

SUMMARY

DR. BARBARA ANNE PILARSKI (CPSO# 61080)

1. Disposition

On November 14, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required family physician Dr. Pilarski to appear before a panel of the Committee to be cautioned with respect to her careless attitude toward maintaining boundaries with patients and inappropriately accepting gifts.

2. Introduction

In 2014, a family member of the patient complained to the College that Dr. Pilarski accepted gifts and monies from the patient, including a cheque in the amount of \$5,000 from May 2010. The Committee referred the allegations to the Discipline Committee, and in 2016, the Discipline Committee found that Dr. Pilarski committed an act of professional misconduct.

In 2017, the family member of the patient complained to the College once again, indicating that Dr. Pilarski or Dr. Pilarski's husband took an additional \$5,000 cheque from the patient in February 2008 while drugging her with large quantities of psychoactive drugs and opioids, which she systematically did not chart in the medical record. The patient's family member also expressed concern that Dr. Pilarski purposely misled the College into believing she had only received one cheque from the patient, when this matter was previously investigated.

Dr. Pilarski responded that she did not attempt to mislead anyone regarding the existence of the 2008 cheque. During the prior investigation, Dr. Pilarski fully acknowledged receiving gifts and monies from the patient. However, she was mistaken with respect to her recollection of receiving only one cheque. Shortly after becoming aware of the second cheque, she promptly repaid the full amount.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpsso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee agreed that some of the concerns raised, including concerns about Dr. Pilarski's prescribing to the patient and Dr. Pilarski's acceptance of certain gifts and monies (including a cheque for \$5,000 dated May 13, 2010), were already addressed as part of the previous Discipline Committee decision. However, that decision and settlement was based on the understanding that Dr. Pilarski accepted only one cheque for \$5,000 from the patient dated May 13, 2010. It was only later that the patient's family member discovered a second cheque from the patient to Dr. Pilarski dated March 5, 2008.

The Committee recognized it was unable to prove with certainty that Dr. Pilarski deliberately misled the College during its first investigation into her acceptance of gifts and monies from the patient by not disclosing that she accepted two cheques for \$5,000 each. Five thousand dollars is a significant sum of money, and it was surprising to the Committee that Dr. Pilarski would not have remembered receiving the additional cheque.

The Committee concluded that Dr. Pilarski's explanation (i.e., that she forgot she received an additional \$5,000, and did not intentionally mislead the College about how much money the patient gave her) was very concerning, even if accepted at face value. This in itself is a reflection of Dr. Pilarski's careless and cavalier attitude toward accepting money and gifts from patients, and her inability to maintain appropriate physician-patient boundaries.

Furthermore, as this was a very vulnerable patient, who was very elderly, in a diminished state, home bound, and with multiple co-morbidities, Dr. Pilarski should have had a heightened concern when the patient offered her money.

Given Dr. Pilarski has already had a Discipline finding with respect to the acceptance of some gifts and monies from the patient and as a result of that matter was ordered to complete an ethics course, in this instance, the Committee was satisfied that a caution in person, as well as a summary of the decision on the Public Register, was appropriate and sufficient, and no additional remediation was required.