



CANADIAN
ATHLETIC
THERAPISTS
ASSOCIATION
ASSOCIATION
CANADIENNE
DES THÉRAPEUTES
DU SPORT

May 1, 2009

Re: Charges of Professional Misconduct against Christopher Lillies

Hearing Date: April 2, 2009

Background

The Canadian Athletic Therapist Association (“CATA”) is the national governing body for athletic therapists practicing in Canada. It is also a not-for-profit organization dedicated to the promotion and delivery of the highest quality care to active individuals through injury prevention, emergency services and rehabilitative techniques. The CATA promotes continuing development, implementation and monitoring of professional standards. In collaboration with other allied health professionals, the CATA creates a healthier environment that encompasses the needs of the active community through to the high performance athlete.

The CATA is a self regulating professional association. It must respond to complaints against members of its association by first assessing the individual’s situation then taking the responsibility to mete out sanctions, if that is determined to be appropriate. The desire of self-regulation is to ensure a minimum standard of performance and conduct among the profession’s members and to thereby ensure the safety of the public. The practice of athletic therapy, of necessity, involves putting patients in vulnerable positions in terms of trust, states of partial or full nudity, and treatment of private or discrete areas. As a result, the CATA is cognizant of the need to promote good practices and to ensure safety for the public.

The means of achieving these goals of self-regulation are through the CATA’s two pieces of legislation to which its members are obliged to adhere. The Code of Ethics deals with members’ obligation to act in accordance with the ideals and standards of the Athletic Therapy profession. With respect to disciplinary issues, the Code of Conduct sets out the minimum standards of practice and conduct. The Code of Conduct also contains a procedural section with the framework for dealing with alleged breaches. The Code of Ethics and the Code of Conduct are complementary.

By letter dated October 20, 2008, the Complainant submitted a complaint to the President of the Manitoba Athletic Therapists Association (MATA). The complaint alleged certain improprieties by the Respondent, Christopher Lillies, a Certified Athletic Therapist, on October 14, 2008, in Winnipeg, Manitoba.

Due to the significance of the allegations and due to potential conflicts of interest within a small membership in Manitoba, the MATA referred this matter to the CATA Ethics Chairperson for handling.

A panel for the Investigative Subcommittee was selected by the Chairperson of the Ethics Committee to investigate the complaints in this matter. Following its investigation, the CATA Investigation Committee recommended to the Ethics Chair that charges be laid against the Respondent. After the Investigative Subcommittee referred the allegations to a hearing, the Chairperson selected a panel of the Judicial Committee to hear the matter.

A Notice of Proceedings dated January 19, 2009, was issued to the Respondent. A Notice of Hearing for April 2, 2009, was sent to the Respondent.

The Judicial Subcommittee, consisting of Dave Campbell, Chairperson, Jamie Rempel, and Cindy Hughes, heard evidence and argument on April 2, 2009.

Charges

The charges against the Respondent, which were dealt with at the hearing on April 2, 2009, are as follows:

3 - CODE OF CONDUCT

Members shall comply with the following Code of Conduct recognizing that failure to do so is professional misconduct and can lead to disciplinary action.

B. Responsibilities to the Client

- ii. Members shall respect the client's dignity, needs, values, and wishes.
- ix. Members shall maintain the generally accepted standard of practice.
- xvii. Members shall not physically, emotionally or sexually abuse or harass a client or any other person.
- xxi. Members shall not contravene a law that is relevant to their suitability to practice.
- xxii. Members shall not engage in conduct that is relevant to the practice of Athletic Therapy that would reasonably be regarded by Members as disgraceful, dishonourable or unprofessional.
- xxiii. Members shall not engage in conduct unbecoming an Athletic Therapist.

Synopsis of Allegations Giving Rise to Charges

On October 14, 2008, the Complainant alleges that while massaging her adductor muscle, the Respondent slipped a finger under the elastic of her shorts and rubbed the outside of her vagina. The Respondent continued and placed his finger about halfway

into her vagina. The Complainant alleges that such contact was inappropriate, unwanted and occurred without her consent.

Brief Summary of the Evidence

The full version of the evidence was available to us by transcript which we have reviewed and considered. The following encompasses a general narrative of the evidence.

Complainant

The Complainant is a 26 year old Contemporary Dancer. She first saw the Respondent in July of 2007 for ongoing problems with her left knee. She was referred by a fellow dancer. The Complainant reposed her trust in his capabilities as an Athletic Therapist. Following her first two treatments with him she said "I would often get much better with the exercises that he gave me". She saw him for four to five treatments in 2007. On each of these occasions the treatment session ended with a massage to her left quadriceps muscle and then ice to the area. The Complainant described the massage pressure in all of her massages in 2007 as consisting of "very firm pressure". The massages took place with her lying on her back on a table, with no curtains closed around the table.

Her trust in him and satisfaction with his treatment were the reasons she returned to see him again at the end of May in 2008 when she had a serious episode with her left knee.

Following the injury, in June of 2008, the Respondent referred the Complainant for an MRI. It showed some degenerative changes in the knee but no structural damage that would require any surgery. The consulting physician told her to "to keep up the work with Chris" (page 34), and at the subsequent visit on August 18, 2008, the Respondent explained the MRI to her. The session ended with a massage to her left quadriceps and ice to that area.

He also suggested 6-12 months away from dance and the Complainant complied with that recommendation. Dance was clearly very important to her. Her journal records (Exhibit 3, Tab 16) show faithful completion of the assigned exercises and evidence the significance of the time away from her career as she counts down the days in her journal.

Treatments following the MRI occurred on September 2, September 18, and September 29, 2008. Again, the Complainant described the massage pressure in these massages as consisting of "very firm pressure". To some extent the pressure was painful and the Complainant usually closed her eyes and tried to breathe to cope with the pain. The Complainant described the treatment protocol as "intense" because she now had to do her exercises 6 days per week.

October 14, 2008, was the date of the complained about incident and the last time the Complainant was treated by the Respondent. Her appointment was at 10:00 a.m. At the time she arrived, there was one other patient in the clinic. A receptionist sat in a different reception area next to the clinic itself. According to the Respondent, he had some cancellations due to illness. On this occasion, the Complainant was wearing

somewhat different shorts than she had on previous occasions. The shorts were marked as exhibit 2. Following her usual course of exercises, the Complainant positioned herself on the massage table. On this occasion the Respondent closed the curtain around the treatment area. He massaged her left quadriceps muscle, and then her iliotibial band and hamstring. He used firm pressure in all of these areas. For the latter massage areas, the Complainant was positioned on her right side. The Respondent then began massaging her adductor area, which is, generally speaking located in and around the inner thigh.

The Complainant then described a point during the massage of her adductors as changing to a specific moment where the intense pressure just became very soft, like rubbing. She immediately felt that there was an inappropriate touch happening, and felt shocked and paralysed. She describes the Respondent as proceeding to slip one finger up into her thigh with a bit of pressure so it could work its way under the tight elastic band of her shorts. This finger just began rubbing or massaging the outside of her vagina. She made a nervous sound, almost a half laugh which she said the Respondent mimicked. She then described the finger continuing to proceed and he inserted it about halfway into her vagina. She moved her left hand near to the area and the Respondent withdrew his finger. She described being in a state of confusion and shock and tried to normalize the situation by making a joke: "there must be some pretty big muscles up there". The Respondent replied: 'oh, are there?', in a tone she perceived to be an inquiry or invitation to continue. She then said: "no, I'm kidding". She rolled onto her back, she pulled her shorts down to cover herself. She then says that the two of them tried to have a normal conversation about some pain she had been having in her gluteal muscles with the Respondent saying there were stretches which might help. She described the Respondent's face as being flushed and red. He showed her the way out and the Complainant was not given ice as was usual. She then made an appointment for one month later, which she did not keep.

According to the Complainant, her shorts never rode up into her genital folds such that there could be an accidental touching of the outside of her vagina. The Respondent did not apologize or refer to the touching in any way.

Almost immediately following her exit from the clinic, the Complainant called a friend and related the details of what was a very upsetting incident for her. She then walked to that friend's house to further discuss the incident. The friend was called as a witness and gave evidence as to the recitation of events.

She also called her boyfriend and briefly related the incident to him. The boyfriend was called as a witness and gave evidence as to the Complainant's account to him.

The Complainant called the Non-Emergency Police telephone number and on October 17, 2008, met with two police officers to give a statement. She was advised that she could press charges or not; the case could always be considered open. The police officers were not called as witnesses and the Complainant's statement to them was not in evidence.

Friend of the Complainant (B.B.)

B.B. is also a 26 year old Contemporary Dancer. She has known the Complainant since September, 2001, and considers her to be one of her closest friends.

She gave evidence as to the Complainant's recital of the incident to her in the telephone call when she left the clinic and while at her home when the Complainant was considering what to do about the incident. Her evidence as to what the Complainant said occurred during the massage was mostly consistent with the Complainant's evidence. Notably, she said that she knew all these things happened (were reported to her) but that she did not recall the order of their occurrence.

Boyfriend of the Complainant (M.S.)

M.S. is 27 years old, an arborist, and resides with the Complainant. On October 14, 2008, during his lunch break, he received a telephone call from the Complainant. Her voice was different and he thought she had had some bad news about her job or her knee. His account of what the Complainant reported to him was generally consistent with the Complainant's evidence. He left work to come and met her at their apartment.

Respondent

The Respondent denies the allegations made by the Complainant and denies that any of his actions constituted a breach of his professional association's regulations.

The Respondent's resume was marked as Exhibit 5. He had been a Certified Athletic Therapist for six years, and practicing in athletic therapy for ten years. He operates out of two clinics.

In 2007, he gave the Complainant massages to her left quadriceps, with some non-extensive work in the iliotibial band region. He was a 'stickler' for draping and always tucked a towel into client's clothing. There were no curtains around the massage table until the summer of 2008.

The Respondent gave evidence to the effect that September 18, 2008, was the first treatment rendered by the Respondent to the Complainant's pubic rami area. He did so because one of the Complainant's adductor muscles was quite sore along the proximal third near the region where the adductors insert into the pubic rami. The pubic rami bones are generally near the genital area. The Respondent was not sure which adductor muscle was irritated. The adductor was also included in the Respondent's massage treatment on September 29, 2008.

On October 14, 2008, the Respondent had a couple of patients cancel their morning appointments due to illness. There were two clients present in the clinic when the Complainant arrived. Once the Complainant had completed her exercise routine, she removed the sweat pants that she usually wore and had grey briefs on, different than the black ones she usually wore, and 'skimpier' in the Respondent's view. By the time the massage component of the treatment began there were no other clients in the clinic. His massage treatment was at first no different than the previous ones. He laid her on her back, tucked a towel in around her shorts, and worked through the quads. He then laid her on her right side so she would have been facing away from him. He placed a bolster between her knees, raised the shorts up and around the iliac crest to expose the

buttock, tucked a towel into her shorts so that towel would be tucked along the buttock fold and then around the iliac crest in the front.

He had finished his work on her iliotibial band and gluts. He found a muscle in her gluts obturator that was still quite tight, he had worked on that for a while but it was not giving way. He went on to work the back of her hamstring and into the adductor again. In his view the adductor was still irritated and he was not certain as to the cause, but speculated that it was because she had quite a decreased vastus medialis. He continued to work on the hamstrings and the adductors and had basically finished without noticing a significant change in the tension of that muscle. He said it was quite high up and he followed it up near the pubic ramus. He had not isolated which adductor muscle was problematic. As a result, he decided to try some diagnostic exploration. He felt around a little bit more for the tight tissue, where it ran to and which adductor might be the problem. That diagnostic exploration changed his massage pressure which had previously been deep tissue pressure. His touch was much lighter because he was trying to feel the tissue, its tension, and where it runs to in an effort to establish what muscle it is. He had not used this light touch on the Complainant previously.

As he was palpating the area on the insert of the adductor on the pubic rami, the Complainant made a comment. She had made a noise earlier which he didn't really note because she had been deep breathing and made some prior groaning sounds during some deep tissue work to a painful area. She made a comment about there being lots of strong muscles in there. The Respondent froze, wondered why the comment was made, checked himself and stood up a little bit. He looked to see what was going on and noticed that her shorts had shifted and that his right finger was against the Complainant's labia. In the Respondent's view, the smaller shorts had moved into her genital fold. He was shocked and embarrassed. He dropped his hand back, withdrew from that region and did just a few minor strokes. As he did those strokes she reached back with her hand and the Respondent perceived her to be concerned that he was going to reach there again. As a result, he decided it best if the session just ended.

He pulled the towel away, wiped off any excessive massage oil and the Complainant rolled onto her back. She asked about the tight muscle in her butt. The Respondent explained what muscle it was and outlined a stretch for that muscle. He prepared the Complainant's exercise sheet and told her he would like to see her in a month. The Complainant set up the appointment and departed. Two weeks later, the police went to his clinic. He met with them the following Monday. He was advised of the allegations by the Complainant and he provided a statement. The police constable advised him that the Complainant had indicated that she did not wish to press charges but that the file would remain open.

Decision

Pursuant to section 77 of the Code of Conduct - Procedures, the Judicial Subcommittee shall first determine whether the factual allegations have been proven on a balance of probabilities based on clear, cogent and convincing evidence consistent with the seriousness of the matter, and whether the facts proved constitute a breach of the Code of Conduct. An allegation of sexual assault or sexual abuse is a very serious matter and we were mindful of that in coming to our conclusions.

There were differing versions of the facts as between the Complainant and her witnesses, and the Respondent. We have done our best to assess all witnesses' credibility and consider corroborating evidence. In the result, we have reached a unanimous decision as follows.

We find that the Respondent did inappropriately and without her consent touch the Complainant by massaging her vagina and inserting his finger into her vagina.

In the result then, we find that the Respondent has breached the CATA Code of Conduct Sections 3. B (ii), (xvii), (xxii), (xxiii) as follows:

ii. Members shall respect the client's dignity, needs, values, and wishes.

On the basis of our finding that the Respondent wrongfully touched the Complainant's vagina he has failed to respect her dignity, needs, values and wishes.

xvii. Members shall not physically, emotionally or sexually abuse or harass a client or any other person.

Generally speaking, sexual abuse refers to inappropriate and unwanted sexual contact. The Complainant did not invite or consent to the unnecessary massage of her vagina nor the insertion of the Respondent's finger into her vagina. These acts constitute sexual abuse of the Complainant, a client.

xxii. Members shall not engage in conduct that is relevant to the practice of Athletic Therapy that would reasonably be regarded by Members as disgraceful, dishonourable or unprofessional.

The wrongful touching of the Complainant's vagina constitutes conduct relevant to the practice of Athletic Therapy and is disgraceful, dishonourable and unprofessional. This section has been breached by the Respondent.

xxiii. Members shall not engage in conduct unbecoming an Athletic Therapist.

The wrongful touching of the Complainant's vagina constitutes conduct unbecoming an athletic therapist. This section has been breached by the Respondent.

We find that there is insufficient evidence to establish a breach of Section 3. B (ix). Although the positioning of the Complainant during the massage treatment of the adductor muscle group was not ideal, we cannot say that this method was clearly wrong or prevented the Respondent from providing insufficient treatment of the adductor group of the left leg. Further, there was insufficient evidence to establish that the Respondent's draping did not fulfill the generally accepted standard of practice. While

there was no towel placed near the front of the Complainant's genital area, her shorts, made of elastic material constituted an adequate barrier for the sake of working on the adductor muscle group. A prudent and reasonable athletic therapist should have described to the patient any intended diagnostic probing in an intimate area. It is preferred that permission be asked and consent given before embarking on such a diagnostic. The client should have at least been forewarned about it. Although these things were not done, in these circumstances, we do not find a breach of accepted practice. Similarly, while it is preferred practice for an athletic therapist to acknowledge and apologize for any inadvertent contact in an intimate place, in these circumstances we do not find that this failure to acknowledge and apologize for the contact is a breach of generally accepted standards of practice. However, if we had found that the touching was inadvertent, the decisions on these two latter points may have been different.

With respect to Section 3. B (xxi), the law related to sexual abuse or sexual assault is relevant to an athletic therapist's suitability to practice given the trust and intimate nature of the treatment relationship. While 'contravention' means to infringe or transgress a law and may not necessarily require a criminal conviction, on the basis that the Respondent has not been charged with a criminal offence, nor convicted of one we decline to find that he breached that section of the Code of Conduct. This item may be re-visited if a criminal conviction should arise out of this matter.

Reasons of the Judicial Subcommittee

The Complainant presented as a forthright, resolute witness who gave her evidence clearly and consistently. It was in many places corroborated by other evidence and our experience with the practice of athletic therapy.

With respect to her consistency, the Complainant was consistent in her version of events through out this process. We reviewed her Complaint letter (exhibit #3, tab 1), her day timers and journal, and considered her direct testimony and cross examination testimony.

The Complainant described the snugness of her shorts as they were pulled up over her buttocks which created further tightness along the edge of the shorts. She was adamant that at no time did the edge of the shorts ride up into her genital folds; therefore it was a barrier unto itself which would not allow an accidental touch. We examined the shorts and, based on our knowledge of the human body, the position she was in, and our own experience, we accept her evidence on that point. This supports our finding that any contact with her vagina was deliberate.

The Complainant's awkward response to the events in question and attempt to normalize the situation are consistent with the shock she felt as a result of an unwanted and inappropriate touching by someone in whom she had trust.

We accept that the Complainant's actions after she left the clinic were consistent with someone who felt upset and violated. She attempted to call one friend and then was able to reach B.B., immediately describing what happened and then going to B.B.'s house to spend time with her going over the events. She then called her boyfriend and related the same events.

Although we accept that she subsequently called the police and made a statement, we place little weight on that as corroborating evidence because the police officers were not called to testify nor was her statement or that of the Respondent produced in evidence.

The Complainant's daytimer shows the appointment with the Respondent for October 14, 2008, and then a note referring to it as: "* incident". She made a journal entry for October 14, 2008, which is near identical to her oral evidence on the important issues. There are notes on October 15, 2008, and subsequently, in which she further details her hurt and upset by the incident. It was her evidence that these entries were made on the dates indicated.

The Respondent was not consistent throughout this process. There are some inconsistencies between letters provided from him through his counsel versus his oral testimony. The Respondent's resume reports him to have "excellent documentation and report writing skills". However, there is a significant divergence between his oral evidence at the hearing as compared with the response letter from his counsel dated December 5, 2008 (Exhibit #3, tab 6) and in his treatment notes for October 14, 2008 (exhibit #3, tab 12 &13).

The Respondent's oral evidence at the hearing justified his light touching near the Complainant's genital area which then resulted in his advertently touching her labia on the basis that he was doing a diagnostic search to see which adductor was sore.

However, the response letter recounts the incident as follows:

It should be noted that the patient in this particular case had what can only be described as a thin pair of shorts on. Therefore, they easily "rode up" into her genital fold. As he treated her thigh, he inadvertently touched her in the genital area. He was not aware that the shorts had rode up that far and mistakenly assumed, when he was moving his hand up her thigh, in carrying out treatment, that the shorts and the towel would create the appropriate barrier. He could not have anticipated that the barrier was no longer there. My client cannot be blamed for inadvertent touching, particularly when he had taken all appropriate and reasonable precautions against such.

The contents of this response letter were formally stipulated to by the Respondent by letter dated December 11, 2008 (Exhibit 3, tab 8). There is no mention of the diagnostic search as a reason for his being in the area, rather, the letter says that he was continuing to treat the area. In athletic therapy, as in most health disciplines, there is a distinction between "diagnosis" and "treatment".

Also, the Respondent's testimony that he was "doing a diagnostic" is not supported by his treatment notes. On October 14, 2008, his treatment notes (Exhibit #3 tab #12) state: "Flushing deep hams/gluts/groin contacted genital surface draping had shifted into genital fold". These notes indicate that he was still doing his deep massage work, with no mention of any softer "diagnostic" work. This lack of documentation for the diagnostic work must be contrasted with the Respondent's evidence during cross examination. He was questioned about whether he had massaged the Complainant on August 18, 2008. The Respondent stated "I would follow my chart notes and say that if it's not there, I did not do it actually", coincident with the "excellent documentation" skills he listed on his resume.

However, on the day where something has admittedly gone wrong, the Respondent did not mention that he may have changed his massage treatment to “do a diagnostic”. The only logical conclusion here is that he did not, in fact, try to do a diagnostic. He did not provide any explanation as to why the diagnostic was not referenced in his chart notes.

This lack of documentation is compounded by the reasons given by the Respondent for changing his course of conduct on October 14, 2008. He testified that he was trying to find which adductor muscle was continuing to be tight. His assertion that he had to go up to the insertion of the adductors on the pubic ramus to determine which adductor was problematic is not plausible. Massage techniques are done on the muscle belly which is where the tissue that can be helped by massage is located; there was no reason for him to go that high into the tendon. The ability to identify the different adductors by palpating the insertion points is not an accurate, nor a plausible way to evaluate the adductor muscles. There are three of them and, contrary to his evidence, only two of them (the adductor longus and brevis) originate on the pubic ramus. The tendinous attachment points of the two adductors that originate from the pubic ramus are too close together and too thick in nature to accurately discern one from the other at their proximal insertion onto the pubic ramus so there is no reason to be in that area in order to determine which one is problematic. Moreover, the third muscle, the adductor magnus, originates more posteriorly on what is described as the ischial ramus on the Ischium bone. The adductor magnus is the one that the Respondent identifies as the muscle that he thought had the recurring problem and the reason for him going up into that area to “do a diagnostic”. However, the adductor magnus does not attach onto the pubic ramus and therefore, again, if he was looking for problems high up on the adductor magnus he did not need to be in that region where he could touch the Complainant’s labia.

We find that is not plausible for him to have done this diagnostic based on what he has described he was trying to accomplish, where he was trying to do it, and then fail to specifically mention anything about it in his chart for the treatment that he did on that day.

There is no mention of the diagnostic work he claims to have done on October 14, 2008, which resulted in the change in pressure and location of his contact on the Complaint in either his own clinical notes or in his response letter. We find it to be extremely damaging to the Respondent’s credibility that the first mention of diagnostic searching near the Complainant’s vagina occurred during his oral evidence at the hearing.

As indicated above, a prudent and reasonable athletic therapist should have described any intended diagnostic probing in an intimate area, and received assent before embarking on a diagnostic probing in such an intimate area. The client should have at least been forewarned about it. The Respondent provided no explanation as to why no prior communication was made with the Complainant. Instead, if his version were to be accepted, he proceeds in that area with no forewarning to the client and then is so shocked and embarrassed himself at the “inadvertent” touch and her comment that he wants the session to end, he does not ice her and generally thinks it best to have the Complainant leave the clinic.

It is common for athletic therapists to work near the genital area for a variety of problems or injuries and there ought not to be any discomfort on the athletic therapist’s part about working near the region, it is generally considered just another part of the human body.

However, athletic therapists are also trained and aware that their clients may not have the same casual attitude with respect to work being done in that area. As a result, while an athletic therapist is working near the genital area, great care is taken to ensure that no incidental touch occurs and one is acutely aware of the sensitivities of working in the area. In our experience an accidental touch in an intimate area like that is extremely rare. However, if an athletic therapist accidentally causes pain, or in some other way makes surprises and causes discomfort to a client, it is standard practice and common sense for the athletic therapist to acknowledge and apologize for this. With respect to inadvertent contact in an intimate place, it is troubling and negatively impacts the Respondent's credibility when his evidence is that he was too embarrassed to even acknowledge the incident, or to apologize for it then or at any time in the two weeks following the incident before he was contacted by the police.

Following what he describes as a very shocking and embarrassing incident in which he accidentally had his finger on the client's labia and heard her to make a strange comment in response, the Respondent apparently did not tell anyone or consult with any fellow practitioners about how to handle the incident. We say apparently because no one was called by the Respondent to give evidence to the effect that he had consulted about how to handle this incident.

Also, the Respondent asserts that his finger came into contact with the outer portion of the labia because the shorts had "not as much cloth to them" (page 298). However, in our view the Respondent fails to account for the type of material of which the shorts are made. The elastic edge of the shorts (and the elastic nature of the whole of the shorts for that matter) would normally be sitting on the upper part of the thigh/groin area when standing; they would ride up slightly when sitting. Side lying with the knees bent would be a similar position for the femur on the pelvis as it would be with sitting. There would be an angle between the femur and the pelvis where the elastic edge of the shorts would rest. The tighter the shorts are pulled – as they would be when the shorts are pulled up over the gluteal fold, the tighter the band would be around the thigh as it sits below the pubic ramus. They are quite elastic in nature and regardless of the amount of material present; the elasticity of the material would still provide a tension that would make it unlikely to ride up over the bony structure of the pubic ramus. This elastic band would be tight enough that for a finger to touch the vaginal region it would have to be because the finger was consciously worked under this elastic band.

There were other lesser inconsistencies, which do not touch on the fundamental issues of the alleged assault, but which, when combined with the above reasons, lend further support to our conclusion that the Respondent was not credible with respect to the incident.

While admittedly a minor point, in his oral evidence he said he does not use electrical modalities in his treatment as he does not find them effective. However, his "Consent for Treatment" says that he does use electrical modalities in his treatment.

The position that the Respondent placed the Complainant while massaging the adductors was unorthodox. While it may allow the adductors to relax, this was not the reason he had the Complainant in this position. His primary reason to have her in this position was to massage her iliotibial band, hamstring and gluteus muscles. This is born out of the fact that on September 2nd he was using this position for iliotibial band, hamstrings and gluteus muscle massage but was not massaging the adductors at that

time. When the Respondent has the Complainant on her back, he is able to visualize her quadriceps as he is massaging them. When the Complainant is sidelying the Respondent is able to visualize the iliotibial band, the hamstrings and the gluteus muscles as he massages them. By proceeding to massage the adductors while she is still in the sidelying position, the Respondent is massaging an area that he cannot see without some effort, thereby losing clear visual bearing of the location of his hands. His reasoning that he does it in this position to get a better "grip" is not consistent with the action, and not consistent with the nature of massage.

The Respondent testified that he referred the Complainant to Dr Saran for an MRI done on July 25, 2008. The Respondent had Dr. Saran's evaluation and MRI report in his chart (Exhibit 3, tab 12). He reviewed the MRI report with the Complainant during her next session with him. There are a number of contradictions and discrepancies between the testimony of the Respondent and both the evaluation of Dr. Saran and the MRI report. Dr Saran reports a positive McMurray test which indicates a possible injury to the meniscus of the knee, the Respondent said he did this test and it was negative. He then stated that this test is for articular cartilage, when in fact it is a test for the meniscus. Dr Saran also noted normal alignment of her knee and feet, which differs from the Respondent testimony of "she was a pretty significant pronator bilaterally". The Respondent also said that he noticed that she had weak adductors, and internally rotated femurs on the left side "probably due to her pronation". While the Respondent stated the finding of weak adductors, Dr Saran said all muscle testing was normal. While the finding of pronation seemed significant to him, it was only on September 29th, 3½ months after the first visit after her re-injury in June 2008, that the Respondent talks to the Complainant about "medial arch supports for her shoes so as to hopefully help her symptoms there". This is not what we would expect from a self described "foot and lower extremity specialist" as indicated in his resume.

Then, the Respondent wrote a letter to The Actors Fund in Toronto dated September 13, 2008 (Exhibit 3, Tab 12). In that letter he indicated that the MRI results included "a lateral meniscus tear" when the MRI report of July 25, 2008, does not indicate any tear. He further states that it was decided a six month conservative management of vastus medialis and hip abductor strengthening would be undertaken, along with other parameters. There is no indication anywhere in previous notes by the Respondent or in Dr Saran's materials that the Complainant of hip abductor weakness, only hip adductor weakness, although admittedly this could have been a typographical error.

In general, and contrary to his assertions, we do not find his chart notes to contain excellent documentation.

Some comments on the Respondent's demeanour and forthrightness are required.

While certainly not the deciding factor on credibility, it was somewhat disconcerting that during the course of his evidence, he rarely looked up at his counsel when answering questions, and he did not look directly at the Judicial Subcommittee panel at any time.

When specifically asked for a response to the Complainant's allegation that he inserted his finger into her vagina, he did not give a clear and unequivocal denial. He responded: "Other than saying that, you know, I certainly probably would have noticed, but, no, that's not what happened. ... I think I would have noticed. ... Yeah, I did notice that I was not."

Similarly, he was questioned by his counsel about the uncomfortable laugh by the Complainant and his alleged mimicking of the sound. He was asked if he responded in kind. He answered: "I certainly don't recall mimicking, which is the word that I've heard earlier today. So, yeah, I don't -- you know, I don't -- necessarily don't recall chuckling. ... So in terms of a response to it, I -- I -- know, I certainly don't think I made that comment or those comments, if I did, and I don't rightfully recall that I made a comment at all."

The Respondent's demeanour and failure to answer key questions in a direct manner is not determinative of our findings on credibility. It is just another factor which, when taken with all of the evidence including the differences between the response letter, his notes and his oral evidence, lends further credence to our assessment that the Complainant was truthful on the question of the finger in the vagina and the Respondent was not.

In conclusion, for the reasons above, we find the Respondent to have breached the CATA Code of Conduct Sections 3. B (ii), (xvii), (xxii), (xxiii).

Signed in series,

Dave Campbell, CAT(C)
Chairperson, Judicial Subcommittee

Cindy Hughes, B.A. Dip ATM CAT(C)
Judicial Subcommittee

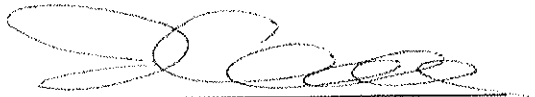
Jamie Rempel, CAT(C)
Judicial Subcommittee

Similarly, he was questioned by his counsel about the uncomfortable laugh by the Complainant and his alleged mimicking of the sound. He was asked if he responded in kind. He answered: "I certainly don't recall mimicking, which is the word that I've heard earlier today. So, yeah, I don't -- you know, I don't -- necessarily don't recall chuckling. ... So in terms of a response to it, I -- I -- know, I certainly don't think I made that comment or those comments, if I did, and I don't rightfully recall that I made a comment at all."

The Respondent's demeanour and failure to answer key questions in a direct manner is not determinative of our findings on credibility. It is just another factor which, when taken with all of the evidence including the differences between the response letter, his notes and his oral evidence, lends further credence to our assessment that the Complainant was truthful on the question of the finger in the vagina and the Respondent was not.

In conclusion, for the reasons above, we find the Respondent to have breached the CATA Code of Conduct Sections 3. B (ii), (xvii), (xxii), (xxiii).

Signed in series,



Dave Campbell, CAT(C) D.O. (Q)
Chairperson, Judicial Subcommittee

Cindy Hughes, B.A. Dip ATM CAT(C)
Judicial Subcommittee

Jamie Rempel, CAT(C)
Judicial Subcommittee

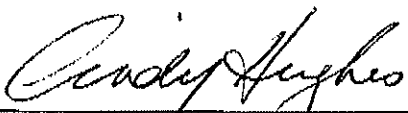
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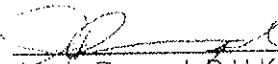
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Dave Campbell, CAT(C)
Chairperson, Judicial Subcommittee

Cindy Hughes, B.A Dip ATM CAT(C)
Judicial Subcommittee



Jamie Rempel, B.H.K., Dip. SIM, CAT(C), CSCS
Judicial Subcommittee