or not busy.

When the College investigator attended at the office on October 7, 2015, Gowry denied that she worked in the dental office. She explained to the Panel that she

did so because she assumed that the investigator was a salesperson and she did not want to have to deal with her.

Gowry testified that on September 21st, she and Dr. Somasundaram went into the office in the morning. She prepared the dental tray in anticipation of the Patient's visit. Gowry testified that she remained in the office during the Patient's appointment, which lasted about five or six minutes. She testified that following the appointment, she cleaned the operatory chairs and table. Gowry testified that she was present when Dr. Somasundaram was with the Patient for the entirety of the appointment and was there to see the Patient pay and leave. She testified that she did not see the Member and Patient hug and that she did not observe that the Patient was in any way upset upon leaving.

When the Patient left, Gowry testified that she brought the Asian man, who was waiting in the reception area to the photocopy room downstairs.

Contrary to the Member's testimony, Gowry testified that Dr. Somasundaram and his wife listen to voicemail messages immediately upon arriving at the office each day.

Gowry testified that Dr. Somasundaram never worked without an assistant, but that she had never seen the Patient before the September 21st visit. However, Gowry was working on May 26, 2015, the same day that the Patient had an appointment. It is difficult to reconcile these two pieces of evidence, as it raises the issue of whether Gowry was in fact always present in the operatory if she did not remember ever meeting the Patient before September 21st.

Gowry admitted that she did not want to say anything to the Panel that would hurt the Member's position.

Gowry's Credibility and Reliability

The Panel found Gowry not to be a reliable witness. She admitted to giving false information to the investigator about working in the dental office when the investigator attended in October 2015.

She testified that she was always in the operatory when patients were present, but did not remember the Patient who, from the records, it was clear had been present on a day Gowry was at work

Gowry testified that she was present when the Patient said good-bye to the Member and left the office. She indicated that she witnessed the full exchange; however that was inconsistent with her testimony that in fact she was cleaning the operatory and getting cleaning supplies from the sterilization area at the time. The two versions are simply not compatible with one another.

While it was clear to the Panel that Gowry was well meaning in her effort to provide information in support of the Member, her evidence was internally inconsistent and not reasonable, given the documentary evidence, as well as the evidence from the other witnesses, including the Member himself.

REASONS FOR DECISION

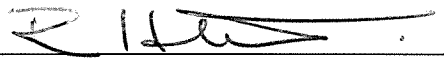
On the balance of probabilities and based on clear, cogent and convincing evidence, the Panel was satisfied that Dr. Somasundaram sexually abused the Patient as alleged in the Notice of Hearing.

For the reasons set out above, the Panel found the Patient's version of events highly credible. Her evidence was internally consistent, plausible and corroborated by much of the documentary evidence, as well as the evidence from the other witnesses. The Member's testimony did not shake the Panel's view of the Patient's testimony. The Panel accepts that the Member engaged in inappropriate touching (hugging, caressing of cheek) and made unsuitable comments to the Patient throughout their professional relationship and that on September 21st, the Member sexually abused the Patient in the manner as alleged.

We are satisfied that the conduct that occurred clearly falls into the category of sexual abuse as that is defined in the *Health Professions Procedural Code*. The physical interaction and the comments were of a sexual nature and were entirely inappropriate.

In addition, the Panel concluded that such conduct would reasonably be regarded by members of the profession as to be disgraceful, dishonourable, unprofessional and unethical. Disgraceful conduct is defined as conduct that shames the member and by extension the profession. Clearly, engaging in sexual abuse with a patient is shameful for both the member and the profession and there can be no tolerance for such behaviour by a dentist. Dr. Somasundaram and any member of this College should have no doubt that it is unacceptable to sexually abuse a patient by making inappropriate comments and by making inappropriate and unwanted physical contact.

I, Richard Hunter, sign these Reasons for Decision on Motion as Chairperson of this Discipline Panel.



Chairperson

Jan 17, 2019

Date

SCHEDULE "A"

#4

Agreed Statement of Facts

Overview

1. The Notice of Hearing in this matter makes five allegations against Dr. Somasundaram. Dr. Somasundaram disputes the allegations contained in paragraphs 3 and 5 of the Notice of Hearing, and disputes the particulars set out in paragraph 3 and in paragraph 5 (with the exception of the first bullet point in paragraph 5). For convenience, these are referred to as the sexual abuse allegations. The evidence in relation to the allegations of sexual abuse is contested, and will be the subject of testimony before the Discipline Committee.

2. Dr. Somasundaram admits the allegations contained in paragraphs 1, 2 and 4 of the Notice of Hearing, and the particulars set out in those paragraphs, and admits that those particulars amount to professional misconduct. He indicated his willingness to admit those allegations very early in these proceedings. For convenience, these are referred to as the standards of practice allegations. The College relies on this Agreed Statement of Facts to prove the standards of practice allegations. At a later date, the Discipline Committee will undoubtedly hear evidence or submissions on behalf of Dr. Somasundaram as to how he has addressed the standards of practice issues subsequent to issuance of the Notice of Hearing.

The Facts

3. Dr. Somasundaram initially practiced dentistry in India before coming to Canada. He began work at the Faculty of Dentistry at the University of Toronto in 1991. He opened his own dental practice in Canada in 1993. His dental practice is located at 2191 Warden Avenue, Toronto, Ontario. Dr. Somasundaram also teaches in the prosthodontic department at the University of Toronto. He has no prior disciplinary record.

4. In 2015, Dr. Somasundaram had several part-time employees at his Toronto dental practice: Mrs. Dayanithi Somasundaram (his wife), Ms. Gurpreet Kaur and Ms. Gowry Umasangar. Dr. Somasundaram's cell phone number at this time was [redacted].

5. The complainant, Ms. L, was Dr. Somasundaram's patient from March 2015 to September 2015. During her time as Dr. Somasundaram's patient, Ms. L's cell phone number was [redacted].

6. Dr. Somasundaram and Ms. L scheduled Ms. L's dental appointments via text messages on the cellphone numbers set out above. Dr. Somasundaram did not document his interactions with Ms. L that took place through text messaging and/or phone calls on his cell phone. Ms. L initiated the use of text messaging to communicate with him.

7. Ms. L first attended at Dr. Somasundaram's office in March 2015. He was to perform orthodontic services for her. At that time, Dr. Somasundaram initiated orthodontic treatment on Ms. L. He placed brackets, banding and elastics on her teeth and told her to return in a couple of weeks.

8. Dr. Somasundaram told Ms. L that she was required to pay him $500 as a down payment and then $100 each month when she returned to see him. She did not receive a written treatment plan, a fee estimate or a financial agreement. The only document that she completed at his office was a new patient information form. Dr. Somasundaram told her that the total fee for orthodontic treatment would be about $3,600.00, but could not tell her how long it would take for treatment to be completed.

9. Dr. Somasundaram's case work-up during this initial appointment was incomplete given the lack of intra-oral and extra-oral findings, a failure to take the necessary diagnostic radiographs, a lack of cephalometric analysis and a failure to obtain models. He formed a diagnosis without first obtaining the necessary diagnostic information. He failed to document and assess Ms. L's periodontal condition, perform a periodontal diagnosis, and/or evaluate her periodontal condition prior to embarking on orthodontic treatment. Dr. Somasundaram also failed to provide Ms. L with the available treatment options to address her malocclusion. Nor did he obtain from Ms. L a consent to treatment or provide her with appropriate written documentation, including a treatment plan, fee estimate or financial agreement.

10. On a subsequent appointment on September 13, 2015, Dr. Somasundaram extracted four of Ms. L's permanent bicuspid teeth. She gave Dr. Somasundaram $400 for the extraction procedure. No radiographs were taken prior to the extractions. The risks of performing the extraction procedure absent radiographs were not explained to Ms. L. Dr. Somasundaram did not provide Ms. L with the alternative treatment options to address her malocclusion.

11. On September 21, 2015, Ms. L attended for a further appointment at Dr. Somasundaram's office. Ms. L understood that the purpose of the appointment was to check on the extractions. Dr. Somasundaram looked at the extractions and said that they looked good. Ms. L gave Dr. Somasundaram $100 in cash. She did not receive an invoice for services or a receipt for payment.

12. Ms. L has not returned to Dr. Somasundaram's office since September 21, 2015.

13. Over the course of her treatment with Dr. Somasundaram, Ms. L was not provided with receipts for any of the fees she paid in cash. Dr. Somasundaram never took x-rays of her teeth and did not make pre-treatment diagnostic models. He failed to appropriately monitor Ms. L's orthodontic progress.

14. Ms. L made a complaint to the College on September 23, 2015. On October 5, 2015, Dr. Somasundaram called her on her cell phone (she did not answer the call) and then sent her text messages asking if her teeth were moving and requesting that she respond. Again, she did not reply. Dr. Somasundaram called her again on October 7, 2015, and texted her on October 14, 2015. On October 15, 2015, Dr. Somasundaram was advised by an investigator for the College that Ms. L did not want to be contacted by him.

15. On October 15, 2015, an investigator for the College attended at Dr. Somasundaram's office. Ms. L's chart, financial account statement, and two standard dental claim forms were provided to the investigator. The chart documented seven attendances. Those documents are attached as Tab A to this ASF.

16. Dr. Somasundaram initially told the investigator that, with respect to his charts for Ms. L:

a. Ms. L had not filled out the initial form and so he had to complete the front of the chart. The patient name noted on the chart was not accurate, as he was the one who filled it out. The chart consisted of a double-sided 11 x 17 printout.

b. He did not take any x-rays or make any models prior to initiating orthodontic treatment or extracting the four bicuspid teeth. The patient told him that she did not have any money for radiographs.

c. He had no other financial records for the patient, aside from an Account Statement and two standard dental claim forms printed from his office computer.

d. He did not provide Ms. L with receipts for payments made as she did not have insurance; she did not ask for a receipt.

17. Ms. L advised that the chart provided was not accurate. She had filled out the form on her first visit in 2015. The form provided to the investigator by Dr. Somasundaram had been filled out by someone else. Further, the chart failed to document at least two and possibly three visits that Ms. L recalled attending.

18. It is conceded by Dr. Somasundaram that his assertion to the College (at para. 16(a), above) that Ms. L had not filled out the initial form was not accurate. The initial form was subsequently located by Dr. Somasundaram and provided to the College.

19. As particularized in paragraph 4 of the Notice of Hearing, Dr. Somasundaram failed to keep records as required. His financial record keeping was incomplete, he failed to fully document the fees for treatment, and he failed to provide Ms. L with receipts for payments made. His clinical chart entries were inadequate and did not fully document the treatment provided, including the methodology used during the extraction appointment. His patient medical history form was incomplete and no dental history was documented. He completed no periodontal charting, diagnosis, assessment or evaluation, no intra-oral and extra-oral findings, and no cephalometric analysis.

20. Ms. L subsequently sought dental treatment from another dentist. That dentist opined that the braces had been on too long and had not been placed correctly. She also opined that no irreparable damage had occurred as a result of the prior work.

21. Dr. Somasundaram admits that the above facts constitute professional misconduct as alleged in paragraphs 1, 2 and 4 of the Notice of Hearing and the particulars contained in those paragraphs. He denies that he committed any professional misconduct as alleged in paragraphs 3 and 5.

Dated at Toronto this _____ day of March, 2018

Mark Sandler and Amanda Ross,
Counsel for the Royal College of Dental Surgeons of Ontario

Dr. Athi Kanapthy Somasundaram

H160013

THE DISCIPLINE COMMITTEE OF THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing of a panel of the Discipline Committee of the Royal College of Dental Surgeons of Ontario held pursuant to the provisions of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, Chapter 18 (*"Code"*) respecting one **DR. ATHI SOMASUNDARAM**, of the City of Scarborough in the Province of Ontario;

AND IN THE MATTER OF the *Dentistry Act* and Ontario Regulation 853, Regulations of Ontario, 1993, as amended ("Dentistry Act Regulation").

Members in Attendance: Dr. Richard Hunter, Chair
Dr. Carol Janik
Dr. Sandy Venditti
Ram Chopra
Margaret Dunn

BETWEEN:

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO	)	Appearances:
	)	Ms. Luisa Ritacca
	)	Independent Counsel for the
	)	Discipline Committee of the Royal
	)	College of Dental Surgeons of Ontario
- and -	)	
	)	Mr. Mark J. Sandler, Ms. Amanda
	)	Ross
	)	For the Royal College of Dental
	)	Surgeons of Ontario
DR. ATHI SOMASUNDARAM	)	Mr. Earl Heiber
	)	For Dr. Athi Somasundaram

Penalty and Costs Hearing held on April 5, 2019.

DECISION AND REASONS FOR DECISION PENALTY AND COSTS

Majority Decision

This matter came on for a hearing before a panel of the Discipline Committee (the "Panel") at the Royal College of Dental Surgeons of Ontario (the "College") in Toronto on March 13, 2018. The matter proceeded for nine days over the course of several months.

On January 17, 2019, the Panel released its decision on liability. In it, the Panel found that the Member engaged in professional misconduct in a number of different ways, including most significantly in sexual abusing his patient, N.L.

Following the release of our decision, the parties re-attended before the Panel to make submissions with respect to penalty and costs.

The Panel's decision on penalty was not unanimous. The decision of the dissenting Panel members follows these reasons.

College's Submission on Penalty

The College filed written submissions in support of its position on penalty. The College sought the following by way of penalty:

- An order directing the Registrar to revoke Dr. Somasundaram's certificate of registration;

- An order directing Dr. Somasundaram to appear before the Panel to be reprimanded; and

- An order requiring Dr. Somasundaram to post security in the amount of $5000.00 for a period of two years to cover reasonable costs for reimbursement of funding provided to the patient, N.L. under section 85.7 of the *Health Professions Procedural Code*.

The College submitted that while the sexual abuse in this case did not give rise to mandatory revocation, the conduct was severe and of such a nature that revocation was the only appropriate penalty in the circumstances. The College argued that the seriousness of the conduct undermined the confidence in the profession and warranted a serious penalty.

The College stated that on a comparative basis the conduct in this case was more egregious than the conduct of the former member in *Royal College of Dental Surgeons of Ontario v. Clokie*, June 8, 2016 because while in that case Dr. Clokie had engaged in a consensual sexual relationship with a patient, here Dr Somasundaram forcibly confined the patient, continued to pursue her even after she asked him to stop and only stopped upon being interrupted by a noise at his office door.

The Final Report of the Task Force on Sexual Abuse of Patients recommended a zero tolerance policy of sexual abuse by professionals. The College listed the Task Force's findings as it applies to this policy and to this hearing:

a. the general vulnerability of patients in such relationships

b. the power imbalance that almost invariably exists in favour of the practitioner, thus facilitating easy invasion of the patient's sexual boundaries

c. the privileged position of doctors in society, based on their education, status and access to resources

d. the breach of trust entailed in such conduct by physicians

e. the serious, long-term injury to the victim, both physical and emotional, that results from sexual abuse, including the harmful effects on the future care caused by the victim's inability to place her trust in other doctors and caregivers

f. the fact that sexual abuse tarnishes the public trust in the entire profession

g. the results of a historical review by the Task Force of sanctioning decisions by the Discipline Committee of the College of Physician and Surgeons of Ontario and the Divisional Court that showed "a profound non-appreciation of the harm done to victims and

h. the significant risk of recidivism by abusers, enhanced by the ineffectiveness of rehabilitation measures and previous restrictions on doctors' practices in providing protection against the re-occurrence of abuse.

The College stated that Dr. Somasundaram failed to accept responsibility and attempted to mislead the College investigation from the beginning. He has demonstrated a lack of insight and contrition and as a result the strongest deterrent penalty is required. The College cited several cases to support its position that revoking Dr. Somasundaram's certificate of registration is the only

means to adequately protect the public and provide suitable specific and general deterrence

[RCDSO v. Clokie, Amended Decision and Reasons – Constitutional Issues and Penalty, June 8, 2016., *CPSO v. Mussani*, Decision and Reasons for Penalty Decision, December 14, 1999., *CPSO v. Minnes*, 2015 ONCPSD 3.]

Member's Submission on Penalty

The Member submitted that revocation was not appropriate in the circumstances of the present case. Instead, the Member urged the Panel to order a lengthy suspension in the range of 12-months.

Dr. Somasundaram believes he co-operated with the College investigation. He stated that he asked his staff to be truthful when giving evidence. The Member submitted that the Panel should consider it a mitigating factor that he took a Record Keeping course in 2017, after learning of the record keeping issues that arose in this case. He also pointed out the fact that he has no prior record with the College and that there has been no suggestion that he engaged in this sort of conduct with patients before. Further, he advised that he voluntarily participated in training involving Cephalometric tracings in the Orthodontic Department at the University of Toronto. He reminded the Panel as well that he continues to offer free dental services to members of his community who cannot otherwise afford it on a regular basis. Through counsel, the Member advised that he is devastated by the Panel's findings and is currently out of the country.

Decision and Reasons

In regard to the finding that the Member committed professional misconduct by sexually abusing the patient (Allegation #3 on Exhibit 1, the "Sexual Abuse Allegation"), the Panel orders as follows:

1. The Registrar is directed to revoke Dr. Somasundaram's certificate of registration (Code, ss. 51(2)1 and 51(5)1;

2. Dr. Somasundaram is required to appear before the Discipline Panel to be reprimanded (Code, ss. 51(2)4 and 55(5)1).

3. Dr. Somasundaram is required to post security in the amount of $5000.00 for a period of two years to cover reasonable costs for reimbursement of funding provided to the patient, N.L. under section 85.7 of the Health Professions Procedural Code.

4. In the event that Dr. Somasundaram decides to apply for reinstatement of his certificate of registration, the Discipline Panel recommends that the panel hearing his reinstatement application impose the following Terms and Conditions. All expenses related to the recommended courses and counseling are at the Member's own expense.

The member must:

a) Successfully complete a College approved course or program of counseling related to prevention of sexual abuse of patients and the need to maintain doctor-patient boundaries.

b) Successfully complete the ProBe Program for Professional/Problem-Based Ethics, and provide proof of successful completion and unconditional pass in writing to the Registrar.

c) Successfully complete a course in Record Keeping

d) Successfully complete a course in Informed Consent

e) A course in Orthodontics for the general practitioner

f) The Member shall co-operate with any office monitoring which the Registrar feels is appropriate.

Dr. Somasundaram broke the trust that is expected between a doctor and his patient. The Panel is extremely concerned about the increasing amount of

physical contact Dr. Somasundaram made with this patient. Initially, he made inappropriate comments, however, as time went on, his behaviour escalated to rubbing N.L.'s face and hugging her. It eventually culminated with Dr. Somasundaram physically confining the patient while attempting to kiss her and putting his face into her neck. Even after the terrified patient ran out of the office, Dr. Somasundaram attempted to reach her by phone and text presumably in an effort to prevent her from lodging a complaint. This will undoubtedly have a profound effect on N.L.'s life and future relationships with other male professionals and clients. At no time did Dr. Somasundaram show any insight as to the damage he has caused nor were there any signs of contrition or remorse.

The Panel considered many aggravating factors. Dr. Somasundaram persistently committed sexual abuse against N.L. He forcibly confined her and repeatedly forced himself on her. He persisted in attempting to contact her after the last and most serious incident took place. Dr. Somasundaram misled the College during its investigation.

The sexual abuse was accompanied by many particulars of misconduct as set out in allegations 1, 2, and 4. The patient has been seriously impacted by Dr. Somasundaram's misconduct as described in her Victim Impact Statement, which was filed during the course of the penalty hearing.

This extremely serious misconduct brings shame and embarrassment to the profession and has the capacity of undermining public confidence in the profession as a whole.

Mitigating factors include the fact that Dr. Somasundaram has not appeared before a discipline panel previously and he has performed charity work for his community.

The Panel spent a great deal of time deliberating on this matter. In light of the seriousness of the misconduct and the limited mitigating factors, the majority of the Panel concluded that revocation was the only appropriate penalty in the circumstances. Although this was not a case wherein the legislation mandates revocation, the Panel concluded that revocation is the only means to adequately protect the public and ensure both specific and general deterrence.

Costs

College's Position on Costs

The College submitted that costs in the amount of $192,937.04 should be awarded to the College in accordance with a timetable for payment in the Panel's discretion.

Under s. 53.1 of the *Health Professions Procedural Code*, a Discipline Panel has authority to award all or partial costs to the College if the panel finds the member has committed professional misconduct. The costs ordered may include:

1.The College's legal costs and expenses
2. The College's costs and expenses incurred in investigating the matter.
3.The College costs and expenses incurred in conducting the hearing.

A Certification of Costs Incurred was submitted by the College. The College did not seek any costs associated with its investigation. In keeping with the case law presented, the College sought two thirds of its hearing and legal expenses.

Member's Position on Costs

The Member submitted that the costs sought by the College were too high given all of the circumstances. The Member submitted that the costs sought by the College should be reduced by 50 percent. The Member's position was that he had a right to a defence and that these costs prevented him from properly defending himself.

Decision on Costs

The Panel supported awarding the costs to the College in the amount of $192,937.04. The Panel recognizes that the costs awarded are significant. However, they represent only a portion of the true costs associated with the prosecution of this matter. The College's approach whereby it did not seek costs of the investigation and reduced its legal costs by one-third was fair and reasonable.

The Panel agrees that the conduct of counsel for the College and the Member during the hearing was focused and efficient. While this certainly helped contain the cost of the hearing, it does not change the cost to conduct this hearing.

While the Member's counsel submitted that the Member would suffer a financial hardship if ordered to pay costs as requested by the College, the Panel notes that it did not receive any evidence from Dr. Somasundaram with respect to his current financial circumstances.

The Panel orders that Dr. Somasundaram pay the costs over a period of 36-months on a monthly basis, starting one month after this order takes effect.

I, Richard Hunter, sign these Reasons for Penalty and Costs as Chairperson of this Discipline Panel and on behalf of the majority of the Panel Members.

Chairperson, Dr. Richard Hunter

April 22, 2019.
Date

Dr. Carol Janik
Dr. Sandy Venditti

Dissenting Decision

We have had the opportunity to review the majority of the Panel's decision on penalty and costs. While we agree with the background and much of the reasoning set out therein, respectfully we do not agree with the majority's decision with respect to revocation.

This Panel made findings of sexual abuse against the Member. The nature of the sexual abuse was serious. The Member's conduct diminishes the profession and brings it into disrepute. The Member's actions erode the public's confidence in dentists and health professionals generally.

The penalty for such conduct must send a clear message to this Member and the profession at large that sexual abuse in any form will not be tolerated. The penalty must also ensure the public that such behaviour will be met with serious sanctions. That said, in deciding an appropriate penalty, the Panel must consider the particular circumstances of the case, the specific nature of the sexual abuse and whether there are any mitigating factors. Here, the dissenting members of the Panel consider that revocation is not the most appropriate recourse for the Member. The dissenting members note that the nature of the sexual abuse in the present case did not attract mandatory revocation under the governing legislation. The dissenting members of the Panel would have ordered a lengthy suspension, coupled with significant terms, limits and conditions the Member would have to meet prior to re-obtaining his certificate.

The dissenting members of the Panel concluded that revocation was not appropriate in this case because this was the first time the Member appeared before the Discipline Committee and because of the good character evidence presented to the Panel during the course of the hearing. In particular, more credit should have been given to the fact that the Member has been an active and generous member of his ethnic and religious community for decades.

In summary, the dissenting members of the Panel would have made an order requiring the suspension of the Member's certificate of registration for a period of 36-months, coupled with a reprimand and terms, conditions and limitations involving re-educations, monitoring and the requirement to take various ethics courses. In the dissenting members' view, such a penalty would go a long way to restore the public's confidence in the profession as a whole. Further, the profession would see that a lengthy suspension, coupled with the required reprimand, would be a deterrent to the profession from engaging in this sort of disgraceful conduct. Finally, in our view, the various terms, limits and conditions that the Member would need to fulfill prior to re-obtaining his certificate would ensure that the public is protected and would greatly minimize any future risk.

I, Margaret Dunn, sign these Dissenting Reasons for Penalty on behalf of the dissenting Panel Members.

Margaret Dunn

Margaret Dunn

22 April 2019

Date

Ram Chopra

Reprimand Delivered on October 4, 2019

Royal College of Dental Surgeons of Ontario and Dr. Athi Somasundaram

(Dr. Somasundaram, not present)

Dr. Somasundaram, as you know, this Discipline panel has ordered you be given an oral reprimand as part of the sanction imposed upon you. The reprimand should impress upon you the seriousness of your misconduct.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

The panel has found that you have engaged in significant acts of professional misconduct. The most serious misconduct related to the sexual abuse of your patient. You abused your position as her treating dentist. You put her in a position where she felt victimized and in danger. In addition, you failed to maintain the Standards of Practice of the profession; your conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, unprofessional and unethical. In addition to your misconduct relating to sexual abuse, you failed to maintain records and obtain informed consent as required by the regulations.

Your professional misconduct is a matter of profound concern. It is completely unacceptable to your fellow dentists and to the public. You have brought discredit to the entire profession and to yourself. Public confidence in this profession has been put in jeopardy.

Of special concern to us is the fact that the professional misconduct in which you engaged has involved uttering a series of untruths in an attempt to mislead the College and this Panel. This attempted deceit reflects negatively on your moral compass.

The escalating level of sexual abuse was alarming. Initially, inappropriate comments made to your patient were the mildest form of abuse. Inappropriate touching elevated the level of abuse to a more serious nature but most frightening was the use of physical restraint to confine your patient.

Your inadequate record keeping, lack of diagnostic radiographs and absence of Informed Consent are also concerns that need to be addressed.

We have ordered the penalty of revocation, being the most significant penalty this Committee can impose. It is appropriate because of the escalating level and persistence of the sexual abuse.

We trust that this experience gives you an opportunity to reflect on the harm you have caused and set a future course where you return to the profession as a valued Member.

We are adjourned.