NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Pilarski, this is notice that the Discipline Committee ordered a ban on the publication or broadcasting of the names or any information that could disclose the identities of the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the Regulated Health Professions Act, 1991.

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

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Pilarski, 2016 ONCPSD 41

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. BARBARA ANNE PILARSKI

PANEL MEMBERS:
DR. P. TADROS (CHAIR)
MR. A. RONALD
DR. P. ZITER
DR. E. ATTIA (PHD)
DR. S. YOUNG

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. E. WIDNER

COUNSEL FOR DR. PILARSKI:

MS. N. NICOLA-HOWORTH
MS. S. GAUDET

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

Hearing Date: October 31, 2016
Decision Date: October 31, 2016
Release of Written Reasons: December 8, 2016

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on October 31, 2016. At the conclusion of the hearing, the Committee stated its finding that Dr. Barbara Anne Pilarski committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

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

1. under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

2. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that she has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Pilarski is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Pilarski admitted the first allegation in the Notice of Hearing, that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The College withdrew the second allegation in the Notice of Hearing as well as the allegation that Dr. Pilarski is incompetent.

THE FACTS

The following Agreed Statement of Facts on Liability was filed as an exhibit and presented to the Committee:

PART I - FACTS

Background

1. Dr. Pilarski is a 52 year old family physician, practicing medicine in Toronto, Ontario. Dr. Pilarski received her certificate of registration authorizing independent practice in Ontario in 1990.

2. The allegations arose in the context of home care visits that Dr. Pilarski was providing to an elderly patient, Patient A. In the course of treating Patient A, Dr. Pilarski received and accepted gifts from her patient, including jewelry and money.

3. Patient A was a patient in Dr. Pilarski's office practice from 1991 until 2006. In 2006, Patient A asked Dr. Pilarski to see her at home as it was difficult for Patient A to get to Dr. Pilarski's office. At the time, Patient A was in her 80s.

4. Dr. Pilarski agreed to make home care visits for Patient A beginning in 2006. Dr. Pilarski continued providing home care visits to Patient A up until approximately 2014, when Patient A's adult child made a complaint to the College pertaining to Dr. Pilarski's dealings with Patient A.

5. Between 2006 and 2014, Dr. Pilarski treated Patient A for a variety of age-related health issues and primarily for long-standing mental health issues that were treated with medications, along with counselling from Dr. Pilarski.

6. In early 2014, Patient A's adult child requested that Dr. Pilarski return the gifts that Patient A had provided to Dr. Pilarski over the years.

7. On January 16, 2014, Dr. Pilarski returned jewelry and other assorted items to Patient A's adult child. A list of the returned items prepared by and as described by Patient A's adult child, is attached at Tab 1 of the Agreed Statement of Facts on Liability. An evaluation from Birks of some of the items, amounting to $8,150.00, is attached at Tab 2 of the Agreed Statement of Facts on Liability. Dr. Pilarski advised the College that she had kept all the items together over the years in order to return them at some point to the family. Photographs of the returned items as provided by Dr. Pilarski are attached as Tab 3 of the Agreed Statement of Facts on Liability.

8. Dr. Pilarski accepted a blank cheque from Patient A in the amount of $5,000.00, dated May 13, 2010. Dr. Pilarski inserted her husband's name on the cheque as payee. A copy of the cheque is attached at Tab 4 of the Agreed Statement of Facts on Liability. Dr. Pilarski used the money to buy a fireplace, chairs and artwork to create a spa like retreat for her patients in her waiting room. Dr. Pilarski returned the $5,000.00 to Patient A by way of a cheque dated October 2016.

9. In the summer of 2010, Dr. Pilarski accepted a gift of a few hundred dollars from Patient A to be used by Dr. Pilarski's children on a family vacation. A card acknowledging the gift is attached at Tab 5 of the Agreed Statement of Facts on Liability.

PART II – ADMISSION

10. Dr. Pilarski admits the facts specified above, and admits that, based on these facts, she engaged in professional misconduct, in that:

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

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts on Liability. Having regard to these facts as correct, the Committee found that Dr. Pilarski committed an act of professional misconduct in that she engaged in an act or omission relevant to

the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The proposed order included a three month suspension, a reprimand, costs of $5,000.00 to the College, and the imposition of the following term, condition, and limitation on Dr. Pilarski’s certificate of registration:

> At her own expense, Dr. Pilarski shall participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Pilarski.

In considering the joint submission on penalty, the Committee took into consideration the submissions of counsel and the exhibits, which included the Agreed Statement of Facts, and letters of support and thank you cards written to Dr. Pilarski. The Committee also reviewed appropriate case law.

The parties referred the Committee to the Ontario Court of Appeal case *R. v. Cerasuolo*, 2001 CanLII 24172 (ONCA), in which the Court stated at paragraph 8:

> This Court has repeatedly held that trial judges should not reject joints submissions unless the joint submission is contrary to the public interest and this sentence would bring the administration of justice into disrepute. This is a high threshold and is intended to foster confidence in an accused, who has given up his right to a trial, that the joint submission he obtained in return for a plea of guilty will be respected by the sentencing judge.

The Committee is aware that the Supreme Court of Canada recently stated the test for rejecting a joint submission as follows: A joint submission should be accepted unless to do so would be

contrary to the public interest *or* would bring the administration of justice into disrepute (*R. v. Anthony-Cook*, 2016 SCC 43). In Dr. Pilarski's case, nothing turns on a distinction between "and" and "or."

The Committee was also guided by the accepted principles that determine an appropriate penalty. First and foremost is the protection of the public. The penalty must also provide both general deterrence to the membership at large and specific deterrence to the physician. In this case, it is necessary to send a clear message that this type of misconduct will not be tolerated.

The penalty must reflect the profession's disapproval of the misconduct and maintain the public confidence in the profession and its ability to govern itself in the public interest.

The Committee also took into consideration the aggravating and mitigating factors in this case, as well as Dr. Pilarski's potential for rehabilitation.

The aggravating factors considered included the fact that this patient was quite vulnerable because she was elderly and was seen on several occasions in her home. She was also vulnerable because of mental health issues.

The fact that Dr. Pilarski accepted a blank cheque from Patient A in the amount of $5,000.00 and inserted her husband's name on the cheque as payee was considered an aggravating factor. The Committee agreed that in some instances the acceptance of a gift from a patient may not be inappropriate. However, the nature and the volume of these gifts at issue in this case were totally inappropriate and should not have been accepted by Dr. Pilarski.

On the other hand, there were substantial mitigating factors in that Dr. Pilarski was very cooperative with the investigation and agreed to a statement of facts and a joint submission on penalty. This saved the College time and expense in conducting a lengthy hearing. In most cases, admitting to professional misconduct and to the agreed statement of facts saves the patient from the trauma of testimony and cross examination, which is an important mitigating factor. In this case, however, there is a further important mitigating factor: as counsel for the College noted in her submissions, it is likely in this case that the College would not have been able to call the patient to testify. Dr. Pilarski's willingness to take responsibility for her actions and admit facts that the College would have difficulty proving speaks to her remorse and insight. Dr. Pilarski

recognized her boundary violations and agreed to participate in individualized instruction in boundary violations. It was also noted that Dr. Pilarski had no prior history of any discipline proceeding.

The Committee was also mindful that like cases should be treated alike. In a similar case, *CPSO vs. Mahon* (1997), Dr. Mahon borrowed money from his patient. The Discipline Committee in that matter imposed a reprimand and a suspension of his certificate of registration for two periods of 30 days, with the suspensions ceasing upon proof that Dr. Mahon had made restitution of the $7,000.00 he had borrowed from the patient. In the present case, Dr. Pilarski repaid the patient's family $5,000.00 and has returned all of the jewelry.

CPSO vs. Vasovich (2015) also involved a physician who borrowed money from a patient. In accordance with a joint submission on penalty, the Committee imposed a penalty which included a reprimand, a four month suspension, a condition on Dr. Vasovich's certificate of practice requiring her to complete a boundaries course, and costs.

The Committee was in agreement that these cases support the joint submission penalty of a three month suspension in this case.

The Committee believes that the terms, conditions, and limitations on Dr. Pilarski's certificate of registration requiring successful completion of an ethics course sufficiently protect the public. The fact that Dr. Pilarski returned the gifts and repaid $5,000.00 to the patient demonstrated that Dr. Pilarski recognized her boundaries violation.

The reprimand and suspension will serve as a specific deterrent to Dr. Pilarski, and will also serve as a general deterrent for the membership at large regarding the obligation of physicians in Ontario to maintain appropriate boundaries and to not accept inappropriate gifts from a patient.

The Committee reviewed the letters of support and thank you cards written to Dr. Pilarski, but gave these little weight in accepting the joint submission of penalty. This was particularly so because the letters of support do not show that any of the writers are aware of the specific facts and misconduct committed by the member.

In its submission, counsel for the College asked the Committee to consider a victim impact statement written by the patient's adult child.

Counsel for the member objected to this based on the fact that this statement was written by the patient's adult child, and not the patient. Counsel for the member further objected because of the content of the statement, submitting that the potential of unfairness and prejudice far overweighed the benefits of allowing the victim impact statement.

Counsel for Dr. Pilarski further noted that this case was not one of sexual abuse (where the Committee is required by section 51(6) of the Code to consider a statement describing the impact of the sexual abuse on the patient). Accordingly, it was at the Committee's discretion to admit the statement or not.

Counsel for Dr. Pilarski noted that the statement was prepared by a third party, not the patient, and that it contained information regarding the patient's health. This information was not part of the Agreed Statement of Facts and was not otherwise in evidence before the Committee.

The Committee is bound by the rules of evidence and, absent consent of the parties, cannot admit hearsay statements.

Counsel for the College directed the Committee to the case of *R v. Gabriel*, 1999 CanLII 15050 (ONSC), in which the Ontario Superior Court of Justice considered the appropriate extent of a victim impact statement in a criminal case. The Court noted that under section 722 of the Criminal Code, the Court was required to consider a victim impact statement if it complies with the conditions in the Code, and that the Court had the discretion to consider a discretion to consider other evidence concerning the victim of an offence beyond the victim impact statement. In *Gabriel*, the Court noted at paragraph 35 that victim impact statements should consider the harm done to, or the loss suffered by, the victim arising from the commission of the offence. The statements should not contain criticisms of the offender, assertions as to the facts of the offence, or recommendations as to the severity of punishment.

In the present case, the Committee found that the victim impact statement went beyond the permissible grounds of a victim impact statement - i.e., describing the impact of the conduct on the victim. The Committee also found that it contained information that was not properly

admissible in this format. The Committee considered whether it was possible to redact the statement to exclude the impermissible portions, but decided to exclude the victim impact statement in its entirety because the portions that would have to be redacted were so extensive that what would remain would be of little value. It was also noted that the potential prejudice to Dr. Pilarski of admitting the statement had to be considered in light of the fact that, as there was an agreed statement of facts and penalty, the Committee was not being asked to choose between two proposed penalties.

ORDER

Therefore, having stated the finding in paragraph 1 of its written order of October 31, 2016, the Committee ordered and directed on the matter of penalty and costs that:

1. The Registrar suspend Dr. Pilarski's Certificate of Registration for a three (3) month period effective immediately.

2. The Registrar impose the following term, condition and limitation on Dr. Pilarski's certificate of registration:

   (a) At her own expense, Dr. Pilarski shall participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Pilarski.

3. Dr. Pilarski appear before the Committee to be reprimanded.

4. Dr. Pilarski pay costs to the College for a one day hearing in the amount of $5,000.00 within 30 days of the date of this Order.

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

TEXT of PUBLIC REPRIMAND
Delivered October 31, 2016
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
AND
DR. BARBARA ANNE PILARSKI

As you know, the practice guidelines of your governing body discourage us as physicians from accepting gifts from our patients.

The extensive nature of gifts you accepted brings dishonour to you and your colleagues.

We hope you have learned from this experience and will not be before this Committee again.