Dr. Yagan PILLAY

Council Decision

Date Charge(s) Laid:	November, 2014
Outcome Date:	September 16, 2016
Hearing:	Completed
Disposition:	Suspension, Costs, Conditions, Ethics Course
Reasons for Decision:	TBA

The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Yagan Pillay pursuant to **The Medical Profession Act, 1981**:

1) Pursuant to Section 54(1)(b) of The Medical Profession Act, 1981, the Council hereby suspends Dr. Pillay for a period of one month commencing at 12:01 a.m. on November 15, 2016;

2) Pursuant to Section 54(1)(b) of The Medical Profession Act, 1981, the suspension will remain in effect unless prior to the end of the suspension, Dr. Pillay provides an undertaking to the College, in a form acceptable to the Registrar, that he will have a chaperone present for all future examinations of female patients. The undertaking will remain in effect while Dr. Pillay remains licensed in Saskatchewan unless the Council agrees to an amendment to or a termination of the undertaking;

3) Pursuant to section 54(1)(i), the Council directs Dr. Pillay to pay the costs of and incidental to the investigation and hearing in the amount of $27,561.78. Such payment shall be made in full by November 15, 2016.

4) Pursuant to section 54(2), if Dr. Pillay should fail to pay the costs as required by paragraph 3, Dr. Pillay's licence shall be suspended until the costs are paid in full.

5) Pursuant to section 54 (1)(g) of The Medical Profession Act, 1981, Dr. Pillay is required to take a Boundaries Course in a form acceptable to the Registrar on or before December 31, 2016. The "Probe Program" offered by CPEP in Toronto on October 28 to 30 is a boundaries course acceptable to the Registrar.

IN THE MATTER OF
THE MEDICAL PROFESSION ACT, 1981, R.S.S. 1980-81, C. M-10.1, AND

DR. YAGAN PILLAY, OF THE CITY OF PRINCE ALBERT,
IN THE PROVINCE OF SASKATCHEWAN

HEARING OF THE DISCIPLINARY HEARING COMMITTEE
OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

Date of Hearing: June 15, 2016

Date of Decision: August 12, 2016

Before: Daniel Shapiro, Q.C., C. Arb.,
Dr. David Johnston
Dr. Stewart McMillan

Counsel: Bryan Salte, Q.C. and Chris Mason
(for the College of Physicians and Surgeons)

Aaron Fox, Q.C. and Michael Conlon
(for Dr. Pillay)

DECISION

A. SUMMARY

[1] A patient complained that during an office visit Dr. Pillay had acted inappropriately, including hugging her and asking if he could kiss her. The issues before the hearing committee were: the standard of proof that should apply, and whether the College of Physicians and Surgeons of Saskatchewan ("the College") has met that standard.

[2] The committee has determined that a charge under the *Medical Profession Act* must be proved on a balance of probabilities, and that the College has met that standard.

B. CHARGE

[3] The Council for the College has directed that the Discipline Hearing Committee hear and determine the following charge laid against Dr. Yagan Pillay:

> You Dr. Yagan Pillay are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and/or Section 46(p) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(ix) and/or bylaw 8.1(b) (xvi) of the bylaws of the College of Physicians and Surgeons.
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> The evidence that will be led in support of this charge will include some or all of the following:
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> a) A female person hereinafter referred to in this charge as Patient Number 1 was your patient;
> b) On or about the 29th day of March, 2012, Patient Number 1 attended upon you in relation [*sic*] her stomach pain;
> c) Patient Number 1 advised you that the lights in the room were bothering her eyes as she had a migraine headache;

d) You massaged parts of Patient Number 1's body while she was lying on the examination table;

e) You massaged Patient Number 1's lower back area while she was standing upright;

f) While you were sitting on the examination table, you pulled Patient Number 1 towards you and massaged her;

g) You did not ask permission of Patient Number 1 to perform a massage;

h) You did not provide an explanation to Patient Number 1 for performing the massage;

i) You pulled Patient Number 1 into a hug with you;

j) You asked Patient Number 1 if you could kiss her.

C. RELEVANT STATUTORY PROVISIONS AND BYLAWS

[4] The directly relevant sections of the *Medical Profession Ac*t, 1981 ("the Act") provide:

> 46. Without restricting the generality of "unbecoming, improper, unprofessional or discreditable conduct", a person whose name is entered on a register is guilty of unbecoming, improper, unprofessional or discreditable conduct if he or she:
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> …
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> (o) does or fails to do any act or thing where the discipline hearing committee considers that action or failure to be unbecoming, improper, unprofessional or discreditable;
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> (p) does or fails to do any act or thing where the council has, by bylaw, defined that act or failure to be unbecoming, improper, unprofessional or discreditable.

[5] Section 6(2)(m) of the Act authorizes Council to enact bylaws that define professional misconduct. Pursuant to that section of the Act, Council enacted a Code of Ethics, Unprofessional Conduct, Discipline, and Competency Assessments, including the following:

> **8.1 Bylaws Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct**
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> …
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> (b) The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of Section 46(p) of the Act. The enumeration of this conduct does not limit the ability of Discipline Hearing Committees to determine that conduct of a physician is unbecoming, improper, unprofessional or discreditable pursuant to Section 46(o):
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> …
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> (ix) Failing to maintain the standard of practice of the profession;
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> …
>
> (xvi) Committing an act of sexual impropriety with a patient or an act of sexual violation of a patient.
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> …

[6] It is left to the medical profession to determine what constitutes unprofessional conduct[1] and in making its determination a committee is entitled to use its medical knowledge and expertise.[2]

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[1] *Green v. The College of Physicians and Surgeons (Sask.)* 1986 CanLII 3238 (SK CA) 51 Sask. R. 241 at 246

[2] *Huerto v. College of Physicians and Surgeons (Sask.),* 2004 SKQB 360 (CanLII) [2004] S.J. No. 550 (Smith J.)

D. BURDEN OF PROOF

[7] Both counsel agree and it is beyond dispute that the burden of proof in disciplinary proceedings such as these lies squarely upon the College.

E. STANDARD OF PROOF

[8] It is also undisputed that the standard of proof required to establish a charge under the Act is not the criminal standard of proof beyond a reasonable doubt, but a lesser standard. What *is* in dispute is whether in a case such as this, that standard is "a balance of probabilities," or something more.

[9] Counsel for Dr. Pillay maintains that proof must be commensurate with the gravity of the allegations and that judicial use of such terms as "clear, strong, and cogent evidence" point to a higher civil standard of proof than a simple "balance of probabilities."

[10] The position of the College is that there is only one civil standard of proof, and that is the balance of probabilities.

[11] In support of Dr. Pillay's position, counsel cites the decision of the Saskatchewan Court of Queens Bench in *Huerto v. College of Physicians and Surgeons of Saskatchewan*[3] where the Court considered the correct standard of proof to apply where a doctor was charged with sexual misconduct as well as other actions characterized as similar to the offences of fraud and perjury. Referencing a number of decisions that had addressed the standard of proof in similar cases, the Court quoted then Chief Justice Laskin in *Continental Insurance Co. v. Dalton Cartage Co*:[4]

> . . . . There is necessarily a matter of judgment involved in weighing evidence that goes to the burden of proof, and a trial judge is justified in scrutinizing evidence with greater care if there are serious allegations to be established by the proof that is offered. I put the matter in the words used by Lord Denning in *Bater v. Bater*, *supra*, at p. 459 as follows:
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> > It is true that by our law there is a higher standard of proof in criminal cases than in civil cases, but this is subject to the qualification that there is no absolute standard in either case. In criminal cases the charge must be proved beyond reasonable doubt, but there may be degrees of proof within that standard. Many great judges have said that, in proportion as the crime is enormous, so ought the proof to be clear. So also in civil cases. The case may be proved by a preponderance of probability, but there may be degrees of probability within that standard. The degree depends on the subject matter. A civil court, when considering a charge of fraud, will naturally require a higher degree of probability than that which it would require if considering whether negligence were established. It does not adopt so high a degree as a criminal court, even when it is considering a charge of a criminal nature, but still it does require a degree of probability which is commensurate with the occasion.
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> I do not regard such an approach as a departure from a standard of proof based on a balance of probabilities nor as supporting a shifting standard. The question in all civil cases is what evidence with what weight that is accorded to it will move the court to conclude that proof on a balance of probabilities has been established.

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[3] *Huerto, supra,* note 2
[4] 1982 CanLII 13 (SCC), [1982] 1 S.C.R. 164

[12] Counsel for Dr. Pillay further references the *Huerto* decision and the Court's determination that where elements of the charges were akin to criminal offences, the "highest possible standard applicable in a civil case" would apply. "Administrative tribunals and arbitrations often express the requisite standard as requiring 'clear, strong and cogent' or 'clear and convincing' evidence," the Court noted. Counsel submits that such references and similar terms can be found throughout College disciplinary case law and in particular: *Young v. College of Physicians and Surgeons (Sask.)* [5] and *College of Physicians and Surgeons of Saskatchewan v. Shamsuzzaman*.[6]

[13] Dr. Pillay notes that a higher standard associated with "clear and convincing evidence" was recently addressed and confirmed by the Ontario Court of Appeal in *Jacobs v. Ottawa (Police Service)*[7] in interpreting the "clear and convincing evidence" language in Ontario's *Police Services Act*. That Court accepted that the standard of proof is a higher standard than the regular civil standard and "lies somewhere between a balance of probabilities and proof beyond a reasonable doubt." Dr. Pillay argues that as College disciplinary hearings are also determined using the same standard, the Committee should take direction from the comments in *Jacobs* to inform its position in these proceedings.

[14] The College submits that the *Jacobs* case is distinguishable in that specific legislation establishes a higher standard of proof. Section 84(1) of the *Police Services Act* provides:

> If at the conclusion of a hearing . . . held by the chief of police, misconduct as defined in section 80 or unsatisfactory work performance is proved on clear and convincing evidence, the chief of police shall take any action described in section 85.

[15] The College submits that the appropriate interpretation to be applied to the phrase "balance of probabilities" within the context of civil proceedings has now been conclusively established by the Supreme Court of Canada in *F.H. v. McDougall*,[8] in which the court rejected the argument that there is more than one civil standard of proof:

> [40] … I think it is time to say, once and for all in Canada, that there is only one civil standard of proof at common law and that is proof on a balance of probabilities. Of course, context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the allegations or consequences. However, these considerations do not change the standard of proof…
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> [43] An intermediate standard of proof presents practical problems. As expressed by Rothstein et al, at pp. 466-67:
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> > As well, suggesting that the standard of proof is "higher" than the "mere balance of probabilities" inevitably leads one to inquire: what percentage of probability must be met? This is unhelpful because while the concept of "51 percent probability," or "more likely than not" can be understood by decision-makers, the concept of 60 percent or 70 percent probability cannot.
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> [44] Put another way, it would seem incongruous for a judge to conclude that it was more likely than not that an event occurred, but not sufficiently likely to some

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[5] 2005 SKCA 118
[6] 2011 SKCA 41 at paragraphs 12 and 32
[7] 2016 ONCA 345
[8] 2008 SCC 53

unspecified standard and therefore that it did not occur. As Lord Hoffmann explained in *In re B* at para. 2:

> If a legal rule requires a fact to be proved (a "fact in issue"), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are zero and one. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of zero is returned and the fact is treated as not having happened. If he does discharge it, a value of one is returned and the fact is treated as having happened.

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.

[45] 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.

[46] Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. But again, there is no objective standard to measure sufficiency. In serious cases, like the present, judges may be faced with evidence of events that are alleged to have occurred many years before, where there is little other evidence than that of the plaintiff and defendant. As difficult as the task may be, the judge must make a decision. If a responsible judge finds for the plaintiff, it must be accepted that the evidence was sufficiently clear, convincing and cogent to that judge that the plaintiff satisfied the balance of probabilities test.

[47] Finally there may be cases in which there is an inherent improbability that an event occurred. Inherent improbability will always depend upon the circumstances. As Baroness Hale stated in In re B, at para. 72:

> Consider the famous example of the animal seen in Regent's Park. If it is seen outside the zoo on a stretch of greensward regularly used for walking dogs, then of course it is more likely to be a dog than a lion. If it is seen in the zoo next to the lions' enclosure when the door is open, then it may well be more likely to be a lion than a dog.

[48] Some alleged events may be highly improbable. Others less so. There can be no rule as to when and to what extent inherent improbability must be taken into account by a trial judge. As Lord Hoffmann observed at para. 15 of *In re B*:

> Common sense, not law, requires that in deciding this question, regard should be had, to whatever extent appropriate, to inherent probabilities. It will be for the trial judge to decide to what extent, if any, the circumstances suggest that an allegation is inherently improbable and where appropriate, that may be taken into account in the assessment of whether the evidence establishes that it is more likely than not that the event occurred. However, there can be no rule of law imposing such a formula.

(5) Conclusion on Standard of Proof

[49] In the result, I would reaffirm that in civil cases there is only one standard of proof and that is proof on a balance of probabilities. In all civil cases, the trial judge must

> scrutinize the relevant evidence with care to determine whether it is more likely than not that an alleged event occurred.

[16] The rationale in *McDougall* was applied to a professional regulatory/disciplinary hearing in the following cases: *Osif v. College of Physicians and Surgeons of Nova Scotia*, [2009] N.S.J. No. 111 (Q.B); *Rassouli-Rashti v. College of Physicians and Surgeons of Ontario*, [2009] O.J. No. 4762 (Div. Ct); *Newton v. Criminal Trial Lawyers Association*, 2008 ABCA 404; *Moll v. College of Alberta Psychologists*, [2011] A.J. No. 369 (C.A.); and *Walsh v. Council for Licensed Practical Nurses* [2010] N.J. No. 61 (N & L C.A.).

[17] While it is true that the standard of proof considered in *Jacobs* was a legislated one, it does not differ materially from that confirmed in *McDougall*. Nevertheless, it appears that a body of case law has been established relative to the unique context of Ontario's *Police Services Act* that most recently does establish a higher standard that "lies somewhere between a balance of probabilities and proof beyond a reasonable doubt." That said, this rationale has not been applied beyond this unique legislative context and does not accord with the preponderance of judicial opinion regarding the applicability of the *McDougall* rationale to disciplinary proceedings. Further, the *Jacobs* case does not provide guidance as to where, between balance of probabilities and proof beyond a reasonable doubt, the standard lies.

[18] The *McDougall* standard was specifically applied in the context of a College of Physicians and Surgeons of Saskatchewan discipline hearing committee in a case involving Dr. Amjad Ali in 2012. While reversing one of two convictions, the Saskatchewan Court of Queen's Bench did not disturb the committee's findings regarding standard of proof, which did not appear to have been challenged on appeal: *Dr. Ali v. College of Physicians and Surgeons*, 2013 SKQB 38 (Zarzeczny J); leave to appeal to Saskatchewan Court of Appeal denied: 2013 SKCA 23.

[19] In the end, there is no basis for us to conclude that *Jacobs* represents the law in Saskatchewan. While undoubtedly at one point there was some divergence in judicial opinion as to the standard of proof required in such matters, the Committee accepts the judicial pronouncement in *McDougall* as being authoritative on the matter of the standard of proof applicable to disciplinary charges pertaining to physicians in Saskatchewan.

F. EVIDENCE

[20] The parties submitted an Agreed Statement of Facts and Documents. In addition, the College called two witnesses, the complainant and her husband. Dr. Pillay testified in his own defence.

Evidence of the Complainant

Evidence in direct examination

[21] The complainant is 53 years of age and lives with her husband of over 6 years in a First Nations community. She is non-Aboriginal. Her 2012 medical conditions included chronic migraines, chemical sensitivities, irritable bowel syndrome, sciatica, fibromyalgia, osteoarthritis, and chronic fatigue syndrome. Over the past several years she has seen more than 30 physicians. She had a digestive disorder and was referred to Dr. Pillay, a general surgeon, regarding gastric discomfort and abdominal pain. As part of these investigations, she was sent for endoscopy, a barium x-ray and a colonoscopy. She saw Dr. Pillay five or six times, including these three procedures and a couple of office visits.

[22] On March 29, 2012, she went to see Dr. Pillay for the results of the colonoscopy. She lay face up on an examining table so that Dr. Pillay could examine the sore part of her stomach. She had a severe migraine that day and asked Dr. Pillay to turn the lights off, which he did. Dr. Pillay examined her stomach and then massaged her temples, checked her lymph nodes, and massaged her neck. He told her to stand up. While he was behind her, he checked her stomach from behind, massaged her neck, back and upper arms. Then he sat on the examining table and had her stand with her back to him, between his legs, while he continued to massage her back, the base of her scalp, neck, and arms. At that point, she thought they were done, but when she moved forward, without saying anything, he gently turned her around and pulled her into a hug. While holding her, he looked into her eyes and said, "I would like to kiss you." She said, "No, I'm a happily married woman." He said, "I humbly apologize," and then got off the table and told her they would discuss her colonoscopy results in his office.

[23] They exited the examining room through a door leading directly into his office, where they discussed the results of the colonoscopy. She said she was in a bit of shock at the time. By the time she got into her car,[9] she broke down in tears. She called her husband from her car and he told her to come home and call her mother.

[24] She said she has not previously filed complaints against health care providers, nor had she ever thought that any other health practitioner had acted improperly towards her.

Evidence in cross-examination

[25] In cross-examination, the complainant testified that she had Grade 12 and some post-secondary technical school training. She helps with her husband's auto towing and wrecking business, but is limited by her medical conditions to phones, paperwork, and dealing with clients. Before this marriage she had been unable to work for many years due to medical problems. She was married twice previously and had two children from her first marriage, which ended because she was too young. Her second marriage ended six months before her current marriage, because her then spouse was very controlling and could not deal with her medical problems.

[26] While she could not be confident as to the exact medications she was taking on the day of the appointment in question, being led through the Preadmission Medication List from March 2012, the complainant did not disagree that as of that time her medications included antibiotics, Nexium (for acid reflux), Estrogel (hormone replacement therapy), and, she believed, Zopiclone (for sleep disturbances) and Trazadone (anti-depressants that assist with sleeping), perhaps among others. Records confirmed that as of February 2012 she was taking Maxalt for headaches and probably Tylenol. As of March 2012, her medical problems included her right kidney, for which she was seeing a urologist; her uterus, for which she was seeing a gynecologist; IBS; and migraines, for which she was seeing a neurologist. She used to have migraines once a month but these became more frequent after an oophorectomy in 2010 to control her migraines. In addition, she regularly saw a nurse practitioner. She was having procedures and appointments at least once a week. She had two CT scans and sonograms. She finds it difficult to separate what happened from one appointment to another. Her medical issues remain unresolved in 2016.

[27] The complainant accepted the records put to her, indicating that in late 2011, her nurse practitioner referred her for a pelvic ultrasound to Dr. Moodliar, a gynecologist. In January 2012, Dr. Moodliar reported that she had chronic pelvic pain and that apart from some constipation had

[9] It is not clear whether this happened immediately after she left Dr. Pillay's office or later that afternoon.

no bowel or UTI symptoms. He performed a hysterectomy and found fibroids, which he thought did not explain her abdominal pain. He referred her to Dr. Pillay for G.I. discomfort. Dr. Pillay did a gastroscopy on February 5, 2012 but had difficulty getting through the pylorus during this procedure. That is when Dr. Pillay ordered a barium x-ray, which did not reveal anything. Although she acknowledged the record of a visit to Dr. Pillay's office on March 6, 2012, she had no memory of it, either now or when interacting with the College in 2013 and 2014. The note from this visit refers to left lower quadrant pain for 2 years, worse the last few months. She does not dispute that Dr. Pillay palpated her abdomen, as the record states. The record notes that she was booked for a colonoscopy and that Dr. Pillay requested her CT scan results.

[28] She has not seen a psychologist or psychiatrist. No medical practitioner has suggested to her that her problems are in her head, although she acknowledged that her second husband did. She smokes half a pack of cigarettes a day.

[29] When Maxalt does not prevent migraines, they can become debilitating, causing numbness in her right arm, then vomiting and vertigo, and she begins to pass out. She goes to the ER once she starts vomiting. She has been in a wheelchair since this winter, as osteoarthritis has pinched her sciatic nerve causing right leg problems. She denied having expressed unhappiness that physicians had been unable to resolve her problems, but admitted she felt disappointed. Her left quadrant pain and enlarged lymph nodes in that region persist today.

[30] On March 26, 2012 Dr. Pillay performed a colonoscopy, which she does not clearly recall, due to sedation.

[31] As to the March 29, 2012 office visit, the complainant does not dispute that the appointment was for 1:30 pm and lasted 5 to 10 minutes, at Dr. Pillay's Prince Albert office. Some of the details even for this appointment are blurred to an extent. She could not recall speaking to a receptionist, nor the person who led her to the examining room.

[32] She said that Dr. Pillay told her, "You look very nice today" when she came into the examining room. Dr. Pillay's abdominal palpation was no different than what she had experienced in other doctors' offices. It did not involve her pelvic area. Her left lower quadrant was still tender and she jumped a bit when pressed. Maxalt hadn't prevented her migraine that day; she might have taken some Tylenol.

[33] In cross-examination, the complainant said that she didn't remember asking Dr. Pillay to turn off the lights and did not think she did so. She agreed with counsel that she may have done so. He turned the light off, did the abdominal exam, checked her temples, possibly below her eyes and checked her lymph nodes. He massaged her cheek bones, possibly below her eyes, down to her neck, while she was lying down. She had had five previous ENT exams, in which other physicians did the same thing. She did not remember whether Dr. Pillay used a light. She may have been slightly off balance due to vertigo. She might have told Dr. Pillay that she felt a bit fuzzy, possibly due to the effects of the migraine. Dr. Pillay may have held out his arm for her to brace herself as she got up off the table. The hug lasted a "millisecond"– she interpreted it as "like a brother" would give, trying to make someone else feel better. She did not interpret it as sexual at that time—it was over quickly and she thought that was that. She wasn't sure if she took a half step back due to losing her balance or in reaction to the hug. She was adamant that Dr. Pillay asked to kiss her. He did not try to kiss her but after he asked, she told him, "Oh, you are lovely." She thought he was a wonderful man and did not want to offend him. She felt stupid and embarrassed and wasn't sure right away that he had made a pass at her.

[34] Rather than leaving through the door to the hallway to the reception area, she put on her hat and coat and followed Dr. Pillay through the door to his office. She was in shock, but she wanted to get the colonoscopy results and then leave. He told her that the colonoscopy was negative; although they could do a laparoscopy, he did not recommend it, and referred her back to her gynecologist. His notes indicate that he discharged her from his care that day.

[35] Later that day, she decided he must have made a pass at her. She did not understand why she needed to think about it until later that afternoon, but that was how her mind worked. When she told her husband, he was calm and did not get angry.

[36] She said that in her second interview with the College, when she said, "This is never going to fly," this did not mean that she was having doubts as to what took place, but only that she was aware that it was her word against the doctor's, with no witnesses.

Evidence of the Complainant's Husband

[37] The complainant's husband recalled that his wife called him that day and was distraught. He sensed both anger and depression. He could see it in her face and body that entire evening, part of the next day and from time to time over the next couple of weeks if the incident was spoken about. He had never seen her in such a mood before or since: usually when she gets upset, it lasts for only 15-30 minutes.

[38] In cross-examination, he acknowledged that before they were married he knew nothing about her medical history or her previous marriages. She did not volunteer anything and he did not ask. Before their marriage he had not been aware that she suffered from migraines and he did not know she was having a migraine that morning. She appeared to be her usual courteous, polite self before the appointment. After her appointment she called him, either late that afternoon or early evening. They did not get into the details because he did not want to upset her. He was calm because he knows that if he gets upset, others get upset.

Evidence of Dr. Pillay

Evidence in direct examination

[39] Dr. Pillay is 47 years of age, has been married for 18 years and has two 16-year old daughters. He is a general surgeon in private practice, on contract (fixed income, not fee for service) with the Prince Albert Health Region. He has a normal rural practice, with "lots of lumps and bumps" - gallbladders, hernias, colorectal surgery, breasts, head and neck surgery. He said, "I think I'm one of the last 'general general' surgeons around." He was born and raised in South Africa, has a BSc in microbiology, a medical degree from India, fellowships from the College of Surgeons of South Africa and the Royal College of Surgeons of Canada and a diploma in laparoscopic surgery from France. He came to Canada in 2006, practised in Malaysia in 2007, and has practised in Prince Albert since 2008. Some Saskatoon general surgeons are quite specialized, he said, but his practice is general.

[40] When contacted by Brenda Hookensen of the Prince Albert Health Region on April 5 or 6, 2012 about this complaint, he was stunned and shocked.

[41] Dr. Pillay said he had seen the patient on a referral from Dr. Botha for abdominal pain. There was some urgency because she was on Nexium but not responding. He conducted a gastroscopy in February 2012 but could not penetrate the pylorus so arranged for a barium x-ray in order to understand what was going on in that part of the duodenum.

[42] He recalled that on March 6, 2012 Dr. Moodliar, in the same clinic, thought that although he could feel fibroids in the uterus, they were not the source of the abdominal pain. Dr. Pillay thought the issue could be diverticular disease or diverticulosis. Thus, he suggested a colonoscopy, which the complainant agreed to and which was booked for March 20, 2012. While Dr. Pillay did not say why they were talking about her marital history, he recalled that at some point the complainant told him she had had two bad marriages previously but was now in a good marriage.

[43] Dr. Pillay testified that on March 29, 2012, when the patient attended at his office to discuss the results of the colonoscopy, he might have told her that she looked nice, to put her at ease. She said she felt fuzzy. She appeared drowsy. He turned off the lights at her request; there was plenty of natural light from the window.

[44] Dr. Pillay said that the patient complained of migraine, which made it difficult for her to sit up, so he told her to lie down on the examining table and he would do an ENT exam. She was tender over the sinus so he looked at her ears with an otoscope, which he then used with a tongue depressor to look down her throat. He checked her lymph nodes behind her neck. He pressed on her sinuses. He denied massaging her neck, shoulders or back. He touched her back in the renal area when he pushed the renal angle, as a CT scan had shown a lesion on the kidney and radiology had suggested a referral to a urologist. He helped her into a seated position on the table by putting his arm on the metal bar on the wall beside the table so she could brace herself on his arm. He asked if she was feeling better. He might have helped her off the examining table. There were no hugs. He neither asked to kiss her nor apologized to her. He does not recall her telling him that he was lovely. Nothing in his interaction with her was done for a sexual purpose. He told her he would speak with her in his office. There, they discussed the colonoscopy findings. He told her he could do nothing for her surgically except a laparoscopy, which he did not recommend.

[45] After he saw the complaint (he was not allowed to keep a copy) at Dr. Hookenson's office on April 5, 2012, that same day Dr. Pillay added the following addendum to his March 29, 2012 electronic medical record (EMR): "She complained of migraine headaches and I did an ENT exam on her that was normal". The Agreed Statement of Facts sets out that on April 7, 2012, Dr. Pillay again accessed the complainant's EMR, this time deleting the previous note and replacing it with "The patient complained of headaches but her ENT was normal." He testified that he had advised the complainant, not specifically that he would do an ENT, but likely that he was going to examine the head and neck. He believed he had her consent for abdominal, ENT and renal exams. At no point did he massage or rub her, make a pass at her or do anything suggesting a sexual purpose.

Evidence on Cross-examination

[46] On cross-examination, Dr. Pillay acknowledged that it was not within the normal role of a general surgeon to do an ENT exam, but he did one here because there is only one ENT specialist in Prince Albert and Dr. Pillay does some work in that area, such as tracheostomies. He agreed that for most general surgeons an ENT exam under these circumstances would be quite unusual and outside of the normal range of office procedures. He agreed that part of the goal of medical records is to document events in the clinic that are outside the norm, and that he only added a reference to an ENT exam after he read the complaint that he had stroked her face,

neck, back, and arms. He did not record a significant migraine or any evaluations in that regard even though most of the time that he spent with the patient was related to the migraine.

[47] Dr. Pillay said that until March 29, 2012, his relationship with this patient was positive, and she had expressed gratitude. There were no complaints or concerns. He agrees that he helped her by turning off the lights, assisting her to get into a seated position and may have complimented her at the beginning of his interaction with her. There was debate as to whether he did anything to upset her. Yet he agreed that his actions went beyond what some other physicians would have done. He suggested that she go back to her G.P. regarding anemia and back to her gynecologist to further explore whether her problems might be gynaecological. He disagreed that he did anything that might have been misinterpreted—including stroking her face, back and neck, progressing to a hug or asking if he could kiss her. Yet he acknowledged that there was no bad diagnosis that might have caused her to be upset.

G. POSITIONS OF THE PARTIES

The College

[48] The College argues that there is no evidence that the complainant's ability to accurately recount the facts was affected by medication or medical conditions. Her testimony was unshaken on the central issues: a hug of short duration and a request to kiss her, followed by an apology. While her memory on other matters is imperfect, this is understandable given the number of doctors she has seen. If Dr. Pillay's version is correct—that he did nothing wrong and they parted on good terms—one would have to conclude that she lied, or created a memory of what occurred. The College concedes that until the point of the hug, or request for a kiss, there may have been some basis for misinterpretation. But she cannot be mistaken on these central points.

[49] Counsel cautioned committee members not to rely on their own understanding of how a person would react in such a situation. This patient was faced with an unwanted sexual approach yet wanted to know the result of the colonoscopy that might explain her problems. She said she told Dr. Pillay, "You are lovely" so as not to offend him. Patients trust their physicians and believe their physician will take care of them. When that trust turns out to be misplaced, the patient is put in a surprising situation and might react very differently than in normal circumstances. The complainant's post-event conduct is consistent with a reaction of shock.

Dr. Pillay

[50] Dr. Pillay submits that even using the McDougall standard, it is necessary to consider the seriousness of the consequences of the allegations. *Jacobs* did not significantly change the law. It is wrong to submit, as the College does, that the committee must pick the testimony of one side or the other: rather, misinterpretation by the complainant is a distinct possibility. Most people do not lie. There may have been many reasons why she was upset, including an extreme migraine. She could not say what medications she took that day. In cross-examination, she contradicted her testimony in chief by stating that it was Dr. Pillay's decision to turn off the lights, not her own request. She did not recall the March 6 visit at all and was still having trouble with the details of the March 29 visit—this was not a long visit and she should have been able to remember the details of a traumatic incident. She had been through enough ENT exams to know this was a normal exam. Dr. Pillay said he put his arm out on the bar to allow her to brace herself. He may have put his arm around her momentarily to steady her. If her evidence is accepted, at worst, he may have given her a brotherly hug for a millisecond. Her reaction at the time was that there was

nothing wrong with this. In the second interview with the College, she was challenged about why she backed up – this occurred because she was uncomfortable. Dr. Pillay questioned why she would say, "You're lovely" if the events occurred as she describes. If he had actually said he wanted to kiss her, why would she need to go outside to think about what had happened? From 1:45 p.m. until late in the day, she wondered about whether he had made a pass at her. If she left distraught, it is difficult to believe that she would have needed hours to decide to call her husband. On her evidence alone, there are many inconsistencies. There were no details as to what she told her husband, just that she was unhappy.

[51] Although he was seeing the patient for abdominal problems, Dr. Pillay said his actions show that he was looking at the overall patient. There is no reason to reject his evidence. He was clear and unshaken that he did not intentionally hug her or ask if he could kiss her. At worst, there was room for misinterpretation.

H. ANALYSIS

[52] In considering whether or not the College has met its burden[10] to provide sufficiently clear, convincing, and cogent evidence to satisfy the balance of probabilities test, we must review the relevant evidence with care to determine whether it is more likely than not that the alleged event occurred.

[53] There is no "smoking gun" in this case. The testimony of the complainant's spouse supports her testimony only to the extent that something had significantly upset her. She did not offer and he did not press her for details about what had happened. There were no independent eyewitnesses. We are left with only the testimony of the complainant and Dr. Pillay, as well as the medical records and the evidence of their conduct following the attendance.

[54] As a starting point in our assessment of the credibility and reliability of the witnesses' evidence, we have considered the comments of O'Halloran, J, in the oft-quoted case of *Faryna v. Chorney*:[11]

> If a trial Judge's finding of credibility is to depend solely on which person he thinks made the better appearance of sincerity in the witness box, we are left with a purely arbitrary finding and justice would then depend upon the best actors in the witness box. On reflection it becomes almost axiomatic that the appearance of telling the truth is but one of the elements that enter into the credibility of the evidence of a witness. Opportunities for knowledge, powers of observation, judgment and memory, ability to describe clearly what he has seen and heard, as well as other factors, combine to produce what is called credibility, and cf. *Raymond v. Bosanquet* (1919), 50 D.L.R. 560 at p. 556, 59 S.C.R. 452 at p. 460, 17 O.W.N. 295. A witness by his manner may create a very unfavourable impression of his truthfulness upon the trial Judge, and yet the surrounding circumstances in the case may point decisively to the conclusion that he is actually telling the truth. I am not referring to the comparatively infrequent cases in which a witness is caught in a clumsy lie.
>
> The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. ... the real test of the truth of the story of a witness in such a case must be its harmony with the

[10] as identified in *McDougall, supra*
[11] [1952] 2 D.L.R. 354 (B.C.C.A.), at pp. 356-7

> preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions. Only thus can a Court satisfactorily appraise the testimony of quick-minded, experienced and confident witnesses, and of those shrewd persons adept in the half-lie and of long and successful experience in combining skilful exaggeration with partial suppression of the truth. Again a witness may testify what he sincerely believes to be true, but he may be quite honestly mistaken. For a trial Judge to say, "I believe him because I judge him to be telling the truth", is to come to a conclusion on consideration of only half the problem. In truth it may easily be self-direction of a dangerous kind.
>
> The trial Judge ought to go further and say that evidence of the witness he believes is in accordance with the preponderance of probabilities in the case and, if his view is to command confidence, also state his reasons for that conclusion.

[55] In proceedings under the *Medical Profession Act, 1981*, as in every civil proceeding, it is necessary to assess both the credibility and the reliability of each witness. By "credible" we mean: was the witness honestly trying to tell the truth? By "reliable" we mean: was the witness able to give accurate testimony? The distinction between those two concepts was discussed by the Ontario Court of Appeal in *R. v. S. (W.)*[12]:

> We all know from our personal experiences as trial lawyers and judges that honest witnesses, whether they are adults or children, may convince themselves that inaccurate versions of a given event are correct and they can be very persuasive. The issue, however, is not the sincerity of the witness but the reliability of the witness' testimony. Demeanour alone should not suffice to found a conviction where there are significant inconsistencies and conflicting evidence on the record.

[56] Some factors we may look at, to determine whether we can rely on a witness's testimony, include:

- its consistency over time—whether the story changes significantly between tellings;
- its consistency with other known facts; and
- whether the story told by the complainant makes sense in the context of what a reasonable and informed person would recognize as likely, in that place and in those conditions.

[57] There is a helpful discussion of a methodology for assessment of credibility by the British Columbia Human Rights Tribunal in the decision *Brar and others v. B.C. Veterinary Medical Association and Osborne*[13]. After referring to *Faryna*, *supra*, the tribunal stated,:

> [78] More recently, in *Bradshaw v. Stenner*, 2010 BCSC 1398 (CanLII), the Court said:
>
> > Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 1919 CanLII 11 (SCC), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes

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[12] (1994), 90 C.C.C. (3d) 242 (Ont. C.A.), at p. 250; leave to appeal to S.C.C. refused 93 C.C.C. (3rd)
[13] (No. 22), 2015 BCHRT 151

> his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Farnya v. Chorny*, [1952] 2 D.L.R. 152 (B.C.C.A.) [*Farnya*]; *R. v. S.(R.D.),* [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Farnya* at para. 356).
>
> It has been suggested that a methodology to adopt is to first consider the testimony of a witness on a 'stand alone' basis, followed by an analysis of whether the witness' story is inherently believable. Then, if the witness' testimony has survived relatively intact, the testimony should be evaluated based upon the consistency with other witnesses and with documentary evidence. The testimony of non-party, disinterested witnesses may provide a reliable yardstick for comparison. Finally, the court should determine which version of events is the most consistent with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions" (*Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.* (1993), 12 Alta. L.R. (3d) 298 at para. 13 (Alta. Q.B.)). I have found this approach useful.
>
> Most helpful in this case has been the documents created at the time of events, particularly the statements of adjustments. These provide the most accurate reflection of what occurred, rather than memories that have aged with the passage of time, hardened through this litigation, or been reconstructed... The inability to produce relevant documents to support one's case is also a relevant factor that negatively affects credibility... (paras. 186-188)

[79] The Tribunal has applied a number of factors in assessing a witness' credibility including "their motives, their powers of observation, their relationship to the parties, the internal consistency of their evidence, and inconsistencies and contradictions in relation to other witnesses' evidence". (*Hadzic v. Pizza Hut Canada* (1999), 37 C.H.R.R. D/252 (B.C.H.R.T); see also *Agduma-Silongan v. University of British Columbia*, 2003 BCHRT 22, para 154). In addition, the fact that a party failed "to call or produce material evidence" might assist determining credibility. (*Bageya*, para. 156; *McKay v. Toronto Police Services Board*, 2011 HRTO 499 (CanLII) ("*McKay*") at para. 11)

[80] Generally, I found the witnesses to be credible in some areas but not others. For example, some witnesses had a clear recollection of the events while giving their direct evidence, but that recollection became more vague, evasive or self-serving in cross-examination. However, I note that the failure of a witness to be consistent in his or her evidence does not necessarily indicate untruthfulness. Some witnesses became argumentative while giving their evidence or unnecessarily embellished and exaggerated their evidence to support their theory of the case. In some cases, when the documents differed from the witness' recollection or his or her theory of the case, the witness strained their evidence in order to make the written document reflect their view of the events. I will outline these concerns in more detail when I review the evidence before me and make my findings of fact. . . . .

[84] It is unfortunate that the parties were unable to resolve the issues between them without the necessity of having me write this decision. Many of the witnesses, who are professionals, will be unhappy with the findings that I make regarding their credibility and their perception of the events. I have attempted to be restrained in my

comments and was guided by the Supreme Court of Canada's statement in R. v. R.E.M., 2008 SCC 51 (CanLII):

> While it is useful for a judge to attempt to articulate the reasons for believing a witness and disbelieving another in general or on a particular point, the fact remains that the exercise may not be purely intellectual and may involve factors that are difficult to verbalize. Furthermore, embellishing why a particular witness's evidence is rejected may involve the judge saying unflattering things about the witness; judges may wish to spare the accused who takes the stand to deny the crime, for example, the indignity of not only rejecting his evidence and convicting him, but adding negative comments about his demeanor. In short, assessing credibility is a difficult and delicate matter that does not always lend itself to precise and complete verbalization. (para. 49; see also *Mariano v. Campbell*, 2010 BCCA 410 (CanLII) para. 39)

[58] As observed by the Saskatchewan Court of Appeal in *Shamsuzzaman v. College of Physicians and Surgeons of Saskatchewan,*[14] an administrative tribunal is obliged to consider the whole of the evidence and determine on a balance of probabilities whether the complaint has been proven. To that end, the Committee must be careful to not:

i) determine the credibility of the complainant without first reviewing the evidence of Dr. Pillay; nor to

ii) determine that the only version of the facts available for the Committee to accept is the version put forward either by the complainant or by Dr. Pillay and in so doing overlook that a third version may be available on the facts and must be considered.

[59] This case readily allows for misinterpretation as to what occurred in some areas, which we will address below. At the same time, both key witnesses were unshaken in their testimony on the key issue: the complainant was adamant that Dr. Pillay asked if he could kiss her while Dr. Pillay is equally adamant that he did not. This is a fundamental issue, because if this is found to have been proven, it frames the interpretation of the balance of the conduct complained of. There is no basis for misinterpretation of what was said—it is either proven to have been said, or it is not. Given the contradictory testimony on this key issue, the Committee must consider the surrounding circumstances to determine whether one version of events is, in the words of *McDougall*, "inherently improbable," bearing in mind that the burden remains on the College to prove the essential ingredients of the charge, not on Dr. Pillay to disprove anything. The Committee agrees with counsel for Dr. Pillay that it need neither accept nor discredit in its entirety the version of events presented by either key witness.

[60] We begin with a consideration of Dr. Pillay's testimony, starting with the unusual circumstances of his examination of the complainant. She did not testify that the ENT exam performed by Dr. Pillay stood out as being different from others she had experienced. There was nothing to suggest that her migraine had reached the level of an emergency or that it required a new assessment. Nor can it by any stretch be characterized as "new" given that the complainant was a well-established migraine sufferer. In these circumstances, and given the reason for the referral, it would be highly unusual for a general surgeon to conduct an ENT exam. This would be so, even if it had been contemporaneously documented. Barring anything new or emergent, a

[14] 2011 SKCA 41

general surgeon would normally be expected to restrict his examination to the reason for the referral—in this case lower left quadrant or abdominal pain. The fact that he exceeded the scope of examination expected of a general surgeon under these circumstances adds support for the complainant's position and casts suspicions on Dr. Pillay's intentions.

[61] The suspicions raised by this unusual examination are compounded by the medical record addenda issued on April 5, 2012 and again on April 7, 2012, which suggest an *ex post facto* attempt to justify the touching of the face and neck, an important part of the context that the complainant said preceded the request to kiss her, and which might be characterized as "grooming" the victim. This must be viewed in the context of Dr. Pillay's concession that he may have complimented the complainant on her appearance at the outset of the attendance.

[62] Further, the evidence of Dr. Pillay's addition to his chart after he learned of the complaint is suggestive of someone seeking to re-write history in order to align with his own perspective and interests. Admittedly, this was an unsophisticated effort given the audit trail created by the electronic records system. However, unlike the situation of the complainant, which we will address below, Dr. Pillay had a great deal to gain from putting a new spin on his conduct by the creation of the addenda to the record: preserving his professional reputation and status and improving his position in responding to the complaint.

[63] The lack of compelling explanation for the ENT exam and subsequent additions to the record combine to cast serious doubts on the believability of Dr. Pillay's testimony on the other key aspects of that visit.

[64] We now turn to an analysis of the complainant's testimony. She had an admittedly imperfect memory of certain peripheral events. For example, she did not recall speaking with office staff who accompanied her to the examining room. Given the extent of her doctoring, this is not surprising. Her testimony as to whether she asked Dr. Pillay to turn the lights off or he volunteered to do this was to some extent internally consistent as between her examination in chief and cross-examination. However, considered in the context of the totality of the evidence, her lack of recall regarding peripheral circumstances does not cause us to doubt the truthfulness of the complainant's testimony as to the core of her allegations.

[65] The complainant had many opportunities to embellish the seriousness of her allegations of misconduct by Dr. Pillay yet declined to do so. Instead, she was prone to understatement, as when she described Dr. Pillay "gently" turning her around. Her conduct in telling Dr. Pillay that he was a lovely person and accompanying him to his office after her experience in the examining room may, on its face, seem inconsistent with her allegation that he had made a "pass" at her. It was clearly embarrassing for her to admit that she told Dr. Pillay he was a lovely person and followed him into his office after what had occurred. This statement was so unexpected and against her interest that it shows even-handedness and lends credibility to her testimony surrounding the core of the incident. Further, self-blame is not uncommon among victims of sexually inappropriate behavior, particularly by those in a relationship of trust with the victim. There was certainly some testimony strongly suggesting self-blame, including her statement to the College to the effect that "this isn't going to fly."

[66] There was no negative diagnosis or other obvious reason for her to break down in her car after this office visit apart from the inappropriate conduct she described. That this previously appreciative, grateful patient became uncharacteristically and seriously upset after leaving her doctor's office strongly suggests that something significant and inappropriate had taken place.

To admit the fact that it took some time for things to sink in and that she needed to process what had occurred before reluctantly coming to this conclusion is consistent with someone in shock and was also against her own interest, bolstering her credibility.

Conclusions of Fact

[67] After careful deliberation, we find it probable that Dr. Pillay did hug the complainant, however briefly. The complainant did not immediately leap to the conclusion that the hug was anything other than innocent. Up to and including the hug, there was indeed room for the complainant to have misinterpreted Dr. Pillay's conduct and intentions. Viewed in isolation from what occurred next, it may have been consistent with a doctor showing legitimate concern for a vulnerable patient and perhaps going beyond the call of duty.

[68] Here we must turn our focus to the key element of the charge: that Dr. Pillay asked the complainant if he could kiss her. First, we note that no evidence suggested that the complainant's migraine or medications impaired her ability to recall the core elements of this attendance. While she admitted to having said that she felt "fuzzy", this appears to have been in the context of the vertigo that accompanied her migraine. Further, while it is one thing not to have solid recall of peripheral details, it is quite another to suggest that a fuzzy sensation or vertigo could result in the innocent creation of a false memory. More importantly, the allegation that the doctor asked if he could kiss her did not change in any material respect in any of her tellings over a period of years—in her complaint to the Health Region; two interviews by the College; and in her testimony at the hearing. The allegation was consistent throughout.

[69] There was no reason for the complainant to fabricate such an allegation. She stood to gain nothing except the aggravation of a trip to the Prince Albert Health Region and multiple trips to Saskatoon for difficult and personal questioning and a hearing, and the accompanying stress, on top of her many serious medical concerns. She has not complained about health care providers apart from this incident. There was no reason for her to do so about Dr. Pillay unless something happened that deeply troubled her. She was uncertain at the time as to whether Dr. Pillay's earlier conduct during that attendance was inappropriate, until he asked for a kiss. Then she saw his conduct in a different light.

[70] Perhaps most people would have had no need to deliberate as to whether this request amounted to a "pass," either on its own or coupled with the preceding hug, but the complainant did just that. She needed to process what had occurred in an appointment with a doctor who until then had been nothing but kind and helpful.

[71] There was no terrible news, no distressing diagnosis, nothing apart from the unexpected conduct of a trusted doctor to explain her shock and tears.

[72] The complainant's husband reacted calmly to the news that something had happened. Significantly, he did nothing either to inflame the situation or incite her into complaining. She knew from their relationship that he was not judgmental.

[73] The complainant acted relatively quickly to bring the complaint to the attention of the health region. Neither the complaint nor the exact date of the complaint was entered in evidence, but it is known that Dr. Pillay met with Dr. Hookenson on April 5, 2012, so the complaint was prepared and delivered no later than that date.

[74] Some of the evidence of the complainant's post-event conduct is against her interest. She did not try to paint herself in a positive light. Yet, her conduct was consistent with that of a troubled victim of an unwanted advance by a trusted health professional.

[75] The Committee accepts the complainant's testimony on the core issues–that Dr. Pillay hugged her and asked if he could kiss her. The Committee rejects Dr. Pillay's testimony on these core issues, for reasons previously stated.

I. CONCLUSION

[76] Upon careful consideration of all of the evidence and submissions, we find it likely that Dr. Pillay set the stage by complimenting the complainant on her appearance and that he tested the waters by starting with what he characterized as an ENT exam, which we find was not justified in the circumstances and which is more consistent with grooming the complainant. We find that the College has proven, according to the standards required by *McDougall*, that Dr. Pillay hugged the complainant and then asked if he could kiss her. As soon as it was plain that the complainant was uncomfortable with his advances, to his credit, Dr. Pillay backed off and did not pursue the matter further. Nevertheless, we find that Dr. Pillay failed to maintain the standard of practice of the profession and committed an act of sexual impropriety with a patient.

[77] We find that the College has met its burden of establishing by clear, cogent and convincing evidence, on a balance of probabilities that Dr. Pillay is guilty of improper, unprofessional, or discreditable conduct, within the meaning of Section 46 (o) of the Act.

[78] We wish to express our gratitude to counsel for their thorough and helpful submissions.

Dated this 12th day of August, 2016.

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Daniel Shapiro, Q.C., C. Arb.,
Chair, Discipline Hearing Committee

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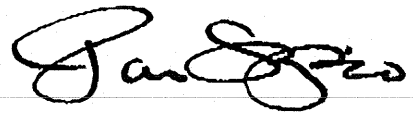

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