PROVINCE OF NOVA SCOTIA
HALIFAX REGIONAL
MUNICIPALITY

IN THE MATTER OF: **The College of Physicians and Surgeons of Nova Scotia**

-and-

Dr. Manivasan Moodley

HEARING COMMITTEE DECISION

Hearing dates:

February 24, 25, 26 & 27, 2020 – and - August 26 & 27, 2020.

Hearing Panel:

Ms. Gwen Haliburton
Dr. M. Naeem Khan
Dr. Gisele Marier
Dr. Erin Awalt
Raymond Larkin, Q.C.

Counsel for the College of Physicians and Surgeons of Nova Scotia:

Ms. Marjorie Hickey, Q.C., and Mr. Ryan Baxter

Counsel for Dr. Manivasan Moodley:

Mr. Robin Cook and Mr. Shane Belbin

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I. Introduction

1. Dr. Moodley is an obstetrician and gynecologist who works at the Cape Breton Regional Hospital. He graduated from medical school at the University of Natal in South Africa in 1987 and became a specialist in obstetrics and gynecology in South Africa in 1996. Dr. Moodley practiced in South Africa until 2017, when he began working in the Department of Obstetrics and Gynecology at the Cape Breton Regional Hospital. In May 2019, he passed the Royal College exams for specialization in obstetrics and gynecology in Canada.

2. On August 18, 2017, A.B. complained to the Nova Scotia College of Physicians and Surgeons about conduct by Dr. Moodley in an office visit on July 13, 2017. On September 20, 2017, C.D. complained to the College about his conduct in an office visit on July 6, 2017, and the events that occurred after that office visit.

3. For the most part, the complaints of A.B. and C.D. both involved allegations that Dr. Moodley made remarks to them or asked them questions which they perceived to be sexual in nature and unrelated to their medical problems. Physicians in Nova Scotia are subject to strict standards in respect of sexual misconduct in the physician-patient relationship. As a Hearing Committee we must decide whether Dr. Moodley failed to meet those standards or otherwise engaged in unprofessional conduct in his dealings with A.B and C.D. This decision is a majority decision with Dr. Khan dissenting.

II. History of the Complaints

4. The initial complaint from A.B. in August,2017 led to an intervention by the College, which resulted in an undertaking by Dr. Moodley to have a regulated healthcare professional as an attendant present for all female patient encounters.

5. The Investigation Committee of the College investigated the complaints and referred them to a hearing in February 2018. Both Dr. Moodley and the College provided additional information to the Investigation Committee in the months that followed the referral to hearing. The Investigation Committee decided on December 14, 2018, to revise its initial referral to hearing, and issued an amended notice of hearing on January 20, 2019. The College sought dates for hearing during April and May 2019. Dr. Moodley requested a postponement of a hearing in order to write his Royal College examinations in April and in late May 2019, Dr. Moodley's counsel advised of available dates in late June or early July, which were not available to the College. The parties ultimately agreed on dates for the hearing to take place from October 21 – October 25, 2019.

6. On October 10th, 2019, Dr. Moodley's legal counsel provided Notices of Motion seeking a publication ban on Dr. Moodley's name until the Hearing Committee rendered its decision on the allegations against him. He also sought production of all the social media postings of one complainant for a three-year period and production of some social media posts from the other

complainant and texts and other communications from both complainants regarding identified individuals.

7. Because of these motions, the scheduled dates for the hearing in October 2019 were withdrawn and rescheduled for February 24-28, 2020. On October 24, 2019, the Hearing Committee heard Dr. Moodley's application for a publication ban on his name, pending the decision of the Hearing Committee on the substance of the matters referred to hearing. The Hearing Committee denied this motion in a written decision with reasons dated December 16, 2019.

8. December 16th and 17th, 2019, were scheduled to hear the motions for the production of social media posts. Before that hearing, Dr. Moodley changed legal counsel. As a result, the motions set for December 16 and 17th could not proceed and were rescheduled for January 20, 2020. On January 20th, 2020, Dr. Moodley's new legal counsel advised that he was withdrawing production motions.

9. The hearing of the complaints against Dr. Moodley was held on February 24, 25, 26, and 27, 2020. Two more days were scheduled to complete the hearing, but the restrictions resulting from the Covid 19 pandemic delayed the hearing which was completed on August 26 and 27, 2020.

10. Counsel for the College and Dr. Moodley made oral submissions during the final days of the hearing and provided extensive written submissions, the last of which we received on September 30, 2020.

III. Mandate of the Hearing Committee

11. This Hearing Committee has been appointed under Section 49 of the *Medical Act.* The Chair of the hearing pool, appointed under Section 47 of the *Medical Act,* has appointed a Hearing Committee of five persons from the hearing pool, including a public representative, three medical practitioners, and the Chair of the hearing pool as Chair of the Hearing Committee.

12. In this case, the mandate of the Hearing Committee is to determine whether Dr. Moodley has engaged in professional misconduct. "Professional misconduct" is defined in section 2 of the *Medical Act* as follows:

> (a)(j) "Professional Misconduct" includes such conduct or acts in the practice of medicine that, having regard to all the circumstances, would be reasonably regarded as disgraceful, dishonourable, or unprofessional, and that, without limiting the generality of the foregoing, may include breaches of:
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> (i) the Code of Ethics approved by the Council;
>
> (ii) the accepted standards of the practice of medicine; and

(iii) this Act and the Regulations and the policies approved by the Council.

13. It should be noted that the definition of "professional misconduct" is inclusive. Apart from whether a medical practitioner's conduct or actions fall within the specific clauses that follow the word "includes" in the definition, we will apply the words "professional misconduct" in their ordinary meaning consistent with the purposes of the *Medical Act.*

14. Several of the allegations by the complainants claim that Dr. Moodley made inappropriate comments of a sexual nature to them in the course of his assessments of their medical issues. As noted above, the College has adopted Professional Standards and Guidelines Regarding Sexual Misconduct in the Physician-Patient Relationship, which sets out the minimum standards of professional and ethical behavior expected of physicians licensed by the College.

15. Consideration of these minimum standards will help us reach a conclusion, which is consistent with the medical profession's declared standards. However, ultimately the decision as to whether Dr. Moodley engaged in professional misconduct is a matter of professional judgment. The majority of the hearing committee are medical practitioners, accompanied by a public representative and a legally trained Chair. We are able to bring to bear our own experience and judgment on whether the conduct engaged in by Dr. Moodley was unprofessional to the extent that it constitutes professional misconduct.

IV. Onus of Proof

16. In this case, the Notice of Hearing alleges that Dr. Moodley engaged in professional misconduct in assessing and treating A.B. and C.D. The College bears the burden of proving the conduct alleged in the Notice of Hearing and of satisfying us that the conduct that is proven constitutes professional misconduct in all of the circumstances.

17. The standard of proof in this matter is proof on the balance of probabilities. We must consider the relevant evidence to decide whether it is more likely than not that the alleged incidents occurred.

18. In *F.H. v. McDougal*, 2008 SCC 53 (CanLII), 2008 S.C.C. 53, the Supreme Court of Canada discussed the applicable standard of proof. The following paragraphs summarize the approach taken by the Supreme Court of Canada:

> Like the House of Lords, 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. I am

of the respectful opinion that the alternatives I have listed above should be rejected for the reasons that follow.

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.

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.

19. These principles apply to hearing of allegations of misconduct under the *Medical Act*; see *Osif v. College of Physicians and Surgeons of Nova Scotia,2009 NSCA 28; see also Re Ezema,2018 CanLII105365 (NSCPS).*

V. Assessment of Credibility and Reliability

20. In determining whether the College has met its burden of proof that it is more likely than not that the events alleged in the Notice of Hearing occurred, the Committee has to assess whether the evidence given by A.B. and C.D. is credible and reliable. In *Re Ezema,* we adopted the following passage from a recent decision of the Discipline Committee of the College of Physicians and Surgeons of Ontario in the *College of Physicians and Surgeons of Ontario v. Yaghini*, 2016 O.N.C.S.D. 52, at pages 14 and 15:

> The Committee must assess both the credibility of each witness and the reliability of their testimony. Credibility refers to the witness' sincerity and willingness to speak the truth as he or she believes the truth to be. Reliability relates to the witness' ability to accurately observe, recall and recount the events in issue. That is, the witness' honesty must be assessed along with whether his or her evidence is reliable or can be counted on to be accurate.
>
> The Committee is aware that there is no legal requirement that a complainant's testimony be corroborated.
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> There is no rule governing when inconsistencies in a witness' evidence will render the evidence not credible or reliable. When assessing the credibility of the witness, inconsistencies on minor matters or matters of detail are normal and are to be expected and must be considered when weighing all of the evidence. The Committee must not

consider a witness's evidence in isolation, but should consider all of the evidence and assess the impact of the inconsistencies on the witness's credibility and reliability as it pertains to the core issue in the case.

21. In making our assessment of credibility and reliability, we are mindful of the approach taken by the British Columbia Court of Appeal in *Farnya v. Chorny*, [1951] BCJ No. 152, [1952] 2 DLR 52:

> 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. **In short, the real test of the truth of the story of a witness in such a case must be its harmony with the 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 people 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 a consideration of only half the problem. In truth it may easily be self-direction of a dangerous kind. He should go further and say that the testimony of the witness whom he believes is in accordance with the preponderance of probabilities in the case and he should also state his reasons for that conclusion. **[Emphasis added]**

22. There is no onus on Dr. Moodley to prove that he did not engage in misconduct, but to the extent that we consider his evidence, we will take this same approach to assess his credibility and the reliability of his testimony in the context of all of the evidence before us.

VI. Conduct of the Hearing

23. The conduct of the hearing by the Hearing Committee is governed by Section 53 of the *Medical Act* and Sections 106 to 110 of the Medical Practitioners Regulations. Sub-section 53 (2) provides that in a proceeding before a hearing committee, the parties have a right to natural justice.

24. In conducting the hearing and assessing the evidence, we are not bound by the formal rules of evidence. Regulation 113(2) of the Medical Practitioners Regulations provides as follows:

> Evidence may be presented at a hearing in any manner that a hearing committee considers appropriate, and the committee is not bound by the rules of law respecting evidence applicable to judicial proceedings, but must consider what evidence to receive in a fair manner.

25. We admitted evidence that would not necessarily be admissible under the rules of law respecting evidence applicable to judicial proceedings during the hearing. While we are permitted to rely on otherwise inadmissible evidence in making our decision, we must be confident that relying on this evidence is fair to Dr. Moodley and the College. We may admit evidence but decide not to give it much or any weight in finding the relevant facts. Generally speaking, we will give the most weight to sworn testimony given at the hearing and subject to cross-examination and evidence from medical records.

26. In considering the charges against Dr. Moodley, the Hearing Committee must bear in mind the purpose and duties of the College as set forth in Section 5 of the *Medical Act*. The purpose and responsibilities of the College are to protect the public interest in the practice of medicine and to preserve the integrity of the medical profession, and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine. In our view, the public interest in the practice of medicine includes not only protection of the public but also the fair treatment of medical practitioners accused of professional misconduct.

VII. Procedural Issues

a) Open Hearings

27. Several issues have arisen in this matter, involving the openness of the hearing. Those issues involved requests for publication bans and exclusion of the public from the hearing.

28. On October 24, 2019, the Hearing Committee banned publication of the two complainants' names and any information that could identify them. On December 16, 2019, the Hearing Committee issued a written decision dismissing a motion for a temporary, partial publication ban on Dr. Moodley's name and country of origin. On February 14, 2020, the Committee made an order, which excluded the public from the hearing but permitted news media or family members of Dr. Moodley and the two complainants to attend.

29. Although we provided written reasons for dismissing Dr. Moodley's motion, we think that a more comprehensive look at the limits on open hearings should be undertaken in these reasons for our decision.

30. Proceedings of the Hearing Committee under *The Medical Act* are governed by Section 53 of the *Act,* which provides as follows:

> A. (1) A proceeding held by a hearing committee shall be conducted in accordance with the regulations and otherwise as the hearing committee deems fit.

(2) In a proceeding before a hearing committee the parties have the right to;

a. natural justice;
b. be represented by legal counsel at the parties' own expense;
c. present evidence and make submissions, including the right to cross-examine witnesses;
d. know all the evidence considering by the committee;
e. and
f. receive written reasons for a decision within a reasonable time

(3) Evidence is not admissible before a hearing committee unless the opposing party has been given, at least 10 days before hearing.

(4) Notwithstanding subsection (3), a hearing committee may, in its discretion, allow the introduction of evidence that is otherwise inadmissible by reason of subsection (3) and may make directions it considers necessary to ensure that a party is not prejudiced.

(5) With respect to any decision issued by a hearing committee, or with respect to any aspect of the hearing committee's process pursuant to this *Act* or Regulations, the committee may impose a publication ban on such portions of its proceedings or decisions as deemed necessary by the committee.

(6) In any proceeding held by a hearing committee, a member is a compellable witness.

31. Section 53(5) authorizes a hearing committee to impose a publication ban on such parts of its proceedings or decisions as deemed necessary by the committee. Section 55 of the *Act* contemplates publication of the decisions of the hearing committee "subject to any publication bans in existence."

32. The Act does not require open hearings, but section 109 of the Medical Practitioners Regulations requires a hearing to be open to the public, subject to limited exceptions. Section 109 provides as follows:

Attendance at hearing and publication bans

109 (1) Except as provided in subsections (2) or (3), a hearing is open to the public.

(2) At the request of a party, a hearing committee may order that the public, in whole or in part, be excluded from a hearing or any part of it if a hearing committee is satisfied that any of the following apply:

(a) personal, medical, financial or other matters that may be disclosed at the hearing are of such a nature that avoiding public disclosure of those matters in the interest of the public or any person affected outweighs adhering to the principle that hearings should be open to the public;

(b) the safety of any person may be jeopardized by permitting public attendance.

(3) A hearing committee may make an order that the public be excluded from a part of a hearing that deals with a request for an order to exclude the public in whole or in part under subsection (2).

(4) A hearing committee may make any orders that it considers necessary, including orders prohibiting publication or broadcasting to prevent the public disclosure of matters disclosed in a hearing in any decision rendered by a hearing committee, or with respect to any matter under subsection (2) or (3).

(5) Subject to any order made under this Section, a hearing committee must state at a hearing its reasons for any order made under this Section.

(6) Despite any decision to exclude the public under this Section, a complainant may attend a hearing unless the hearing committee directs otherwise."

33. Section 30 of the *Act* requires the disposition of disciplinary matters in accordance with the objects of the College. These objects are set out in Section 5 which provides in part:

"In order to

a. serve and protect the public interest in the practice of medicine; and
b. subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall:

c. regulate the practice of medicine and govern its members through

(i) the registration, licensing, professional conduct and other processes set out in this *Act* and the regulations,
(ii) the approval and promotion of a code of ethics,
(iii) the establishment and promotion of standards for the practice of medicine, and
(iv) the establishment and promotion of a continuing professional development program; and

d. do such other lawful acts and things as are incidental to the attainment of the purpose and objects of the College. 2011, c. 38, s. 5."

34. Under this statutory framework, consideration of the openness of hearings, publication bans, and exclusions of the public from a hearing is governed by the overriding principle of protecting the public interest in the practice of medicine and the objective of maintaining the confidence of the public and the profession in the ability of the College to regulate the practice of medicine.

35. In our opinion, where professional misconduct and incompetence by a physician is alleged, an open hearing is essential to maintain the confidence of the public that the public interest is protected.

36. Open hearings are important to professional regulation generally, where a governing statute recognizes self-regulation. Hearings behind closed doors lead to speculation that the self-regulating profession is protecting its members rather than the public. Open hearings allow the public to see for themselves the evidence considered by a hearing committee through reporting by the news media. The publication of hearing committees' decisions with written reasons permit the public to judge the fairness of decision-making and the priority given to protecting the public by the self-regulating professions. Open hearings considering professional misconduct or incompetence are the cornerstone of accountability for hearing committees.

37. The medical profession in Nova Scotia regulates its members through the College. As in other self-regulating professions, open hearings and published decisions assure the public that the medical profession meets high standards of conduct and competence.

38. Accordingly, in our view, the requirement for open hearings in section 109 of the Medical Practitioners Regulations is an essential feature of regulating the medical profession in Nova Scotia. The exceptions to open hearings should be strictly interpreted. The application of those exceptions involves the exercise of discretion by the hearing committee. In exercising that discretion, the hearing committee must consider whether making the exception will serve the public interest in the practice of medicine and whether it will affect the confidence of the public and the profession in the ability of the College to regulate the practice of medicine.

39. We believe that this approach is consistent with the broad constitutional limits on statutory bodies exercising powers that restrict open hearings or ban publication of evidence from hearings. These limits reflect the historic recognition of open hearings by courts. In *Toronto Star Newspapers Limited v. Attorney General of Ontario, 2018 ONSC 2586,* the court states the following:

> [3] The venerability of the open courts, or openness principle is not in doubt. In the 13th century, Magna Carta confirmed the prohibition against selling writs, or admission tickets to trials, in favour of open public access to court proceedings. The openness

> principle was reiterated by Sir Matthew Hale in the 17th century, who noted that witnesses must be examined "in the open court, and in the presence of the parties, their attorneys, counsel and all bystanders." In the 18th century, William Blackstone understatedly observed that, "the open examination of witnesses...is much more conducive to the clearing up of the truth."
>
> [4] The concept of open justice easily made the crossing from England; accordingly, Canadian courts have historically recognized that, "it is of vast importance to the public that the proceedings of courts of justice should be universally known." This has been reinforced in the post-Charter era, with the Supreme Court of Canada emphasizing that public access to legal proceedings includes access by the press:
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> Discussion of court cases and constructive criticism of court proceedings is dependent upon the receipt by the public of information as to what transpired in court. Practically speaking, this information can only be obtained from the newspapers or other media.

40. Judicial recognition of the principle of open hearings is closely tied to the rights guaranteed in Section 2(b) of the *Canadian Charter of Rights and Freedoms.* In *Canadian Broadcasting Corp v. New Brunswick (Attorney General),* [1996] 3 SCR 480 at paragraph 26 the Supreme Court of Canada states that the open court principle includes "guaranteed access to the courts to gather information" and limits "measures that prevent the media from gathering that information, and from disseminating it to the public, restrict freedom of the press".

41. These judicial principles apply to the exercise of statutory powers by a decision-making body like this Hearing Committee. In *Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board) v. Laseur, 2003 S.C.R. 54* (CANLII), the Supreme Court adopted the following passage from the dissenting judgement of McLachlin J. (as she then was) in *Cooper v. Canada (Human Rights Commission),* [1996] 3 S.C.R. 854 at par 70:

> The *Charter* is not some holy grail which only judicial initiates of the superior courts may touch. The *Charter* belongs to the people. All law and law-makers that touch the people and thus conform to it. Tribunals and commissions charged with deciding legal issues are no exception. Many more citizens have their rights determined by these tribunals than by the courts. If the *Charter* is to be meaningful to ordinary people, then it must find its expression in the decisions of these tribunals.

42. Accordingly, the exercise of discretion by the Hearing Committee to ban publication of its proceedings or to make an exception to the requirement of an open hearing in section 109 of the Medical Practitioners Regulations is an exercise of statutory power, which is subject to section 2(b) of the *Charter of Rights.* Exclusion of the public from a hearing or a publication ban is a restriction on the freedom of the press.

43. Both parties have cited *R. v Mentuck,* [2001] 3 S.C.R. 442 and *Sierra Club of Canada v Canada (Minister of Finance)* 2002 SCC 41 in respect of a publication ban's constitutionality. In *R.*

v. Mentuck at paragraph 32, the Court set out the test for a Charter compliant publication ban as follows:

> A publication ban should only be ordered when:
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> a. such an order is necessary in order to prevent a serious risk to the proper administration of justice because reasonably alternative measures will not prevent the risk; and
>
> b. the salutary effects of the publication ban outweigh the deleterious effects on the rights and interests of the parties and the public, including the effects on the right to free expression, the right of the accused to a fair and public trial, and the efficacy of the administration of justice.

44. The Court also elaborated on the concept of necessity at paragraph 34 stating as follows:

> I would add some general comments that should be kept in mind in applying the test. The first branch of the test contains several important elements that can be collapsed in the concept of "necessity", but that are worth pausing to enumerate. One required element is that the risk in question be a serious one, or, as Lamer C.J. put it at p.878 in *Dagenais*, a "real and substantial" risk. That is, it must be a risk the reality of which is well-grounded in the evidence. It must also be a risk that poses a serious threat to the proper administration of justice. In other words, it is a serious danger sought to be avoided that is required, not a substantial benefit or advantage to the administration of justice sought to be obtained.

45. In *Sierra Club of Canada* the Court applied the same principle in the context of an application for judicial review reciting the test as follows in paragraph 53:

> Applying the rights and interests engaged in this case to the analytical framework of *Dagenais* and subsequent cases discussed above, the test for whether a confidentiality order ought to be granted in a case such as this one should be framed as follows:
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> A confidentiality order under Rule 151 should only be granted when:
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> a. such an order is necessary in order to prevent a serious risk to an important interest, including a commercial interest, in the context of litigation because reasonably alternative measures will not prevent the risk; and
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> b. the salutary effects of the confidentiality order, including the effects on the right of civil litigants to a fair trial, outweigh its deleterious effects, including the effects on the right to free expression, which in this context includes the public interest in open and accessible court proceedings.

46. The court elaborated on the idea of "important commercial interest" in paragraph 55 as follows:

> In addition, the phrase "important commercial interest" is in need of some clarification. **In order to qualify as an "important commercial interest", the interest in question cannot merely be specific to the party requesting the order; the interest must be one which can be expressed in terms of a public interest in confidentiality**. For example, a private company could not argue simply that the existence of a particular contract should not be made public because to do so would cause the company to lose business, thus harming its commercial interests. However, if, as in this case, exposure of information would cause a breach of a confidentiality agreement, then the commercial interest affected can be characterized more broadly as the general commercial interest of preserving confidential information. **Simply put, if there is no general principle at stake, there can be no "important commercial interest" for the purposes of this test**. Or, in the words of Binnie J. in F.N. (Re), [2000] 1 S.C.R. 880, 2000 SCC 35 (CanLII), at para. 10, the open court rule only yields "where the public interest in confidentiality outweighs the public interest in openness." **[Emphasis added]**

47. The first element of the legal test used in *Sierra Club* is the test of necessity in the public interest. This element is reflected in Section 53(5) of the Medical Act's requirement that a publication ban must be necessary. The second element of the legal test is proportionality, which requires consideration both of the salutary effects of a publication ban and its deleterious effects. In our opinion, proportionality is always a consideration in the exercise of discretion by the Hearing Committee. In our view, the Medical Act and Medical Practitioners Regulations' requirements are consistent with and embody the applicable constitutional principles.

48. Although there is no express requirement for necessity in the public interest or proportionality stated in Section 109(2) of the Regulations for exclusion of the public from a hearing, in our opinion, those requirements nevertheless should be applied to be consistent with Section 53(5) of the Act and Section 2(b) of the *Charter of Rights and Freedoms*.

49. Section 109(2) of the Regulations requires a hearing committee to be satisfied that avoiding public disclosure of matters disclosed at the hearing is in the public interest or the interest of any person and outweighs the principle that the hearing should be open. In our opinion, this balancing exercise requires consideration of whether the exclusion of the public is necessary to protect the public interest in the practice of medicine and to maintain public confidence. If exclusion of the public is necessary and meets the requirement of proportionality, we can exercise our discretion to order exclusion of some or all of the public from the hearing.

50. When considering whether to ban publication of aspects of a hearing or a decision or to exclude the public from a hearing, we will apply the requirements of necessity and proportionality along with the overriding principles of promoting the public interest in the practice of medicine and maintaining the confidence of the public and the profession and the ability of the College to regulate in the public interest.

b) Publication ban of the identities of the complainants

51. On October 24, 2019, the Hearing Committee imposed a publication ban on the two complainants' names in this matter and on any information that could identify those complainants. The ban was proposed by the College and consented to by Dr. Moodley. The Hearing Committee agreed that the publication ban was necessary in the circumstances of this case and so ordered. We did so for two reasons.

52. It seemed evident to us that there was a public interest in banning the publication of the complainants' identities. They are members of the public, and the subject matter of their complaints involves intimate details on personal medical issues that will be fully explored in a public hearing.

53. Just as importantly, in our view, it was in the public interest not to discourage other women who experience professional misconduct of a sexual nature from complaining to the College because of the potential public examination of intimate personal details. The College's ability to protect the public from professional misconduct of this nature depends on the readiness of victims to complain.

54. In retrospect, we are satisfied that banning the disclosure of complainants' identities did not significantly compromise the hearing's openness, nor did it impair a fair hearing for Dr. Moodley.

55. When we made our order banning the publication of the identities of the complainant's, we didn't have the advantage of submissions on the more sophisticated issues involved in the application of the *Charter of Rights,* so they were not part of our considerations in deciding that the publication ban on the identities of the complainants was necessary.

c) Publication Ban of Dr. Moodley's Identity

56. Different considerations apply to a request for a publication ban on a physician's identity facing allegations of professional misconduct. In our decision rejecting Dr. Moodley's request for a temporary partial publication ban of his name, the majority of this hearing Committee adopted the following analysis:

> In our opinion, apart entirely from constitutional considerations, a temporary public ban on Dr. Moodley's name and place of origin is not necessary to protect the public interest in the practice of medicine or to maintain the confidence of the public and the ability of the college to regulate the medical profession.
>
> It is clear that the publication of Dr. Moodley's name and place of origin will be embarrassing and stressful for him and it seems likely that it could have a negative impact on his practice. However, a ban on publishing his name is not necessary to ensure

a fair hearing of the issues which have been referred from the Investigation Committee to the Hearing Committee.

Nor is a publication ban necessary to protect the public. Unlike the ban on the names of the complainants who are members of the public whose personal and medical information will be considered in open hearing, the temporary partial publication ban sought by Dr. Moodley would protect Dr. Moodley only. There is no evidence that the pubic will be harmed by publishing Dr. Moodley's name. Nor is there evidence that the publication of Dr. Moodley's name would jeopardize the health care of the public. Dr. Moodley suggests that patients will be reluctant to see him. The evidence does show that the CBC story and the practise restrictions in 2017 were followed by a decline in new patients, but there is no evidence that any patients went without medical services that they needed as a result.

There is a public interest in the fair treatment of physicians who are charged with professional misconduct. However, the requirement of open hearings in the Medical Practitioner's Regulations and the limits on publication bans in the Act and the Regulations are inconsistent with a publication ban on the name of the physician where there is no risk to a fair hearing and no public interest separate from the physician's interest.

In our opinion, there is no overriding public interest in preventing the publication of a physician's name in the sense of that found by the British Columbia Court of Appeal in *Q. v College of Physician's* and *G. v British Columbia College of Teachers*. The principle in those cases that "...There is a public interest in not damaging professional reputations unnecessarily..." reverses the requirement in the *Medical Act* and Medical Practitioners Regulations that the Hearing Committee must be satisfied that the publication ban is necessary.

Apart from our conclusion that a temporary partial publication ban on Dr. Moodley's name and place of origin is not necessary for the purpose of the *Medical Act*, in our opinion, this case does not meet the requirement for infringement of freedom of expression as set out by the Supreme Court of Canada *R. v Mentuck* and *Sierra Club v Canada*. The proposed temporary partial publication ban of Dr. Moodley's name and place of origin does not meet the requirements either of necessity or proportionality that would justify infringing on freedom of expression.

In our opinion, a publication ban is not necessary in this case to prevent a serious risk to the regulation of the practice of medicine in the public interest under the *Medical Act*. In our view, there is no risk to the fairness of the hearing of the matters which have been referred to us from the Investigation Committee. Dr. Moodley's interest in a publication ban is specific to him but there is no general principle at stake that would lead to the conclusion that a publication ban is necessary to prevent a serious risk either to a fair hearing or more generally the regulation of the practice of medicine by the College.

Furthermore, the request for a publication ban in this matter does not meet the requirements of proportionality. The salutary effect of a publication ban would be to protect Dr. Moodley from shame and embarrassment and the possibility of a reduction in his practice. On the other hand, the effect of a publication ban on open and accessible hearings under the *Medical Act* and the effect on freedom of expression more generally would be a deleterious effect of a publication ban in this case.

The specific reason for open hearings of serious allegations of professional misconduct in the *Medical Act* is to instill the confidence of the public in the College's regulation of the practice of medicine in the public interest. The consistent practice of the College publishing a Notice of Hearing containing the physician's name and conducting a hearing without a publication ban on the physician's name allows the public to see for themselves, through the media, that the College is meeting its responsibilities for regulating the practice of medicine in the public interest. A temporary partial publication ban on Dr. Moodley's name and place of origin with no clearly justifiable public interest is a deleterious effect that outweighs the salutary effects of the publication ban in this matter.

As a matter of general principle, in our view, the name of a physician facing allegations of misconduct which have been referred from the Investigation Committee to the Hearing Committee should be published unless the ban is necessary and the benefit of the ban outweighs the negative impact on freedom of expression and the ability of the College to regulate and the public interest. Not many allegations of professional misconduct go to hearing. Our hearings are open to the public and the allegations are usually serious allegations that are stressful and embarrassing for the physician involved. We are unable to justify a distinction between Dr. Moodley and other physicians facing a hearing.

d) Exclusion of the public from the Hearing

57. On February 14th, 2020, the Hearing Committee agreed to order the public's exclusion from the hearing other than members of the media and individuals such as family members who would be identified by counsel for Dr. Moodley or the College as their supporters in the hearing.

58. The circumstances giving rise to the Exclusion Order were very unusual. On January 23, 2020, the College published the Notice of Hearing in this matter on its website. The Notice of Hearing included allegations of serious professional misconduct by Dr. Moodley. Coincidentally, and unrelated to the allegations of misconduct, Dr. Moodley lost the sponsor required for his license. As the holder of a Defined License, Dr. Moodley could only practice with a sponsor. With a week's notice, he was required to cease practice on January 24th, 2020.

59. The potential loss of a valued specialist in Cape Breton was a matter of legitimate concern in the community. Some of Dr. Moodley's patients and other supporters organized a rally in his

support, held on the evening of January 24, 2020. Evidently, some of those supporters of Dr. Moodley at the rally and later on social media believed that the allegations of misconduct were the reason for the loss of Dr. Moodley's sponsor. These supporters believed that Dr. Moodley had lost his sponsor for no good reason and saw the purpose of the Notice of Hearing as a way to discredit him unfairly. The rally attracted the attention of the media. News reports included pictures of protestors at the rally. Some were carrying signs, including one that read "Name Those Who Want Moodley Out". Other reports in the media referred to the allegations against Dr. Moodley as a "railroad job." In the social media outlets, there were hostile comments raising questions about the Notice of Hearing. One of them asked, "Who was aiming these false claims at our beloved Dr. Moodley?"

60. Social media comments were critical of the complainants, referring to them as victims looking for attention or "people looking to get an easy buck." Messages included "something stinks to high heaven here" and "we will stand together as one voice with him regarding his allegations and at the time of his hearings."

61. One of the Complainants, C.D., filed an affidavit which indicated that she had been extremely upset by the media and the public attention that this matter was getting and that she had considered backing out of the process. She provided evidence that members of the public attending the hearing could easily identify her and expressed her fear that word would get around of her identity without delay. In her affidavit, she states, "If my identity is leaked it will have harmful effects on my personal life, my working life and the lives of my family members, people will hold me responsible for any consequences to Dr. Moodley that may flow from my complaint, and the consequences of our community losing an Obstetrician."

62. From the materials provided to us, it appeared to us that some members of the public who were concerned about the possibility of losing a needed specialist in Cape Breton could attend the hearing and could identify the Complainants. We did not doubt that the media would comply with our publication ban, as they have in previous hearings. However, we were not confident that our prohibition on the publication of the Complainants' identities would be effective, if the public was not excluded from the hearing. We concluded that there was a real risk that members of the public attending at the hearing could identify one or both Complainants and share that knowledge with others who supported Dr. Moodley at the rally and on social media.

63. In our opinion, what was at stake in the Motion to exclude the public other than the media from the hearing is the effectiveness of the publication ban that we imposed in October. When we imposed a publication ban on the Complainants' names or on any information that could identify those Complainants, we were satisfied that there was a public interest in banning publication of their identities. The purpose of the request for the public's exclusion from the hearing was to ensure that the publication ban is effective. In our opinion, ensuring that a publication ban is effective is necessary and is in the public interest. The circumstances of the rally and the social media messaging showed a real risk that the identity of the Complainants would become public and with that, a real risk that the College would be hampered in protecting

the public because women would be discouraged from coming forward with legitimate complaints of sexual misconduct by physicians.

64. Dr. Moodley argued that, if we decided to exclude the public from the hearing, there should be no media exception. In our opinion, a complete closure of the hearing did not meet the requirement of proportionality. In our experience, the media have complied with publication bans ordered by the Hearing Committee. As a practical matter, the media's attendance at the hearings under the *Medical Act* is the principal vehicle of open hearings. By attending the hearing and reporting on witnesses' evidence and the arguments of counsel, the media has been the primary source of information for the public about hearings under the *Act.*

65. In our view, ensuring the Publication Ban's effectiveness on the identities of the Complainants did not require exclusion of the media. It was not necessary to exclude the media to protect the public interest in the practice of medicine or to maintain the confidence of the public and the medical profession in the process of adjudication of complaints under the *Medical Act.*

e) Investigation Committee Interview Transcripts

66. Counsel agreed to provide the Hearing Committee with the full transcripts of the interviews of the complainants and Dr. Moodley by the Investigation Committee. The question of admission of the Investigation Committee interview transcripts came up after the evidence of the College had been completed. During the direct and cross-examination of the complainants, portions of their interviews by the Investigation Committee were read to them, and they were questioned about what they had said to the Investigation Committee. Counsel for the College indicated that she intended to put specific extracts from Dr. Moodley's interview by the Investigation Committee to him in cross-examination.

67. The parties agreed that the full transcripts of the Investigation Committee interviews of Dr. Moodley, A.B. and C.D. would be provided to the Hearing Committee on the basis that they would be given weight only to the extent that they had been referred to in the direct or cross-examination of the witness in the hearing before the Committee.

68. We agreed on this basis to admit the Investigation Committee interview transcripts, noting that we could not give any weight to portions of those interviews that had not been put to a witness in the hearing.

f) Procedural Fairness

69. One of the allegations concerning A.B. in the Notice of Hearing was that Dr. Moodley committed professional misconduct by "performing a physical examination of the patient in a sexualized manner, or alternatively in a manner inconsistent with accepted standards." In the College's final submissions, counsel indicated that the College was withdrawing part of that

allegation, namely the claim that Dr. Moodley had performed a physical examination of A.B. in a sexualized manner.

70. The College submits that Dr. Moodley committed professional misconduct by performing a physical examination of A.B. in a manner inconsistent with accepted standards by failing to obtain A.B.'s consent for direct application of lubricant to A.B.'s vaginal opening during a pap examination. Counsel for Dr. Moodley objects that the nature of the allegation had so fundamentally changed that it would be improper to consider the issue of patient consent. He submitted that there is no specific reference in the Notice of Hearing to Dr. Moodley's failure to obtain consent for this aspect of the pap procedure and no reference to consent in the evidence given by Dr. Villjoen. Counsel argued that the Notice of Hearing did, therefore, not cover the issue of whether or not Dr. Moodley obtained consent to the procedure, and the Hearing Committee should not consider that issue.

71. In our opinion, the allegation that Dr. Moodley committed professional misconduct with respect to A.B. by performing a physical examination in a manner inconsistent with accepted standards by applying lubricant directly to A.B.'s vaginal opening during her pap examination without consent falls squarely within the allegations in the Notice of Hearing.

72. We do not see any unfairness in that conclusion. The question of whether Dr. Moodley had A.B.'s consent to lubricate her vaginal opening during the pap procedure was raised with A.B. in her direct examination. In cross-examination, counsel questioned A.B. about Dr. Moodley's explanation of what he was going to do during the pap procedure as each step of the examination was taken, including what Dr. Moodley said he was going to do regarding applying lubricant as alleged.

73. In our view, the question of whether or not Dr. Moodley performed the examination in a manner consistent with accepted standards for obtaining consent from A.B. is properly before us. It can be considered without unfairness to Dr. Moodley.

74. Counsel for Dr. Moodley raised a similar issue concerning the allegation in the Notice of Hearing with respect to C.D. that he had committed professional misconduct by conducting a pelvic ultrasound in a manner inconsistent with accepted standards.

75. Counsel for Dr. Moodley argued that the allegation that Dr. Moodley did not give C.D. a sheet or a tissue to tuck into her pants and the allegation that he removed the gel from her body himself was not specifically raised before C.D.'s direct examination at the hearing.

76. It appears to us that these specific claims fall within "conducting a pelvic ultrasound in a manner inconsistent with accepted standards." as alleged in the Notice of Hearing. The facts on which this allegation is based were addressed both in the direct and cross-examination of C.D. without objection. In our view, it is not unfair for us to consider those facts in assessing the

allegation that Dr. Moodley conducted a pelvic ultrasound examination of C.D. in a manner inconsistent with accepted standards.

VIII. Allegations of Misconduct in dealings with A.B.

77. A.B. is a female professional in her thirties. In May 2017, she experienced symptoms, including limited periods, mood swings, hot flashes, vaginal discharge, and cloudy urine. She asked her family doctor to refer her to a gynecologist. Her family doctor referred her to a gynecologist whose first available appointment was one year later. She asked for an earlier appointment, so he referred her to Dr. Moodley, who was open to see her on July 13, 2017. A.B.s family doctor indicated the reasons for the referral as follows:

> "Her current complaints include mood swings throughout the month relieved by the onset of the period, abnormal watery PVD, bloating of the abdomen, cramping of the abdomen occasional USI, hot flashes, and pain over the coccyx... ovulatory pains during the last menstrual period. Her menses have become scanty over the year. Her last PAP smear was in October and was normal".

78. Dr. Moodley saw A.B. on July 13 and reported back to A.B.'s family doctor as follows:

> Many thanks for asking me to see [ ] who is now [ ] years of age P2. She had developed what appears to be a spontaneous RVF which was fixed by Dr. Gardner. She then went on to have [ ] children, the first was assigned vaginal delivery and the second was a C section for APH. She did not have a recurrence of the fistula and the cause of the fistula was undetermined. Her current complaints include mood swings throughout the month relieved by the onset of the period, abnormal watery PVD, bloating of the abdomen, cramping of the abdomen (IBS-like symptoms), occasional USI, hot flashes, pain over coccyx, ovulatory pains. Her LMP was June 28 x 2 days. Her menses have become scanty over the last year. Her last PAP smear was in October and was normal. Clinically, she was in good condition. Her B.P. was 100/60. Examination of the CVS, chest and abdomen was normal. Speculum examination showed the presence of cervical ectropion with a watery discharge. A PAP smear was taken. Genital examination was normal. I have requested bloods for hormone status, urine for MCS. I have prescribed Replens and will see her with all results. Warmest Regards.
> ***[Redacted]***

79. This contact between Dr. Moodley and A.B. lead to a complaint to the College, and ultimately the following allegations which have been referred to the Hearing Committee:

> With respect to patient A.B., on a date in July 2017, Dr. Moodley committed professional misconduct and/or was incompetent by:
>
> a. Commenting inappropriately on the patient's physical appearance;

b. Performing a physical examination of the patent in a sexualized manner, or alternatively in a manner inconsistent with accepted standards;
c. In the course of the clinical encounter, initiating a discussion of a personal or sexual nature with the patient that was not relevant to the patient's medical issues; and
d. Following the physical examination, asking questions of a sexual nature that were not relevant to the patient's medical issues.

80. Dr. Moodley's reply to the complaint indicates that he had no recollection of seeing A.B. on July 13, 2017, or that he recalls anything unusual about that day or about A.B. Relying on his usual practices in similar situations, he said that he keeps his dealings with patients entirely professional and that he "totally and completely denies the allegations in the complaint."

a) Evidence of A.B.

81. At the hearing, A.B. testified that she had an appointment with Dr. Moodley on July 13, 2017, at 1:30 pm. She says that she arrived a few minutes early and the secretary asked her to wait in the waiting area. After waiting a couple of minutes, Dr. Moodley called her to his office. As she walked into the office towards the chair where she would be sitting and as Dr. Moodley was closing the door to the office, he said, "And what would a young, beautiful girl like you be doing here?".

82. A.B. testified that she explained to Dr. Moodley why she was there. He reviewed the referral from the family physician and then took a more detailed history. He asked her about previous surgeries. That led to the following exchange:

Q. What was the next line of questioning, then, after you discussed these various surgeries that you had had?

A. So he had asked me if I had anal sex and I answered him. And then he asked if I used toys.

Q. How did the conversation proceed from there?

A. After that, he'd asked me about childbirth and my children. I had told him I had [ ]. The first one was assisted with forceps and the vacuum. And the second child was, as I said, an emergency C-section with placental abruption. And he had then asked me if I was tight, and I was a little bit shocked by the question, and I knew it was inappropriate. So I said to him, what do you mean? And he had said that, you know, because some men like it tight and some men like it loose. I didn't know how to respond to the question. I think you'll probably see that maybe I was a little bit taken aback by it. So then he proceeded to ask about children and if I wanted any more children. I had told him, no, I don't want any more children. He said, Are you sure? And I said, yes. My husband had a vasectomy due to the complications I've had with labours so ... and we don't plan to have any more. And he said again, but are you sure you don't want any

more children? I said no again. I was ... I don't know why he continued to pursue that question. "
[Redacted]

83. A.B. testified that as Dr. Moodley conducted this review and took her history, he typed on his computer. She says that as he was typing, "he would pause in between when no conversation was even being had, and he would stare at me. He would just stare at me. I don't know why. It made me extremely uncomfortable".

84. After this discussion, Dr. Moodley conducted an ultrasound examination in his office and a pap test in an examination room close by. A.B. testified that as he was conducting the ultrasound examination, "he noticed that I had tattoos on my hips and commented on how nice my tattoos were". A.B.'s reaction was that she thought that this was very inappropriate; she testified "I'd rather not anybody comment on anything on my body unless it was a medical concern that they noticed".

85. After the ultrasound examination, Dr. Moodley took A.B. to an exam room and conducted the pap test. A.B. testified as follows:

"So I was laying down on the table. I know that ... I could only see the top of his head, and I know that I could see that he put gloves on. He had gloves on. And then he told me that he was going to lubricate a name that I've never heard before, so I just assumed naturally it was some piece of equipment or something. I wasn't sure. And so then he took his hand and fingers and rubbed lubricant on my vagina."

Q. Did he ask you for your consent about that ... process beforehand?

A. No....

Q Did he say anything to you while he was doing this?

A. No.

Q. And did you say anything?

A. No.

Q. Were you observing him?

A. No, I was laying down. It was just by feel.

Q. Okay. And what was going through your mind at this time?

A. I was ... I was disgusted. I've had lots of PAP tests over my years and lots of invasive procedures with lots of doctors, and I've never ever had anyone physically touch me with their hands in an area that is ... you know, that I don't want to be touched, so I felt very uncomfortable and just angry.

86. After the pap test, Dr. Moodley and A.B. returned to his office. He asked her where she worked and if she took the whole afternoon off for this appointment. She testified:

"And after that, he had asked me what kind of orgasms I have. I didn't really know how to respond to that one, so I said, Excuse me? And he said, you know, clitoral or vaginal. And I was taken back - why does he need to know this, very embarrassed. And I had responded with, I'm not quite sure. And he says, well, you know you have the ability to have a vaginal orgasm. And then he proceeded to say after that that a woman can be stimulated through her nipples and clitoris."

Q. Had you raised any sexual performance issues with Dr. Moodley during this examination?

A. No.

87. Dr. Moodley then prescribed Replens, a vaginal lubricant, and another medication for irritable bowel. He provided her with a bloodwork requisition and asked her to attend a follow-up appointment.

88. As she left Dr. Moodley's office, Dr. Moodley's assistant arranged the follow-up appointment and noted later that A.B. showed "no distress." but A.B. testified:

a. I mean, I don't know really what she expected me to show. I was totally just ... my professional self, I was ... you know, I'm kind to all. And I walked out of there and was probably in a lot of shock. I had a lot of questions going through my head. I was really confused. I felt violated. I felt, you know, disrespected. So I just ... to be honest, I don't know how she felt I looked because I think I just walked out, did what I was supposed to and got out of there.

89. When she left Dr. Moodley's office, A.B. needed to get change for parking and so went to the Pharmasave in the hospital complex. She made a small purchase, got her change, and went to the parking lot. She believes that it took 10 minutes from the time she left Dr. Moodley's office to the time that she got to the parking space. She provided a receipt from the Pharmasave that showed that she paid for her parking at 14:46:06.

90. A.B. was quite upset about the contact with Dr. Moodley. She discussed the examination immediately with her husband. She went to see her family physician. She told her doctor that she felt that the pap test was inappropriate and that Dr. Moodley had physically rubbed lubricant on her vagina.

91. On cross-examination, A.B. acknowledged that she had no issue with the pap test procedure conducted by Dr. Moodley other than his rubbing lubricant on the entrance to her vagina. She acknowledged that she had brought up the possibility that she had a prolapse, which she understood to be the dropping down of the pelvic floor. She was asked about whether the discussion with Dr. Moodley of a possible prolapse was part of the discussion with him that she had described using the words "tight" and "loose". She testified as follows:

Q. So is it possible that the reference to what you thought was tight or what ... the word "loose", I mean those sort of characterizations, would that come up in the context, do you think, of the prolapse discussions?

A. Could have been poss- ...?

Q. Is it possible?

A. It was possible. However, I don't think it was appropriate. The terminology was not appropriate.

Q. So you take issue with the terminology.

A. Yes, I do.

Q. Okay. But it's possible that could have come up in the context of the discussion about prolapse, though. Possible?

A. Possible.

Q. Okay. Is it possible that you mistook that the word "tight" was used or the word "loose" was used, or is that ... you're sure that that's the word that was used?

A. A hundred percent.

92. When asked about Dr. Moodley's questions about anal sex, A.B. acknowledged that it was not the first time physicians had asked about anal sex because of her previous history of an anal fistula. She did not remember any physicians asking about sex toys.

93. She acknowledged that at each step of the pap test, Dr. Moodley would explain what he would do next. She agreed that before he applied the lubricant to her vaginal opening, he explained what he would do. Her evidence on cross-examination included the following:

Q. When you were giving your evidence in direct - that's when Ms. Hickey was asking you questions - you indicated that, you know, he was explaining to you sort of as he was going along what the procedure what he was going to do.

A. Uh-huh.

Q. Right? So you know, each step of the PAP that he was ... he would explain, okay, I'm going to do this, I'm going to do this next ...

A. Yeah.

Q. ... I'm going to do that next.

A. Yeah.

Q. You know, I'm going to put the speculum in. Like, did he do that all the way through?

A. He did. He explained ... yeah.

Q. Explained things, okay.

A. The whole way through, yeah.

Q. All the way through.

A. Yeah.

Q. Okay. So before he was going to apply the lubricant

A. Uh-huh.

Q. ... he explained to you what he was going to do. And I believe you said that you didn't really know what word it was. You didn't hear the word before. And you thought maybe it might have been an instrument or something.

A. Yes.

Q. I'm going to suggest to you that it was the area that he talked about was the introitus.

A. Uh-huh.

Q. Is that possible that's what he said? I'm going to apply the lubricant to the introitus?

A. Yes.

b) Evidence of Dr. Moodley

94. In his evidence, Dr. Moodley said that he had no recollection of seeing A.B. He testified that his evidence was based on the report he sent to A.B.s family physician. He explained that this appointment was at an early stage in his practice in Canada, and he followed the practice of recording positive findings only. A patient's complaint that did not lead to a positive finding would not be recorded. For example, his report to A.B.'s family physician made no mention of prolapse. He indicated that he would not have recorded a discussion with A.B. about prolapse unless there was a positive prolapse finding.

95. Despite his lack of memory of the encounter with A.B., Dr. Moodley denied making the remarks she attributed to him. He described his normal practices. Essentially he said that he never makes remarks about a patient's appearance, including their tattoos, if they have them, that he would not use the word "tight" and would not initiate a discussion of orgasms unless the patient raised the issue.

96. Counsel asked if prolapse could affect sexual functioning. He testified that if the vagina is too dilated due to prolapse, the patient may tell him that there is a loss of sexual satisfaction or that the partner felt it is too loose. He said that a prolapse could affect a woman's ability to have an orgasm because, during orgasm, there is a rhythmic contraction of the bulbospongiosus muscle so that if that muscle is stretched, the more stretched it gets, affects sexual satisfaction. He also testified that if a patient presented with an issue with a rectovaginal fistula with an unknown cause, it would be relevant to ask questions about anal sex but not sex toys.

97. On cross-examination, Dr. Moodley categorically denied each of the alleged comments described by A.B.

98. Counsel asked Dr. Moodley about the claim in his response to the complaint that A.B. had colluded with C.D. and had improper motives for making the complaint. Dr. Moodley confirmed he believed this but had no proof.

99. Counsel asked Dr. Moodley about his apparent claim that some of his comments to A.B. had been misunderstood or misconstrued. He acknowledged that he had not made this claim in any of his earlier communications with the College or his applications for the production of documents and other pre-hearing matters. He maintained his position that A.B.'s complaint was improperly motivated and false.

c) Evidence of Dr. Viljoen

100. Dr. Johan Viljoen gave opinion evidence on the standards for the conduct of a pap examination and of an ultrasound examination. He is presently the Chief of Staff for the Niagara Health System at St. Catherine's Ontario. He trained and practiced as an obstetrician and

gynecologist in South Africa and continued in that practice in Canada since 1990, serving as the Chief of Obstetrics and gynecology for the Niagara Health System from 2006 until July 2008.

101. Counsel asked Dr. Viljoen whether it was an acceptable practice while conducting a pap examination for a physician to apply lubrication with a gloved hand directly to the patient's vagina. He explained that the pap test is an examination performed to obtain a specimen from the cervix to screen for cervical cancer. This involves placing an instrument called a speculum in the patient's vagina in order to see the cervix. Then the physician uses a brush or spatula to obtain cells from the cervix for lab analysis. He explained that a physician applies lubrication to the front end of the speculum before placing it in the patient's vagina. Dr. Viljoen testified that it is not the practice to apply lubricant directly to the entry to the vagina. He said this was not the practice in his training and his practice as an obstetrician and gynecologist in South Africa, nor had he ever observed this to be the practice in Canada.

102. Dr. Viljoen was asked more broadly, whether it is appropriate, in any part of a gynecological examination, for a physician to apply lubricant with a gloved hand to any part of the woman's perineum area. He said there was no reason to do that. If instrumentation is necessary, it can be safely applied to the instrument to make the examination as comfortable as humanly possible.

103. Dr. Viljoen testified that it is not appropriate to apply lubricant to the woman's perineum in a clinical pelvic examination. A physician occupies a position of power. In Dr. Viljoen's opinion, it is necessary to go to every possible length to remain professional in touching a female patient in such a private area. There is a very thin boundary and a very thin line between professional, clinical examination, and inappropriate touching.

104. Counsel asked Dr. Viljoen how a pelvic examination prolapse was diagnosed. He explained that it would be diagnosed by a visual inspection. An ultrasound is not used. Prolapse could be seen when conducting a pap examination with a specialized speculum. He was asked whether a vaginal prolapse may affect a woman's ability to have an orgasm and whether it would appropriate for a physician to ask questions about orgasms. He said that it would be unusual to take that line of questioning. Dr. Viljoen was also asked whether it would be appropriate for a physician to comment on a patient's tattoos as had been alleged by A.B. He said that was never appropriate; it was not a clinical inquiry.

105. On cross-examination, Dr. Viljoen agreed that if you precede placement of an instrument with a digital examination, that lubricant would have been applied on the gloved hand. Digital examination would then have caused lubrication of the entry to the vagina, and it would facilitate the placement of the speculum under the circumstances.

106. Dr. Viljoen agreed that whether it was appropriate to discuss orgasm between the physician and the patient would depend on the context. There may be times when it is

appropriate in the context of a prolapse, but it would be rare to have to go into that. He agreed that orgasm would be partially related to muscles.

107. Dr. Viljoen testified that, concerning a patient with prolapse, where a physician believes there is some medical reason to ask questions about orgasm, it would be appropriate to inquire about the impact of the prolapse on the patient's life. That could lead to a discussion of sexual response. He said that it is good practice before approaching the subject of sexuality first to probe the patient for their comfort with going along that line of questioning.

d) Evidence of Dr. Adam

108. Dr. Christian Adam provided opinion evidence as an obstetrician and gynecologist on the standards for conducting a pap smear examination and the standards for recommending and conducting a LEEP procedure.

109. Dr. Adam received a Bachelor of Medicine/Bachelor of Surgery from the University of Cape Town, South Africa, in 1981. He moved to Canada in 1986 and completed a residency in obstetrics and gynecology in 1990. Dr. Adam worked as an obstetrician and gynecologist in Gander, Newfoundland, and then in Fredericton, New Brunswick, where he has continued to practice since July of 1994. Since 1994, he has served on the Faculty of Medicine at Dalhousie University and the Faculty of Medicine at Memorial University, teaching residents in Fredericton.

110. Dr. Adam testified that he took no issue with the way in which Dr. Moodley applies lubricant during the pap smear. He disagreed with Dr. Viljoen that this was non-clinical touching.

111. In direct examination, Counsel asked Dr. Adam about patient consent during a pap examination in the following passage from the transcript:

> Q. Okay. When you're conducting a PAP exam, is it acceptable for a physician to tell the patient what he or she is going to do next at each step of the procedure?
>
> A. Absolutely. Again, I think it depends on the familiarity that you have with the person you're examining. Anyone that I would examine for the first time, even though they may have had PAP smears before, I would walk them through the way that I would do it. So I'd be talking to them as I'm doing it.
>
> Obviously if it's someone that I've done a Pap smear on before I don't necessarily go into that detail. I'll just say I'm going to do your PAP smear and I'll do it but, otherwise, yes, you would.
>
> Q. And would that be an acceptable way of obtaining a patient's consent to proceed with the steps of the PAP smear?

A. As long as the patient does not object to what you are proposing to do yes, I would take that as an implied consent.

112. In cross-examination, Dr. Adam repeated that he had no objection to what Dr. Moodley does in applying lubricant to the vaginal opening, "because...he is doing that with an aim to make the examination less uncomfortable... and I think that if there is anything that he is doing there that is medically inappropriate." He agreed that "the greater the touching in an intimate area, the greater the need for explicit consent." He testified as follows:

Q. And so if the lubricant is going to be applied by a physician directly to the introitus, I would suggest to you that it would be insufficient for the physician to simply tell the patient, Lubricant is going ... I'm going to apply lubricant to the introitus, without taking steps to ensure that the patient knew what that meant.

A. The ... yeah. It's always difficult to know what the patient is understanding because . . .

Q. Certainly.

A. ... we're told if it comes to patient education pamphlets, they have to be put down to a grade six level or something like that. And I've had people who are offended at getting materials, saying, you're talking to me like a child, and they're offended by it. So I think you ... yes, you try and strike a balance and hopefully are going to say something to the patient that she will understand; and if she doesn't understand, that she will question you on it.

Q. And in the course of explanations you provide to your patients, is "introitus" a word that you would use in normal conversation?

A. I usually would say the "vaginal opening".

113. Further along in his evidence in cross-examination, Dr. Adam testified as follows:

Q. Okay. And if it is done, you do agree, however, that it has to be very carefully and explicitly explained to the patient so that the patient understands what is to happen.

A. I think it should be explained, yes, so that ... yes, that she understands.

e) Evidence of character and reputation

114. Counsel for Dr. Moodley called several witnesses to testify about Dr. Moodley's character and reputation.

115. Dr. Craig Stone, a staff Anesthesiologist at the Cape Breton Regional Hospital, testified that he knows Dr. Moodley as a staff Obstetrician/Gynecologist at the Cape Breton Regional Hospital and that he and Dr. Moodley work together in the operating room and the Labour and Delivery suites. He has known Dr. Moodley since 2017. He testified that Dr. Moodley is a very skilled surgeon who inspires confidence in the operating room in staff and in patients. He said that Dr. Moodley is a very good surgeon who is very kind and calm. Dr. Stone described his observations of Dr. Moodley's interaction with hospital staff and doctors; he described him as a very soft-spoken man who inspires confidence. He said that Dr. Moodley's reputation in the hospital is one of high regard and trust.

116. Dr. Stone testified that in all of his interactions, he had never seen Dr. Moodley interacting with a patient in a way that he viewed as inappropriate. He testified that when he heard about the allegations in this matter, he could not believe them and said it is not compatible with his view of Dr. Moodley over 3.5 years, not compatible with the things he heard people talk about him at work, and not compatible with his reputation at the hospital.

117. Dr. Sanda Scherbarth, a family physician who practices in high-volume low-risk obstetrics at the Cape Breton Regional Hospital, testified that she had known Dr. Moodley for about 3 years. She said that she had seen him often interacting with patients and that in her experience, he has always been professional, extremely knowledgeable, and compassionate and that she never had any concerns or issues about him. Dr. Sherbarth testified that Dr. Moodley's reputation in the hospital more generally was that everyone was happy with his demeanor, happy with his skills and that he had excellent surgical and obstetrical skills. She said that nurses at the hospital seek him out to take care of their pregnancies or some of their gynecological issues and that he was one of the people they prefer to see. She said she had never seen him interact with a patient in a way that she viewed as inappropriate or make a comment about a patient that she viewed as inappropriate.

118. Dr. Scherbarth indicated that she was surprised when she learned about the allegations against Dr. Moodley. It seemed out of character for the person she had worked with, and continued to refer patients to him. She said that none of her patients had ever come back to her with concerns or objections about Dr. Moodley's care, and no one had ever asked to be switched to another obstetrician or did not want to see him again for any reason that they expressed to her. Dr. Scherbarth said that the allegations against Dr. Moodley were out of character for what she had come to know in her involvement with him. She said she had never heard anything negative in the community about Dr. Moodley.

119. Donna Tatlock testified that she is a Licensed Practical Nurse who works as a chaperone in Dr. Moodley's office. She understood that he had a chaperone because of the complainants' reports and that he is required to have a chaperone. She works with him only in his office, not in the ambulatory care setting or at a hospital. Having worked with him for 2.5 years, she is familiar with his standard practices. She says that she has never observed him asking a patient a question

that she thought was inappropriate or commented on a patient's appearance or clothing. She has seen him treat patients with visible tattoos, but he has never commented on the patient's tattoos.

120. Ms. Tatlock has been present when Dr. Moodley performs internal examinations in the examination room in his office area. She said he had never conducted an internal exam in his office. She has also been present when he conducted ultrasounds in his office. Based on her observation of Dr. Moodley over the past 2.5 years, she was asked whether the allegations against Dr. Moodley are consistent with the way he treats his patients. She said no.

121. Dr. Brad Kelln was called to give expert testimony in the area of clinical psychology with respect to sexual and violence risk. Dr. Kelln has a Ph.D. in Clinical Psychology that he received in 1998. His subspecialty within clinical psychology is forensic psychology, working with people who have been in conflict with the law. He is currently employed full-time with the East Coast Forensic Hospital, where he has been a full-time psychologist for over 20 years. His primary role is to conduct risk assessments with the population of people who have either been found unfit by the court system or have been found criminally responsible. His duties involve working with patients at the East Coast Forensic Hospital to understand the risk they might pose to the community when they leave the hospital. A consistent element of his work over the past 20 years has been preparing sexual and violence risk assessments. He has given testimony at all levels of the Court system in Nova Scotia, qualified as an expert in understanding, managing, and assessing violence risk and sexual risk.

122. Dr. Kelln testified that there was no concerning information that he had determined through a sexual functioning assessment in his assessment of Dr. Moodley. He summarized the results of his testing as follows:

> "There is no evidence from psychological testing that Dr. Moodley has any significant or diagnosable mental health issues. In addition, there is not evidence of any maladaptive personality characteristics or sexual preoccupation/distortions that cause concern."

123. Dr. Kelln's overall assessment was as follows:

> "There is absolutely no evidence that Dr. Moodley had any sexual attitudes of patterns of behaviour that would place any person at risk. Additionally, the weight of evidence is that he is a highly respected, highly functional expert in his field of medicine who has always maintained good professional boundaries. His demeanour during the clinical interview, psychological testing, and every collateral source of information suggests that the allegations against him are inconsistent with his personality and professional reputation. As an expert in sexual violence risk, I find no reason to have even the slightest bit of concern about Dr. Moodley, particularly in light of his expressed desire to continue the use of a chaperone regardless of the outcome of the disciplinary hearing."

124. Dr.Kelln testified that the allegations against Dr. Moodley in this matter were inconsistent with his personality and professional reputation.

125. Dr. Kelln concluded his direct examination as follows:

> "If ... I mean, this ... the allegations are of such a nature that it would be odd if that was the only time he's ever done that. That there would be other times where people would have suspected or felt uncomfortable around him or just had concerns about the way he was acting, you'd find something, and I just didn't.
> And the weight of it, including the letters that were received as well as the people I spoke to as well as his receptionist, the chaperone, I mean everyone just can't say enough positive things ..."

126. Dr. Kelln acknowledged in answering a question from the Chair of the Hearing Committee that he is usually brought in to give evidence in a case where "where do we go from here" is the question, not "how do we adjudicate a past incident." He indicated that he had been asked to do a psychosocial assessment to try to determine what risk if any, Dr. Moodley poses to the public. He says:

> "...and so I find, I mean based on my experience and my ... the collateral information and the testing and the interview and all of it, the weight of it, I really have difficulty having a lot of concerns over any about him in that regard."

f) Analysis

127. In closing argument, counsel for the College advised that the College was withdrawing certain aspects of the allegations in the Notice of Hearing. The College is not pursuing the allegation that Dr. Moodley was incompetent and the allegation that he committed professional misconduct by performing a physical examination in a sexualized manner. Counsel advised that the College would continue to support the allegation that Dr. Moodley committed professional misconduct by performing a physical examination of the patient in a manner inconsistent with the accepted standard; specifically, that Dr. Moodley, in performing the pap examination, applied lubricant with a gloved hand directly to A.B.'s vaginal opening without her consent.

128. Our first task is to assess the evidence and make findings of fact in respect of each of the allegations in the Notice of Hearing. With respect to paragraphs 1(a), (c), and (d) of the Notice of Hearing, this requires us to make findings a fact concerning the comments made, the discussion initiated and the questions asked by Dr. Moodley. Having determined what Dr. Moodley said, we then have to decide whether what he said was "inappropriate or not medically relevant" to A.B.'s medical issues.

129. As noted earlier, the College has the onus of proof, and we must be satisfied that it is more likely than not that the allegations are true.

i) What did Dr. Moodley say to A.B.?

130. Dr. Moodley does not remember his encounter with A.B. on July 13, 2017. The records he kept of the encounter did not include very much that pertains to the allegations of A.B. Given the onus of proof on the College to prove each of the allegations, we must assess whether A.B.'s testimony concerning the allegations is credible and reliable.

131. Having assessed the evidence, we don't see any reason not to accept A.B.'s evidence that:

a. As A.B. walked into Dr. Moodley's office towards the chair where she would be sitting and, as Dr. Moodley was closing the door to the office, he said to her, "...and what would a young beautiful girl like you be doing here?"

b. Dr. Moodley asked A.B. if she had anal sex.

c. Dr. Moodley asked A.B. if she used toys.

d. Dr. Moodley asked A.B. about childbirth, her children, and if she was tight and told her that some men like it tight and some men like it loose.

e. Dr. Moodley asked A.B. whether she was sure that she didn't want any more children.

f. In conducting an ultrasound, Dr. Moodley noticed that she had tattoos on her hips and commented on how nice her tattoos were.

g. After conducting the PAP test and returning to Dr. Moodley's office he asked what kind of orgasms she had, clitoral or vaginal saying you know you have the ability to have a vaginal orgasm and that a woman can be stimulated through her nipples and clitoris.

132. A.B has nothing to gain from her complaint and participation in the process under the *Medical Act*. She testified that she thought about a relative seeing a gynecologist. She said she thought about her nieces and how she would never want something like this to happen to them. She thought about girls whom she would encounter professionally who would need to see a gynecologist. She felt that they would not have the support she had and worried about what would happen to them. She said she could not live with herself, she had a duty to report, and she felt she had to do it. In our opinion, she had no reason to deceive the Hearing Committee in giving her evidence.

133. A.B. gave her evidence in a sincere and forthright manner. Looking at her evidence as a whole, we find that her testimony was measured and fair. She did not exaggerate her evidence or embellish the things that she was describing. On cross-examination, she made appropriate acknowledgments about how Dr. Moodley conducted the pap examination and the questions about anal sex. In our opinion, A.B.'s evidence was truthful.

134. Dr. Moodley questions the reliability of A.B.'s evidence, generally. In his submission, even if the evidence was honestly given, her testimony is not reliable for two reasons. A.B. was shocked and disgusted by the unexpected application of lubricant directly to her vaginal opening during the pap examination. It was the most significant aspect of her encounter with Dr.

Moodley. Dr. Moodley argues that this reaction coloured her perception of the comments made by Dr. Moodley and resulted in her perceiving appropriate questions as sexualized comments.

135. Furthermore, Dr. Moodley submits that A.B.'s evidence was not sufficiently reliable to accept, given the evidence in the hearing as a whole. He contrasts her account with the evidence of Dr. Moodley's normal practices as confirmed by several witnesses who have been working with Dr. Moodley since 2017 and confirmed that he did not make inappropriate or sexualized comments to patients. He relied on the evidence of Dr. Brad Kelln, whose psychological assessment of Dr. Moodley was not consistent with the conduct attributed to him by A.B. Dr. Moodley submits that, in the face of this evidence, the College has not met the burden of proving that it was more likely than not that Dr. Moodley had said the things described in A.B.'s testimony.

136. While it is true that A.B. was shocked by Dr. Moodley's application of lubricant to the opening of her vagina during the pap examination, we cannot accept that this shock prevented her from accurately remembering comments on her beauty and her tattoos before the pap procedure and the questions about her orgasms afterward. The words attributed to Dr. Moodley are not technical in nature or easily misunderstood.

137. A.B says that Dr. Moodley asked her if she was tight because some men like it tight, and some men like it loose. A.B. acknowledged that she had raised a possible prolapse with Dr. Moodley and that it was possible that the use of "tight and loose" could have come up in her discussion with Dr. Moodley. Dr. Moodley does not remember. Still, he maintained that he would not use the word "tight" because a prolapse discussion is not concerned with tightness but rather with laxity. He says that it is possible there was a discussion with A.B. related to vaginal laxity and a change to satisfaction from intercourse for both A.B. and her partner.

138. As a Hearing Committee, we have to be cautious about evidence that Dr. Moodley is not the kind of person to make the remarks described by A.B. It is reasonable to expect that where he does not remember the visit with A.B., he would deny saying those things. In our opinion, his denial of the comments and questions attributed to him by A.B. does little to lessen the reliability of her evidence.

139. We can accept that Dr. Moodley does not normally make sexualized comments to his patients. Given the distinctive nature of the remarks she describes, we do not conclude that A.B.'s evidence is untruthful or mistaken, even if his normal practices do not include that kind of conduct. To accept that Dr. Moodley would never make such comments would require us to believe that A.B. misunderstood what he said or just made them up. Given the nature of the statements and her testimony overall, we do not think she misunderstood what Dr. Moodley said. Furthermore, A.B. had no reason to deceive the College when she made her complaint and none to deceive this Hearing Committee. We cannot accept that she made up those comments.

140. We accept that Dr. Moodley started his visit with A.B. by saying, "...what would a young beautiful girl like you be doing here?". From that comment, it seems more likely than not that he found her attractive and more likely than not that he commented on her tattoos. Having crossed a line, the questions about her orgasms followed. We have no reason to doubt her evidence that Dr. Moodley asked if she was tight because some men like it tight, and some like it loose. We accept that A.B.'s description of the office visit on July 13, 2017, is more likely than Dr. Moodley's denials.

141. The witnesses of Dr. Moodley's character and reputation are all colleagues who have worked with him since the College intervened in August 2017 to require that he work with a chaperone. Dr. Moodley was put on notice that those kinds of comments were a significant issue. It would be very surprising if he openly made inappropriate remarks or questions in the presence of his colleagues. There is no way Dr. Moodley's colleagues could know how he behaved in private one on one encounters with patients before August 2017 or at any time. We, therefore, give the evidence of Dr. Moodley's character and reputation little weight in assessing the reliability of A.B.'s evidence.

142. Counsel for the College argued that the previous statements by A.B. to her husband and others, in her complaint to the College and her interviews by the Complaints Investigation Committee are consistent with A.B.'s evidence in the hearing except in minor matters. We are not inclined to give those previous consistent statements any weight. While previous inconsistent statements may be significant in assessing evidence given at the hearing because they may show that a witness exaggerates or embellishes their account, previous and repeated statements do not add to their sworn testimony, subject to cross-examination.

143. We are not inclined to rely on similar fact evidence based on the similarities between A.B.'s evidence and the evidence of C.D. It doesn't add to the sworn testimony in the hearing. We think it would be unfair to Dr. Moodley in all of the circumstances to draw a conclusion on what he said to A.B. based on what he said to C.D.

144. Based on all of these considerations, we find that A.B.'s evidence on the remarks made by Dr. Moodley and the questions he asked is credible and reliable. Considering all of the evidence, we conclude that it is more likely than not that Dr. Moodley made the remarks set out in paragraph 131 above.

ii) Was what Dr. Moodley said medically relevant?

145. That, of course, does not end the fact-finding exercise. We have to assess whether Dr. Moodley's comments and statements were inappropriate or not relevant to A.B.'s medical issues.

146. There is no dispute that Dr. Moodley's comments that A.B. was beautiful and that her tattoos were nice are inappropriate and irrelevant to her medical issues. On the other hand, Dr.

Moodley's questions to A.B. whether she had anal sex were medically relevant given her history and the referral from her family doctor.

147. Dr. Moodley confirmed on direct examination that comments about stimulation of the nipples and the clitoris were not medically relevant. In cross-examination, he said that, unless a patient raises a question of sexual functioning, he would not normally bring it up unless it was a presenting symptom. He conceded that, given her medical issues, there would be no medical relevance for questions to A.B. about orgasms, whether they were clitoral or vaginal, and suggestions to A.B. that she could have vaginal orgasms.

148. Dr. Moodley did not remember the encounter with A.B. but denied that he made the comments attributed to him. He speculated that an issue of prolapse could lead a patient to have inability to have an orgasm that would be medically relevant in A.B.'s case but not in a sexualized manner described by her. Likewise, the discussion of prolapse could raise questions about vaginal laxity.

149. At best, a discussion of prolapse would have been medically relevant, but that does not explain the graphic sexualized questions about orgasms, tightness, and looseness he put to A.B. Those questions were not medically relevant. In the context of the whole encounter, starting with Dr. Moodley's comment about A.B.'s beauty, his comments about her hip tattoos, and his questions and comments about her orgasms, we cannot accept that asking A.B. if she was tight because some men like it tight and some men like it loose was anything other than an inappropriate sexual reference unrelated to her medical issues.

iii) Did A.B. consent to Dr. Moodley's application of lubricant to the entry of her vagina?

150. The College has alleged that Dr. Moodley performed A.B.'s pap examination in a manner inconsistent with accepted standards. The specific question raised by this allegation is whether Dr. Moodley had A.B.'s consent for applying lubricant to the entrance of her vagina with a gloved hand. There is no dispute about the accepted standard. In his response to the complaint, Dr. Moodley described his understanding of the requirement of consent. He states:

> "As I was trained, and as I have practiced throughout my career, I will also, with a gloved hand, add some lubricant to the introitus to avoid discomfort. I explain this, along with each step of the examination, to the patient as I am going through the exam, but before doing each step and obtain their consent to proceed."

151. Dr. Adam was asked about the required standard in his evidence. His evidence includes the following extracts from his direct examination, his cross-examination, and redirect examination as follows:

Q. Okay. When you're conducting a Pap exam, is it acceptable for a physician to tell the patient what he or she is going to do next at each step of the procedure?

A. Absolutely. Again, I think it depends on the familiarity that you have with the person you're examining. Anyone that I would examine for the first time, even though they may have had a Pap smears before, I would walk them through the way I would do it. So I'd be talking to them as I'm doing it.

Obviously if it's someone that I've done a Pap smear on before I don't necessarily go into that detail. I'll just say I'm going to do your Pap smear and I'll do it but, otherwise, yes, you would.

Q And would that be an acceptable way of obtaining a patient's consent to proceed with the steps of the Pap smear?

A. As long as the patient does not object to what you are proposing to do yes, I would take that as an implied consent.

152. On cross examination Dr. Adam testified as follows:

Q. And I take it then, Dr. Adam, and I think your evidence was to this effect, that you do need the consent to the patient in order to conduct an examination of the kind ...

A. Absolutely.

Q. ... that we're describing here. And that that consent can only be given after the physician has described what is being done and ensures that the patient understands what is being done. Is that correct?

A. Yes.

Q. And would you agree, as well, Dr. Adam, that the greater touching in an intimate area, the greater the need for explicit consent?

A. Yes, I would.

153. On redirect examination the issue of consent was raised again as follows:

Q. As far as consent issues go when you're doing the Pap exam, you had given evidence previously that it's okay to tell the patient what ... each step you're going to do, what your going to do next before you do it. You indicated that would be an acceptable way to get consent. Is that ... your evidence still the same on that point?

A. Yes.

154. A.B. testified that Dr. Moodley took his fingers and lubricated the vaginal opening but did not ask her consent about that process beforehand. Dr. Moodley testified that his practice is to inform the patient as he goes along what he is doing so they are aware of what he is going to do. He does not specifically necessarily ask for consent because a patient understands what he is saying.

155. As a matter of common sense, is it clear to us that A.B. did not consent to Dr. Moodley applying lubricant with his fingers in a gloved hand to the entrance to her vagina. She was shocked and disgusted when he did this. She testified, "I have had lots of PAP tests over my years and lots of invasive procedures with lots of doctors, and I have never ever had anyone physically touch me with their hands in an area that is .... you know that I don't want to be touched, so I felt very uncomfortable and very angry." She was so shocked by Dr. Moodley's application of the lubricant directly to the entrance to her vagina that she immediately complained to her husband and later to others, including her family doctor.

156. Dr. Adam testified that this type of procedure used by Dr. Moodley is not one he had seen often, and it was not his normal practice and not to the manner used by him in teaching students how to conduct a pap test. While not medically inappropriate, it was not the usual or expected method that a gynecologist would perform.

157. In conducting A.B.'s pap examination, Dr. Moodley told her that he was going to lubricate, but she wasn't familiar with the name that he used. Looking at the evidence as a whole, in our view, Dr. Moodley likely told her that he was going to lubricate her introitus. A.B. was not familiar with that term, and she thought it was a tool or something. He then took his fingers and then lubricated the vaginal opening.

158. In our view, A.B. did not understand what Dr. Moodley was going to do and did not consent to what he did. We agree that the accepted practice of obtaining consent does not necessarily hold a physician to a standard that requires that the patient understand the physician's explanation of what he was going to do as the examination proceeded. Nevertheless, in our view, the greater the touching in an intimate area, the greater the need for explicit consent. A physician should take steps to ensure that the patient knows and understands what was intended. In conducting the pap examination of A.B., Dr. Moodley failed to do this. In our view, he failed to meet the acceptable standard for obtaining consent.

159. Based on the above analysis, we have concluded that Dr. Moodley, in his encounter with A.B. commented inappropriately on her physical appearance, initiated a discussion of a personal or sexual nature with the patient that was not relevant to her medical issues and following physical examination asked questions of a sexual nature that were not relevant to her medical issues. Furthermore, we find that in performing the pap procedure on A.B. he conducted in a manner inconsistent with the accepted standards for obtaining consent.

g) Misconduct

160. Whether or not this conduct constitutes professional misconduct requires further analysis.

161. The Professional Standards and Guidelines Regarding Sexual Misconduct in a Physician Patient Relationship established by the College includes reference to physicians' ethical responsibilities in the Canadian Medical Associations Code of Ethics. The professional standards of the College are related to several principles stated in the Code as follows:

1. Consider first the well-being of the patient.

2. Practice the profession of medicine in a manner that treats patients with dignity and as a person worthy of respect.

13. Do not exploit patients for personal advantage.

162. The Professional Standard includes certain additional principles:

> The following principles which form the basis of this professional standard are:
>
> (a) Trust is the basis of the patient-physician relationship;
> (b) The patient is considered to be the vulnerable individual in the professional relationship;
> (c) Power imbalance exists in the patient-physician relationship; ...
> (e) Sexualized behaviour in the patient-physician relationship is never acceptable;
> (f) A breach of sexual boundaries has potential for significant harm to the patient; ...
> (h) The onus is always on the physician to maintain professional boundaries with a patient and not to exploit the patient in any way...

163. On the basis of these principles, the College has set out the professional standard. The standard that applied in the circumstances of this case is stated as follows:

> 1) Standards in a Physician-Patient Relationship
>
> > (a) Physicians must respect professional boundaries in their interactions with their patients and must not sexually interact with their patients nor exploit them in any way.

164. The College has adopted guidelines to assist physicians to meet the professional standard. The guidelines relevant to this case include the following:

Professional misconduct in the physician-patient relationship includes, *but is not limited to* the following:

b) Inappropriate comments about or to the patient, including making sexual comments about the patient's body or clothing; ...

d) Making comments about the patient's potential sexual performance during an examination or consultation, except when the examination or consultation is for the purpose of addressing issues of sexual function or dysfunction, and the comments are relevant to the management of that patient's problem;

e) Requesting details of sexual history or sexual preference in any situation when this is inappropriate;

f) Initiation by the physician of inappropriate conversation regarding the sexual problems, preferences or fantasies of the physician or patient; ...

165. The guidelines include the following guideline on communications:

b) Communications:

(i) A physician should be careful to ensure that any remarks or questions that are asked cannot be constructed as demeaning, seductive or sexual in nature; and

(ii) When sensitive subjects, such as sexual matters, have to be discussed, the physician should explain why the questions have to be asked, so that the intention cannot be misconstrued.

166. In our opinion, to determine whether Dr. Moodley engaged in professional misconduct during his office visit with A.B. on July 13, 2017, we must consider our findings of fact as a whole, not just look at each of his statements in isolation. For example, if Dr. Moodley's only inappropriate comment during the whole visit was to ask what a young beautiful girl like her would be doing here, we would not find that this comment in isolation constituted professional misconduct. Such a comment in isolation would be careless and perhaps unwise but not professional misconduct. However, when you consider the entire course of conduct during Dr. Moodley's encounter with A.B. on July 13, 2017, that comment indicates that he found her attractive. He then expressed that attraction in a series of sexually-oriented remarks and questions.

167. Considering his remarks and questions as a whole, Dr. Moodley failed to treat A.B. with dignity and as a person worthy of respect as a vulnerable individual in a professional relationship with a power imbalance.

168. Taken as a whole, Dr. Moodley's comments and questions, in our opinion, breach Professional Standard 1(a). He did not respect professional boundaries in dealing with A.B. He crossed a sexual boundary by making inappropriate sexually-oriented remarks to her and asking her sex-related questions, which were not relevant to her medical condition. In our opinion, Dr. Moodley made inappropriate comments, which are inconsistent with Guideline 1(b). He requested details of sexual history when this was inappropriate, contrary to Guideline 1 (e), and he initiated inappropriate conversation regarding A.B.'s sexual problems contrary to Guideline 1(f).

169. Dr. Moodley completely failed to ensure that any remarks or questions he asked could not be construed as sexual in nature and when sexual matters were discussed he did not explain why the questions had to be asked so that the intention could not be misconstrued. All of this is inconsistent with Guideline 2(b).

170. Apart from the specifics of Dr. Moodley's breaches of ethics and the professional standard requiring respect for professional boundaries, in our view, our findings of fact above demonstrate unprofessional conduct generally. In our opinion, this unprofessional conduct constitutes professional misconduct.

171. Regarding Dr. Moodley's failure to obtain consent from A.B. before applying lubricant with a gloved hand directly to the opening of her vagina when he conducted a pap examination, we do not think that this constituted professional misconduct. He followed the correct process by telling A.B. before he took each step in the pap examination. She did not understand what he told her in part because his technique, although medically proper, was unfamiliar, and he probably used the word "introitus," which was unfamiliar to her. We regard his failure to get consent as a communications problem but not as misconduct.

IX. Complaint of C.D.

172. C.D.'s family doctor referred her to Dr. Moodley in a letter of April 20, 2017, which stated as follows:

> I would appreciate it if you could see this [ ] female whose pap smear returned suggesting Colposcopy. A copy of her PAP is included for your perusal.
> ***[Redacted]***

173. The report of the pap smear with this letter included the following:

> **Cytology Results:**
> Smear Evaluation: Satisfactory for evaluation
> Spécimen Adimicey: Transformation zone component absent,
> **Interpretation/Result:**
> High grade squamous intraepithelial lesion

174. Dr. Moodley saw C.D. on May 4, 2017, at the Ambulatory Clinic of the Cape Breton Regional Hospital, where he began to perform a Colposcopy but stopped when he suspected that she was pregnant. He ordered a blood test. The blood test ruled out pregnancy, so he called her with the result and made arrangements for her to return for the Colposcopy on June 6, 2017.

175. Dr. Moodley reported to C.D.'s family doctor on June 6, 2017, as follows:

> Just an update on [ ]. She had HGSIL on PAP smear. Colposcopy done today showed HGSIL. A biopsy was taken. I will review her in 3 weeks and book her for LEEP at [ ] Hospital.
> ***[Redacted]***

176. The biopsy referred to in Dr. Moodley's report to the family doctor was available on June 7, 2017, and it included the following:

> Diagnosis
> Uterine Cervix Biopsy:
>
> Low grade squamous intraepithelial lesion (CIN1 with HPV effects),
> Negative for high grade dysplasia and malignancy

177. Dr. Moodley saw C.D. again on July 6, 2017 in his office. He ordered a pelvic ultrasound which was then conducted on July 18, 2017 and it was reported to him as follows:

> Ultrasound Pelvis
>
> Indication: Large pelvic cyst
> Findings
>
> Normal anteverted uterus noted and measures 11.4 x 5 cm in length. Endometrial thickness is 3 mm. Both ovaries are visualized and appears normal. Left ovary measures 25 cc with dominant follicle measures 3.2 x 3 cm. Right ovary measures 3.3 cc. A small cyst structure seen in the right adnexal region measures 1.4 x 1.3 cm, this could represent par ovarian cyst.
>
> Impression
>
> Small cystic structure in the right adnexal region with no definite relation to the right ovary. This could represent par ovarian cyst. Further assessment with pelvic MRI is recommended to delineate the relation to the surrounding anatomical structures.

178. On September 20, 2017, C.D. made a complaint to the College concerning the office visit on July 6, 2017, and the events that occurred after that office visit. Her complaint has resulted in the following allegations which had been referred to the hearing committee:

With respect to patient C.D. on a date in July 2017 Dr. Moodley committed professional misconduct and/or was incompetent by:

a) Prior to informing her of test results, asking questions and making comments of a personal and sexual nature that were not relevant to the patient's medical issues;
b) Unnecessary requesting an internal examination;
c) In the course of conducting a pelvic ultrasound, complimenting her on the colour of her underwear;
d) Following the physical examination, asking questions and making comments of a personal or sexual nature that were not relevant to the patient's medical issues, including a suggestion about seeing her at her home and advising he knew where she lived;
e) Conducting a pelvic ultrasound in a manner inconsistent with accepted standards;
f) Unnecessarily magnifying the extent of the patient's medical issues;

With respect to the patient C.D. after the July, 2017 clinical encounter, Dr. Moodley committed professional misconduct by violating the boundaries between physician and patient through his attendance at the patient's workplace, where he sought her out.

179. In his reply to the complaint by letter of September 29, 2017, Dr. Moodley stated as follows:

To be clear: I absolutely, deny all allegations of misconduct, sexual or otherwise, as alleged by [ ]. I do however, stand by my medical management of this patient.
[Redacted]

180. Dr. Moodley also explained in his reply that he attended at C.D.'s workplace when he was on his way home and stopped at that workplace to obtain a particular product. He asked for C.D. by name with the intention of reminding her of her appointment in case she had forgotten.

(a) Evidence of C.D.

181. In her direct examination, C.D. testified about the office visit with Dr. Moodley on July 6, 2017. She said that Dr. Moodley asked her if she had been with her sexual partner; she advised that she had not. He asked her how she looked after herself while her partner was away. He clarified that he was referring to how she looked after herself sexually and whether she used her fingers or used toys. Counsel referred her to her complaint of September 20, 2017, where she described that discussion as follows;

Sat down with just him and I present and he inquired as to how I had been doing since he last saw me. I told him I had been well and no issues. He asked me if I had intercourse over the weeks previous to my appointment and asked if my sexual partner had been home during that time. I replied that he had not and no I hadn't been. He then continued asking me "how do you look after yourself while he's gone" I assumed he was asking a general comment and replied that I continued on as I always did and went to work, looked after my children and was really quite busy. He then responded that he meant sexually, and said that I seemed as though I would have a very healthy appetite sexually and asked if I used my hands toys etc. to satisfy myself. I told him that no, I did not. He said that he would look after me well.

182. In her direct examination, C.D confirmed that Dr. Moodley said those things and testified that, "I had taken that to mean that he would look after me sexually."

183. C.D. said that, as the conversation progressed, she was feeling uneasy. She said that Dr. Moodley requested another internal examination, but she was not clear why he would seek another. Because of the first line of questioning and her unsettled feelings, she did not want another examination done. Therefore, she responded to his request by falsely telling him that she was menstruating and did not want to have an internal examination.

184. Dr. Moodley then conducted an ultrasound examination. First, he asked her to lower her pants. She lowered her pants to just below her hip line. He did not give her a sheet or covering or any tissue papers. He did not ask any questions about whether she had any liquids to drink before doing the ultrasound. During the examination, Dr. Moodley was using the wand moving it around her stomach. She said he was prodding with the wand further and further down and that was not within her comfort zone. She had her thumbs hooked in the waistband of her pants so that they could not be pushed down further with the wand. She says that Dr. Moodley "commented on the fact that he liked that my underwear had matched the colour of lipstick I was wearing on that day." She was not sure why he made that comment in a professional setting.

185. When the ultrasound was complete, Dr. Moodley used kleenex to wipe off the gel used in the examination. He gave her some kleenex because some gel had gotten onto her pants. Dr. Moodley told her that "...he had found what I believe he described as a mass during the ultrasound" and that he said "would need to be looked at in depth at another ultrasound." C.D. was concerned that she did not have a clear picture of what was going on and automatically thought that the mass he described must be cancer.

186. During a discussion after the ultrasound Dr. Moodley made comments which C.D. described as follows:

Q. And did you have further discussion with him at that point?

A. I did. There was kind of more ... more questions that he had asked me regarding my living arrangements, where I lived, and he asked if he had, you know, been

on the [ ] would he see me, and I had, I had asked him what he meant by that and he said, you know, would I see you if I came to the [ ]? And I had told him he wouldn't because I don't work at the [ ] location of the [ ], and he said, no, that's not what I meant. I meant would I see you at your house. And at that time I had replied that he may see me if I was out mowing my lawn or if I was doing something in the yard, you know, letting my dog out or something of that nature. And then he ... he was asking where my bedroom was located in, you know reference to my [children's] bedrooms in the home, if they were relatively close to my bedroom or if they were at a farther distance. And then he, he ... at one point, asked me if I lived with my father, which, again, I was unclear as to why any of that would matter with anything to do with the appointment. And then he had asked me if I was in my room, if I was engaging in any sexual activity, if my children would hear me if I was to scream or make any noises.
[Places redacted and words substituted]

187. C.D. was referred to her complaint where she had stated the following:

> I got up from the table with my head spinning and I sat at his desk while he was scheduling me for another Ultra-sound, He then asked me if he came to see me where he could find me. I asked him what he meant, and he said "well if I drive to [ ] would I see you". I told him I did not work in [ ] so no, he would not. He then replied and said no, if I came to your house. I replied saying he did not know where I lived to which he responded after looking at his computer and by saying yes, I have your address right here. He continued with asking me if I lived alone or with my Dad. He then went on to ask if my children had bedrooms near mine and I and if they could hear me scream during sexual activities. I was at this point very upset and was only nodding or replying with a headshake. He told me has he was looking through his computer that I wouldn't need to worry because next appointment he would-thoroughly look after me and that I wouldn't need my partner and added that it would be "our secret" "you tell no one."
> ***[Places redacted]***

188. She was asked by counsel whether Dr. Moodley said those words and she answered, "He did."

189. Dr. Moodley told her to set up a follow-up appointment with his secretary, which she did. He made arrangements for the additional ultrasound, and she had the ultrasound on July 12. She did not return to see Dr. Moodley for the follow-up appointment.

190. C.D. complained about the July 6 appointment to the Cape Breton Regional Health Authority. Tarin Wells, who was the Executive Assistant to the Zone Medical Directors' office, first interviewed her. They spoke on the telephone on July 20, 2017, and Ms. Wells referred her to Dr. Angus Gardner, who was the head of the Department of Obstetrics and Gynecology at the Cape Breton Regional Authority when Dr. Moodley came to Cape Breton. Dr. Gardner met with

C.D. on August 4, 2017. Dr. Gardner testified that he discussed C.D.'s complaints with Dr. Moodley before meeting her and made a note to file dated August 9, 2017, as follows:

> **Note to File: Dr. Moodley**
> **Complaint [ ]**
>
> I met with [ ] on August 4, 2017 in the Administrative Office at 1100 hours. I reviewed with her the complaint that she stated to Tarin Wells regarding her meeting with Dr. Moodley. I also stated that I had met twice with Dr. Moodley to indicate that some of his methods and questioning were inappropriate in our culture. I stated to [ ] that we take these complaints very seriously and do whatever we can to make sure they do not happen again. I will also dictate a letter to Dr. Moodley stating that this is a caution that will stay on his file. [ ] felt that the meeting today was professional and was quite acceptable to her. She has been referred through our office to Dr. Erin MacLellan for follow-up and treatment. She does have an appointment scheduled for September 9, 2017 with Dr. MacLellan. I will discuss this further with Dr. Moodley to make sure he understands the gravity of the situation.
> ***[Redacted]***

191. Dr. Gardner wrote a letter on August 4, 2017, to Dr. Moodley, which stated as follows:

> I met with [ ] today to discuss her complaint against you. I stressed to her that we take these complaints very seriously. We did discuss the difference of cultures between South Africa and North America, but she felt that some of her complaints went beyond a difference in culture. I have told her that we will place a caution in your file indicating the nature of the complaint which will stay in your file for as long as you are in the Eastern Zone, Nova Scotia Health Authority. This should have no impact on your practice at present.
> ***[Redacted]***

192. In his direct examination, Dr. Gardner clarified what he had written in the note to file and Dr. Moodley's letter. He says he meant that, if what C.D. was saying was true about Dr. Moodley's interview with her, it was inappropriate, but he could not sort out whether her allegations were true. He said that the caution letter to Dr. Moodley was not meant to indicate guilt. Dr. Gardner testified that C.D. indicated that the August 4 meeting was "professional and quite acceptable to her." He arranged for her to see another gynecologist, Dr. Erin MacLellan, on September 9, 2017.

193. Dr. Gardner wrote to Dr. Moodley on August 25, 2017, asking him to respond in writing to the allegations made by C.D. Both in his written response to Dr. Gardener's request and in his reply to the complaint to the College, Dr. Moodley denied all the allegations made by C.D.

194. C.D. testified that on July 20, 2017, another employee at her workplace paged her and told her that someone there had asked to speak to her directly, saying she believed he was a

doctor. C.D. saw that the person looking for her was Dr. Moodley and took steps to avoid him. Dr. Moodley left without speaking to her.

195. In cross-examination, C.D. agreed that, in her first meeting with Dr. Moodley on May 4, 2017, he had asked her about her sexual activity, whether she had regular intercourse with her main partner and she told him that her sexual partner worked away and that she was sexually active when he came home on vacation. She understood that these questions were completely normal and had relevance to the medical issue for which she was seeking treatment.

196. C.D. confirmed that she had been comfortable in her initial interview with Dr. Moodley. They chatted about her personal circumstances. She confirmed that she was comfortable with the discussion. She also confirmed that she did not remember the colposcopy that had been conducted on June 4th.

197. She agreed that after the ultrasound in Dr. Moodley's office on July 6, Dr. Moodley discussed the June 6 biopsy results and advised her to have a further ultrasound and a LEEP procedure. Counsel suggested that Dr. Moodley told her that the LEEP procedure was at the a hospital where she would be under a local anesthetic and would have to get somebody to drive her home. C.D. did not agree to counsel's suggestion. Counsel suggested that she had told Dr. Moodley that her partner was away, and he would not be able to drive herself home. She did not agree with this suggestion.

198. C.D acknowledged that Dr. Moodley did not tell her she had cancer or told her she would die when he told her about the "mass" he observed in the ultrasound in his office. She disagreed that Dr. Moodley told her he found a cyst, not a mass.

199. C.D. did not attend the follow-up appointment with Dr. Moodley, and she did not speak to him when he came to her workplace. She acknowledged that Dr. Moodley called her the day after he came to her workplace, telling her that she missed her appointment and stressed the importance of not missing appointments.

200. On re-direct examination, C.D was referred to report of the ultrasound conducted on July 11, 2017, which identified a "large pelvic cyst" and her evidence that Dr. Moodley had described that to her as a "mass." She was asked if there was a distinction in her mind between the word "mass" and the word "cyst." She answered that "mass sounded a lot more detrimental" and that she assumed that it was "either a cancerous mass or something of that nature."

(b) Evidence of Dr. Moodley

201. Dr. Moodley testified that the report of the pap smear included with the referral letter from C.D.'s family physician showed High Grade Squamous Intraepithelial Lesion (HGSIL) which indicated a very high risk of going on to develop cancer of the cervix. This indicated the need for a colposcopy, which involved examining the area of the cervix with HGSIL by microscope and taking a biopsy.

202. Dr. Moodley saw C.D. on May 2017 in the ambulatory clinic of the Cape Breton Regional Hospital to perform the colposcopy but did not complete it because he observed vaginal signs of pregnancy. He ordered a blood test to rule out pregnancy. When he received the blood test results, he called C.D. and advised that they could go ahead with the colposcopy.

203. The colposcopy was conducted on June 6, 2017. Dr. Moodley observed an area of high grade cells. Given a high grade abnormality on the pap smear and a high grade abnormality in the colposcopy, he concluded that C.D. needed to have a LEEP procedure, which would have involved excision of the entire abnormal area. Before performing the LEEP, Dr. Moodley arranged for a follow up visit with C.D. in his office on July 6, 2017, to better explain the LEEP procedure and to conduct an ultrasound examination. Meanwhile, Dr. Moodley received the biopsy report taken during the colposcopy; it reported a low grade abnormality. Despite this, given the high grade abnormality identified on the pap test and observed in the colposcopy, he concluded that a LEEP procedure was necessary.

204. The office visit with Dr. Moodley on July 6, 2017, was the subject of the complaint from C.D. to the College and the referral to hearing in this matter. For the most part, Dr. Moodley does not remember that office visit. He answered most questions by saying what he would do, not what he actually remembers doing.

205. Dr. Moodley denied requesting C.D. to do another vaginal examination in the office. He explained that he conducted those examinations in a separate examination room. He did not have the necessary equipment for such an examination in his office. Dr. Moodley explained that he does not do intimate examinations in his office and that there was no need to do an internal examination. Dr. Moodley did not recall any discussion of menstruation. He said there was no need for one.

206. Dr. Moodley was asked why he wished to perform an ultrasound examination. He indicated that sometimes there is a pathology that could be identified by the ultrasound and that such a finding could be addressed at the same time as the LEEP procedure.

207. Dr. Moodley conducted the ultrasound and observed a "cystic mass." He was unsure whether he described it to C.D. as a cyst or a mass. He concluded that C.D. would need a formal ultrasound in a hospital ultrasound department. He wanted this done on an urgent basis before the LEEP procedure because removing the cyst could be done simultaneously as the LEEP procedure. Dr. Moodley denied that he told C.D. that she had cancer.

208. Dr. Moodley told C.D. that he would perform the LEEP procedure at a hospital. He said he told her that she would need someone to pick her up after the procedure.

209. Dr. Moodley denied that he told C.D. that he would come to her house or that he asked if she lived alone or with her dad. He denied that he asked her if her children's bedrooms were near hers, and if they could hear her scream during sexual activity.

210. Dr. Moodley was asked about C.D.'s evidence that he would look after her or words to that effect. He said he thought she misunderstood. He said that he usually tells patients that he would be doing the procedure and that she'd be taken care of and that she'd be fine.

211. Dr. Moodley was asked about C.D.'s evidence that he had said she would not need her partner, and it would be their secret and to tell no one. He answered, "No way."

212. Dr. Moodley testified that a follow up appointment was scheduled for July 13, 2017, and that C.D. did not show up for that appointment. He was asked about C.D.'s evidence that he had shown up at her workplace. He explained that he and his wife were looking for a product and went to various shopping outlets. He stopped at C.D.'s workplace and did not see any of the product outside, so he went inside. He says he remembered that C.D. worked there, and he asked for her and was told that she was not there. He said that he was there solely for the purpose of looking for the product. He asked to see C.D. about the missed appointment and that she needed to come back for the laboratory results that he had ordered on July 6th.

213. Dr. Moodley testified that he was contacted by Dr. Angus Gardner about the complaint that C.D. had made to the hospital. He said that he was very surprised by the things written in the report of the complaint provided by Tarin Wells. He said that he denied the allegations other than that he did go to C.D.'s workplace.

214. Dr. Moodley thought that the complaints of C.D. and A.B. were racially motivated. He believed that there was collusion between C.D. and A.B. or racial motivation, but he could not prove it.

215. On cross-examination, counsel asked Dr. Moodley whether he agreed with each of the allegations in the Notice of Hearing. In each case, he indicated that the allegations were not correct or not true. He acknowledged that he had gone to C.D.'s workplace and understood that whether he had violated professional boundaries by doing so was a judgment the College needed to make.

216. Dr. Moodley denied asking C.D. how she had looked after herself while he partner was gone, whether she looked after herself sexually and whether she used her hands or toys, that he told C.D. in that context that he would look after her well, that he had requested an internal examination, that he had commented on the colour of C.D's underwear compared to her lipstick, whether he could find her in her home, that he asked C.D. whether she lived at home or with her father, whether he asked her about the location of her children's bedrooms, whether her children could hear her scream during sexual activities, and that he told C.D. she should tell no one and that it would be their secret.

217. Dr. Moodley confirmed on cross-examination that he did go to her place of work. He denied that he had unnecessarily magnified the extent of C.D.'s diagnosis.

218. Dr. Moodley admitted that he had no evidence that A.B. or C.D. were motivated by racism and that there was collusion between A.B. and C.D. in filing their complaints to the College. He agreed he had accused the complainants of perjury in their affidavit evidence in a complaint that he made to the College but admitted that he had no direct evidence for that accusation.

(c) Evidence of Dr. Adam

219. Dr. Christian Adam gave expert evidence about the standards for the recommendation and conduct of a LEEP procedure.

220. He explained that a LEEP procedure is a procedure where the physician uses a little metal loop by passing a current through the loop to act both as a scalpel and as a cauterizing instrument. It cuts through tissue but, at the same time, it coagulates or burns so that there is no excessive bleeding. The aim of the LEEP procedure is to remove a cone shaped piece of tissue, eliminating the abnormal area that had been identified in the in a colposcopy examination.

221. In the case of C.D., Dr. Moodley took a biopsy during the colposcopy, and the biopsy results indicated low grade abnormality. Dr. Adam explained that a biopsy showing low grade changes tells you that something is going on; low grade changes are a precursor to high grade changes. He explained that there is a cause for concern in the situation where there is a high grade abnormality noted in the pap test and a high grade lesion visualized on colposcopy, and a biopsy comes back as low grade. He indicated that the age of the woman is significant. If a woman is mother in a particular age range and had a pap test showing high grade changes, high grade changes visualized on a colposcopy yet a biopsy showing low grade, he would recommend a LEEP. In his opinion, it is just safer to treat. If the patient does not get LEEP done, abnormal cells can progress to cancer. In his opinion, it is appropriate to advise the patient with a high grade abnormality that if it's left alone, most move onto cancer.

222. On cross-examination, he was asked about the biopsy results in C.D.'s case; it was suggested to him that the results of the biopsy do not show a progression of symptoms or a progression or a worsening. He disagreed. He explained that the biopsy is only as good as where it is taken. He pointed out that in this case, there was a large area labeled HGSIL in the report of the colposcopy, and the biopsy was taken from one spot only, so there may be low grade changes in one spot and high grade changes in another spot.

(d) Analysis

223. In closing argument, counsel for the College advised that the College was withdrawing certain aspects of the allegations in the Notice of Hearing. The College is not pursuing the allegation that Dr. Moodley was incompetent and the allegation that he committed professional misconduct by unnecessarily magnifying the extent of C.D.'s medical issues. The College also narrowed its position on the allegation that Dr. Moodley had conducted a pelvic ultrasound in a manner inconsistent with accepted standards.

224. As with the analysis of A.B.'s complaint, our first task is to assess the evidence and make findings of fact in respect of each of the allegations in the Notice of Hearing.

i) Unnecessary request for an internal examination

225. The College alleges that Dr. Moodley committed professional misconduct with respect to C.D. by unnecessarily requesting an internal examination. Considering all of the evidence, we have concluded that it is not likely that Dr. Moodley requested an internal examination in his office on July 6, 2017.

226. C.D. testified that Dr. Moodley "requested to do another internal exam." She "wasn't clear why he would request another exam." She says, "just because of the first line of questions and kind of the unsettled feeling I had, I didn't want to have another exam done." She says that she told him that she was menstruating and would not be able to have an internal examination on that day.

227. Dr. Moodley testified that he never performs internal examinations in his office and that he does not have the necessary equipment in that room to perform one. He testified that there was no need to do an internal examination on July 6th because a colposcopy had been done in the ambulatory clinic on June 4th. He said that he requested to do an ultrasound examination because that had not been done at the time of the ambulatory clinic.

228. Dr. Moodley testified that it was his normal practice to do a point-of-care ultrasound in his office. In Dr. Viljoen's testimony, he had confirmed that conducting a point of care ultrasound in the office had been part of his South Africa training, as it would have been for Dr. Moodley. On July 6th, Dr. Moodley was looking for any unexpected abnormalities, which could be addressed at the same time as the LEEP surgery that he was recommending.

229. Considering both the evidence of C.D. and Dr. Moodley in context, we concluded that C.D. likely misheard or misunderstood Dr. Moodley when he requested an ultrasound examination as part of his standard practice. It is likely that C.D., who was already unsettled by Dr. Moodley's questioning, heard him requesting an exam and misunderstood that to be an internal exam.

230. We have not concluded that C.D. was lying in her testimony. Having misunderstood or misheard what Dr. Moodley said to her on July 6th, we believe that her evidence was honestly given but mistaken. Accordingly, in our opinion, with respect to patient C.D., Dr. Moodley did not unnecessarily request an internal examination.

ii) Conducting a pelvic ultrasound in a manner inconsistent with excepted standards

231. During C.D.'s testimony, the College led extensive evidence of how Dr. Moodley conducted a pelvic ultrasound in his office on July 6th. In closing submissions, the College

narrowed its approach to this allegation and indicated that it was seeking a finding of misconduct on Dr. Moodley's failure to provide C.D. with tissues tucked into her waistband and the act of Dr. Moodley personally wiping off the gel from the ultrasound.

232. In our opinion, even if this were true, it would not constitute unprofessional conduct, or professional misconduct.

iii) Remarks and questions

233. Other than Dr. Moodley's attendance at C.D.'s workplace, the remaining allegations in the Notice of Hearing all relate to remarks made and questions asked by Dr. Moodley in his office visit with C.D. on July 6, 2017.

234. As in our analysis of A.B.'s complaint, we must first decide what Dr. Moodley said to C.D. in his office on July 6, 2017, and whether what he said was relevant to her medical issues.

235. C.D.'s case is more complicated than A.B.'s. We have to assess whether her evidence is credible and reliable and whether it is more likely than not that Dr. Moodley made some or all of those remarks or asked any of those questions.

236. On the one hand, C.D. appeared to be a truthful witness. She gave clear evidence of the remarks and questions from Dr. Moodley that are listed above. The remarks and questions are quite distinctive and memorable. C.D. brought her complaint forward only after being contacted by the College and was motivated by her wish to prevent similar conduct from happening with others. C.D. had nothing to gain from making up these remarks and questions, but she had a lot to lose by being drawn into this three-year process culminating in public testimony about intimate personal matters.

237. C.D. readily acknowledged that her first contact with Dr. Moodley was positive. On cross-examination, she agreed that Dr. Moodley had asked her about her sexual activity and indicated that she understood that those questions were completely normal and relevant to her medical issues. She acknowledged that she had been comfortable in the initial interview with Dr. Moodley.

238. Dr. Moodley argues that C.D.'s evidence is not reliable for several reasons. First, in his submission, C.D.'s memory is not reliable. She remembers her initial assessment by Dr. Moodley on May 4, 2017, and testified about her visit to his office on July 13, 2017, but she does not remember the colposcopy examination he conducted on June 4, 2017. Nor does she remember the ultrasound procedure at a hospital on July 11, 2017. She acknowledged that these procedures took place based on the medical record, but she does not remember them.

239. C.D. has no recollection of the referral to Dr. MacLellan by Dr. Kalifa on July 20, 2017, and has no explanation for the letter of referral from Dr. Kalifa to Dr. MacLellan on that date.

240. Dr. Moodley argues that C.D.'s evidence also conflicts with the medical record related to her evidence that he walked her to the Blood Clinic after he saw her on June 4th in the Ambulatory Clinic. He argues that the records of Dr. Moodley's schedule and his appointments make that impossible.

241. Dr. Moodley says that these lapses and inconsistencies with the medical records demonstrate C.D.'s inability to testify about the surrounding context of the alleged comments accurately and, therefore, the reliability of her testimony altogether. Dr. Moodley also questions the reliability of her testimony given the impact of thinking that she had cancer when Dr. Moodley explained the colposcopy results and the biopsy from June 4, 2017. Her head was "spinning,"; she was very upset. Dr. Moodley argues that the "ripple effect" of this upset puts her overall recollection in question and makes it likely that she misunderstood or misperceived remarks and questions from Dr. Moodley.

242. Apart from the "ripple effect", C.D. did misunderstand Dr. Moodley's request for an ultrasound examination thinking that he requested an internal exam. Dr. Moodley argues that her memory lapses, her head spinning reaction to having what she thought was cancer, and her misunderstanding of the request for an ultrasound puts her testimony as a whole in question.

243. Dr. Moodley questions not only the reliability of C.D.'s recollection but also the truthfulness of her testimony. He points to a prior inconsistent statement made to Ms. Wells on July 20, 2017. While Ms. Wells did not recall whether C.D. had told her that Dr. Moodley pulled her pants to her knees or whether C.D. had said she pulled her own pants to her knees, Ms. Wells confirmed that C.D. said that her pants had been pulled down to her knees. This was inconsistent with C.D.'s testimony at the hearing. In her testimony at the hearing, C.D. testified that Dr. Moodley just said to lower her pants and that she pulled her pants down to just above the hipline. Dr. Moodley argues that this is an example of C.D. embellishing her account of what happened in the office on July 6th.

244. Dr. Moodley argues that C.D.'s evidence about being walked to the Blood Clinic and her statement to Tarin Wells are embellishments, which point to the conclusion that her evidence of Dr. Moodley asking her about her living arrangements was also an embellishment.

245. Based on these considerations, Dr. Moodley argues that the College's evidence is not clear, convincing, and cogent enough to satisfy the College's burden of proof. Although there was no burden on Dr. Moodley to prove that he did not engage in the conduct as alleged by C.D., he argues that her evidence overall must be considered in light of Dr. Moodley's evidence of his normal practices, upon which his denial of her allegations is based. He argues that the evidence of his normal practices is corroborated by his colleagues' evidence and the evidence of his character and reputation. In that context, Dr. Moodley submits that C.D.'s evidence on what Dr. Moodley said to her in the office on July 6, 2017, lacks the cogency needed for the Hearing Committee to accept what she says on the balance of probabilities.

246. Some of Dr. Moodley's points have no direct relation to the core of the complaints about what Dr. Moodley said on July 6, 2017, in his office. It would not be surprising that C.D. would remember clearly the sexually-oriented remarks and questions from Dr. Moodley on July 6th but not remember other events, which were not problematic in any way.

247. In our opinion, the core complaint here relates to what happened in the office visit on July 7, 2017. We disagree that the reliability of her testimony on the core matters in issue is affected by whether C.D. remembers the June 4, 2017 appointment or the ultrasound on July 11, 2017. Nor is there a need to untangle whether or not Dr. Moodley walked C.D. to the Blood Clinic and the time of her appointments.

248. Concerning her memory of being referred to Dr. Erin MacLellan by Dr. Kalifa on January 20, 2017, it should be noted that in Dr. Gardner's memo to file on August 9, 2017, he says that C.D. "has been referred through our office to Dr. Erin MacLellan for follow up and treatment" and that she had an appointment on September 9, 2017, with Dr. MacLellan. The referral from Dr. Kalifa on July 20, 2017, is the same day that C.D. spoke to Tarin Wells. It seems likely that Dr. Gardner's office arranged with Dr. Kalifa to send the referral letter.

249. In our opinion, C.D.'s lapses of memory do not impact the reliability of C.D.'s evidence as to what Dr. Moodley said to her on July 6, 2017, given the nature of her evidence of what he said.

250. We have already addressed the issue of whether Dr. Moodley requested an internal examination. We conclude that it is likely that C.D. misheard or misunderstood Dr. Moodley's request to do an ultrasound examination. In our opinion, that does not impact the reliability of her evidence of what he said otherwise. Just because C.D. misunderstood a reference to a medical procedure does not mean she would misunderstand unexpected sexually-oriented remarks and questions from Dr. Moodley.

251. Further, we do not see how C.D.'s mistaken belief that she had cancer created a "ripple effect" of misunderstandings that calls into question her evidence of what he said. The remarks she describes are shocking in themselves. We cannot conclude that C.D.'s concern about cancer caused her to misunderstand Dr. Moodley's remarks and questions.

252. We have to assess all of the evidence to conclude whether Dr. Moodley made the remarks or asked the questions that C.D. alleges. This includes the evidence of Dr. Moodley's normal practices and the evidence of character and reputation. Although Dr. Moodley does not remember much of the July 6, 2017 office visit with C.D., he denies saying the things she attributes to him. He says that it is not his normal practice to comment on a patient's underwear or personal appearance and that his normal practice in addressing sexual matters and arranging treatment must have been misunderstood by C.D. if she is telling the truth. In this regard, several colleagues of Dr. Moodley who had worked with him since 2017 confirmed Dr. Moodley's normal practices and they indicated that the statements attributed to him by A.B. and C.D. were not compatible with their observations and his reputation at the hospital.

253. As in our assessment of A.B.'s evidence, we have to be cautious about evidence that Dr. Moodley is not the kind of person to make the remarks described by C.D. Even if his normal practice is not to make such comments, that does not mean that C.D. is wrong in her description of what he said to her. To accept that he would never make such comments or ask questions in the way described by C.D. would require us to believe that C.D. had made them up. Given the specific nature of the remarks and questions that she describes, we do not accept that she made up what she reports.

254. As we stated in assessing A.B.'s evidence, the witnesses of Dr. Moodley's character and reputation are all colleagues who have worked with him since the College intervened in August 2017 to require that he work with a chaperone. Dr. Moodley was put on notice that these kinds of comments were a significant issue. It would be very surprising that he would openly engage in such conduct repeat in the presence of his colleagues. We admitted the evidence of Dr. Moodley's character and reputation. However, we accept the submission of the College that in cases of sexual impropriety where the conduct takes place in private, this kind of character and reputation evidence has little, if any, weight.

255. Counsel for the College argued that previous statements by C.D. in her complaint to the College and her interviews by the investigation committee are consistent with C.D.'s evidence as the hearing except in minor details. As in the A.B. matter, we are not inclined to give those previous consistent statements any weight. While previous inconsistent statements may be significant in assessing evidence given at a hearing, previous and repeated statements do not add to sworn testimony at a hearing which has been subject to cross-examination.

256. Likewise, we are not inclined to rely on any similarities in the evidence of A.B. and C.D. as we assess the credibility and reliability of C.D.'s evidence. In our view, each case needs to be proven on the evidence relevant to the allegations made by the individual complainant. We cannot conclude on the evidence before us that Dr. Moodley has a propensity to engage in sexual misconduct. It would be unfair to draw any conclusion based on what he said to A.B.

257. We conclude that C.D. is a credible witness and that her testimony of Dr. Moodley's remarks and questions is reliable. Accordingly, we conclude that it is more likely than not that Dr. Moodley made the following remarks:

a. How do you look after yourself sexually while your partner is away;
b. It seemed that C.D. would have a very healthy appetite sexually;
c. Did you use your fingers or sex toys;
d. He would look after me well;
e. He liked that my underwear matched the colour of my lipstick;
f. Asked her about her living arrangements;
g. Would I see you if I came to the [her community] – at your house – I know where you live;
h. Where my bedroom is located in reference to children;

i. If I lived with my father;
j. If engaging in sexual activity would my children hear if I was to scream or make any noises; and
k. I wouldn't need to worry because at the next appointment he would thoroughly look after me and I wouldn't need my partner – it would be our secret. ***[Location redacted]***

iv) Was what Dr. Moodley said medically relevant?

258. There is no dispute that there was no medical relevance to the comment that C.D.'s underwear matched the colour of her lipstick.

259. In our opinion, there was no medical relevance to asking C.D. how she looked after herself sexually while her partner was away, commenting that she had a healthy sexual appetite and whether she used her fingers or sex toys. Similarly, there is no medical reason for asking about her living arrangements, commenting where she lived, where her bedroom was located, and whether her children would hear if she engaged in sexual activity.

260. There may have been a misunderstanding about Dr. Moodley's remark that she would not have to worry because he would thoroughly look after her in her next appointment. However, there is no medical reason for him connecting this with not needing her partner and that "it would be our secret."

v) Attendance at C.D.'s workplace

261. There is no dispute that Dr. Moodley went to C.D.'s workplace and asked an employee there if he could speak with her. The employee paged C.D. and told her that someone had asked to speak to her directly, indicating that she believed he was a doctor. C.D. saw that the person looking for her was Dr. Moodley and took steps to avoid him. Dr. Moodley left without speaking to her.

262. Dr. Moodley says that he went to C.D.'s workplace looking to buy a product, and when he could not find one in the store, he remembered that C.D. worked there and decided to see if he could speak to her and remind her to make a follow-up appointment.

263. We find it difficult to accept Dr. Moodley's explanation for trying to contact C.D. at her workplace in light of his comments and questions on July 6, 2017, about her living arrangements asking whether he would see her if he came to her house and asking her if her children could hear her engaging in sexual activity.

264. The only conclusion we can draw is that Dr. Moodley was interested in seeing C.D. for personal reasons outside of the physician-patient relationship.

vi) Summary of factual findings

265. To conclude our analysis of the facts related to the complaint by C.D., we have found that the College has established on a balance of probabilities the following:

a) During the office visit on July 6, 2017, before informing C.D. of test results, Dr. Moodley asked her questions and made comments of a personal and sexual nature that were not relevant to her medical issues;

b) In that office visit, in the course of conducting a pelvic ultrasound, Dr. Moodley complimented C.D. on the colour of her underwear;

c) In that office visit, following the physical examination, Dr. Moodley asked C.D. questions and made comments to her of a physical and sexual nature that were not relevant to her medical issues including a suggestion about seeing her at her home and advising he knew where she lived; and

d) Dr. Moodley violated the boundaries between physician and patient through his attendance at C.D.'s worksite where he sought her out.

266. These findings relate to paragraphs (a), (c), (d) of the Notice of Hearing and the allegation concerning Dr. Moodley's attendance at C.D.'s workplace in the Notice of Hearing.

267. The Committee has also concluded that the College did not establish that Dr. Moodley unnecessarily requested an internal examination at the office visit on July 6, 2017. The College withdrew its allegation that Dr. Moodley had unnecessarily magnified the extent of C.D.s medical issues. These findings have led us to reject paragraphs (b) and (f) as listed in the Notice of Hearing. With respect to paragraph (e) in the Notice of Hearing, we have rejected the claim of the College that Dr. Moodley conducted a pelvic ultrasound in a manner inconsistent with accepted standards by failing to provide C.D. with tissues into her waistband and by personally wiping off the gel for the ultrasound.

(e) Misconduct

268. Having found the relevant facts, we have to determine whether, in those circumstances, Dr. Moodley committed professional misconduct. This involves applying the definition of "professional misconduct" in the *Medical Act* and is a matter of judgment by the Hearing Committee.

269. In considering whether any of Dr. Moodley's conduct involving C.D. amounted to professional misconduct, we are basing our conclusions on the principles stated in the Canadian Medical Association Code of Ethics and the Professional Standards and Guidelines Regarding Professional Conduct in the Physician-Patient Relationship. In his dealings with C.D. Dr., Moodley

was bound to consider her well-being, treat her with dignity and as a person worthy of respect, and not exploit her for personal reasons. Dr. Moodley was obliged to treat C.D. as a vulnerable individual in a professional relationship with a power imbalance and to maintain professional boundaries with her.

270. In our opinion, Dr. Moodley did not treat C.D. with the dignity and respect required by the professional standard when he went to her workplace and asked to speak to her there. In our opinion, attending her workplace did not just constitute a compromise of her right to privacy on medical matters when another employee recognized that he was a physician, but in context, he failed to treat her as a person worthy of respect. As a vulnerable individual in a professional relationship with a power imbalance, he did not respect the professional boundary in their physician-patient relationship. Likewise, his sexually-oriented remarks and questions in that relationship were disrespectful and an abuse of his power.

271. Taken as a whole, Dr. Moodley's remarks and questions breached professional standard 1(a). He did not respect professional boundaries in dealing with C.D. He crossed a sexual boundary by making inappropriate sexually-oriented remarks to her and asking her sex-related questions, which were not relevant to her medical condition. Furthermore, in our opinion, Dr. Moodley completely failed to ensure that any remarks or questions that he asked could not be construed as sexual in nature and when sexual matters were discussed, he did not explain to C.D. why the questions had to be asked so that his intention could not be misconstrued.

272. Given our factual findings, in our opinion, Dr. Moodley's conduct was unprofessional, and this unprofessional conduct constituted professional misconduct.

X. Conclusion

273. We have concluded that Dr. Moodley engaged in professional misconduct with A.B. by commenting inappropriately on her physical appearance and by initiating a discussion of a personal or sexual nature with her that was not relevant to her medical issues, and that following a physical examination, he asked questions of a sexual nature that were not relevant to her medical issue.

274. We have also concluded that Dr. Moodley engaged in unprofessional conduct by asking C.D. questions and making comments of a personal and sexual nature that were not relevant to her medical issues and that he violated the boundaries between physician and patient by attending at C.D.'s worksite.

275. Accordingly, having found professional misconduct, we will proceed under section 54(1) of the *Medical Act* to dispose of the matter in accordance with Section 115 of the Medical Practitioners Regulations. We request counsel to propose a date for hearing on disposition matters, including costs. We invite the College to provide affidavit evidence supporting any claim for costs and encourage the parties to agree on costs.

276. The Hearing Committee reserves jurisdiction to edit these reasons if the College identifies passages that would expose the identity of the complainants contrary to the Publication Ban.

277. We wish to express our appreciation for the very thorough and capable work done by both counsel for the College and counsel for Dr. Moodley.

XI. Dissenting opinion of Dr. Khan

I disagree with the conclusions of my colleagues. In my opinion, Dr. Moodley did not engage in professional misconduct as alleged in the Notice of Hearing. All of the allegations against him should be dismissed.

I am not satisfied with the process of reaching a decision and disappointed in how the majority came to its conclusions.

I agree with my colleagues that the College has the onus of proving the allegations in the Notice of Hearing and that it must prove these allegations on the balance of probabilities with clear, convincing and cogent evidence. However, in my opinion, the College has not proven the allegations. Instead we are asked to accept that the allegations of the complainants are facts and that we must believe them.

I do not agree with my colleagues that the allegations of A.B. and C.D. are credible and reliable, while the statements of Dr. Moodley are not. Allegations are not facts. The probability of the complainants' allegations being true is no greater than what Dr. Moodley says is true. Both A.B. and C.D. and Dr. Moodley have forgotten some details. I don't agree that C.D. completely forgetting procedures and appointments including appointments with other physicians (Dr. Khalifa) is ok but if Dr. Moodley forgets appointments he is not reliable. In my opinion, the College has not provided any convincing proof that the complainants' allegations are true. The quality of proof is poor.

In my opinion, Dr. Moodley's evidence is equally reliable and credible. He is a respected professional without any history of such conduct. The public interest requires letting good clinicians continue medical practice. The credibility of the medical profession includes the protection of medical professionals.

I disagree with the majority decision. Dr. Moodley's approach was uncommon for the new practice he joined with good intent and mostly according to acceptable practices in the speciality of his medical practice. The College appointed a sponsor and a supervisor who failed to appraise and train him with local sensitivities and cultural differences in medical practice before he actually started his practice.

Issued at Halifax, Nova Scotia this 23rd day of November, 2020.

Raymond Larkin, Q.C.

Gwen Haliburton

Dr. Gisele Marier

Dr. Erin Awalt

Dr. Naeem Khan, ***Dissenting***