COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
RSA 2000, c H-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. MOHAMMED AL-GHAMDI

FINAL DECISION
OF
THE HEARING TRIBUNAL
OF
THE COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

Hearing Tribunal	**Dr. Eldon Smith** **Mr. Wayne McKendrick**
Independent Counsel to Hearing Tribunal	**Ms. Ritu Khullar, Q.C.*** *as of March 24, 2017 appointed to the Alberta Court of Queen's Bench
Complaints Director Counsel	**Mr. Craig Boyer**
Dr. Al-Ghamdi	**Self-Represented (Until May 2016)**
Counsel for Dr. Al-Ghamdi (Commencing May 2016)	**Mr. Arman Chak**

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I. Introduction

1. This is a sad and difficult case concerning Dr. Mohammed Al-Ghamdi, an orthopedic surgeon in Grande Prairie, Alberta. Dr. Al-Ghamdi is charged with engaging in disruptive conduct over ten years to the detriment of health services. His working relationship with his surgical and nursing colleagues deteriorated to the point that they refused to continue to work with him.

2. Dr. Al-Ghamdi does not deny that the working relationships are broken, but paints a different picture, claiming that he has been the victim of workplace mobbing. He alleges the mobbing has many sources, including: discrimination because of his ethnic origin and religion; retaliation for his raising concerns and complaints about colleagues and practices that, in his view, were not meeting current practice standards; and retaliation for being a patient advocate. In Dr. Al-Ghamdi's view, any difficulties in his working relationships with his colleagues are their fault and the administration's fault for failing to address the issues.

3. For the reasons outlined below, this Tribunal has concluded that Dr. Al-Ghamdi is guilty of the charge of disruptive conduct amounting to unprofessional conduct. This is a sad case because Dr. Al-Ghamdi's lack of insight into his behaviour, and refusal to accept responsibility for the impact of his actions, has impacted his practice as an orthopedic surgeon, a profession for which he has spent years training, cares about deeply, and is skilled in practicing.

4. After summarizing the hearing process and setting out the Charge, this Decision provides a general overview of the evidence, summarizes the parties' arguments, addresses the applicable legal principles, and then addresses the evidence in the context of those legal principles by first dealing with the evidence related to the particulars, then the evidence related to disruptive conduct. While the Tribunal reviewed each witnesses' evidence carefully, much of the evidence was repetitive, and some of it was of questionable relevance. Therefore, in this Decision, instead of summarizing each witnesses' evidence chronologically, the Tribunal addresses the evidences by theme.

II. Hearing Process

5. The hearing regarding Dr. Mohammed Al-Ghamdi's conduct beginning on October 17, 2014 and concluding on September 23, 2016, was conducted pursuant to the *Health Professions Act* ("HPA"). It was held primarily at the offices of the College of Physicians and Surgeons of Alberta ("CPSA") in Edmonton, Alberta. However, several days of the hearing were held in Grande Prairie, Alberta, for the convenience of Dr. Al-Ghamdi and a number of witnesses.

6. Present were:

- Dr. Eldon Smith, Chair;
- Mr. Wayne McKendrick, public member;
- Dr. Peter Jamieson (until December 1, 2014);
- Ms. Ritu Khullar, Q.C., independent legal counsel to the Tribunal;
- Mr. Craig Boyer, legal counsel to the Complaints Director;
- Ms. Fiona Vance substituted for Mr. Boyer on May 15, 2015;
- Dr. Mohammed Al-Ghamdi, investigated person who was self-represented until May, 2016; and
- Mr. Arman Chak, legal counsel to Dr. Al-Ghamdi (beginning in May, 2016).

7. Dr. Al-Ghamdi, a lawyer and a member of the Law Society of British Columbia, chose to represent himself for most of the hearing (all but the last five days).

8. Over 47 hearing days, the Hearing Tribunal ("Tribunal") received evidence from 17 witnesses for the College and 50 witnesses (including Dr. Al-Ghamdi) for Dr. Al-Ghamdi. A total of 276 Exhibits were entered (see Appendix A for a list of witnesses, and Appendix B for a list of Exhibits). From time to time the parties also provided the Tribunal with cases.

9. Over the 24 months of this hearing, the parties made a number of applications, both during the hearing days and between hearing days, by way of written application or telephone conference call. The Tribunal issued written Interim Decisions that are not reflected in the Record. For completeness, these are attached as Appendix C to these reasons.

10. The first of these applications arose on October 17, 2014, the first hearing day. Dr. Al-Ghamdi raised a number of objections, including alleging that the process under the HPA was unfair, the complaint process and investigation were unfair, and there was a reasonable apprehension of bias because of the Tribunal Members' involvement with the health care system or Alberta Health Services ("AHS"). The Tribunal dismissed these objections, and specifically dismissed the allegation of a reasonable apprehension of bias (See Interim Decision #1, paragraphs 28-36). However, the Chair of the Tribunal, Dr. Peter Jamieson, decided to recuse himself based on the procedural evidence heard on October 17, 2014 and "his knowledge of and interaction with, people who had been identified as key witnesses" (para 36 of Interim Decision #1). The Tribunal maintained quorum with the two remaining members (s.16 (3) of the HPA), and the balance of the hearing was conducted with a two member Tribunal.

11. Throughout the hearing, Dr. Al-Ghamdi continued to argue there was a reasonable apprehension of bias. He also repeatedly attacked the Tribunal and the process, and even accused the Tribunal of being corrupt (April 18, 2016 transcript pp. 7625 to 7637). Given the frequency and repetitiveness of such allegations, the Tribunal did not address each and every one when they were raised.

12. In addition to making allegations against the Tribunal, at various times Dr. Al-Ghamdi levelled allegations against Independent Counsel to the Tribunal, Ritu Khullar, Q.C., Counsel for the CPSA, Craig Boyer, and even the court reporter for the proceedings. As these claims rarely gave rise to an actual application from Dr. Al-Ghamdi, the Tribunal generally did not address them.

13. The other particularly significant application Dr. Al-Ghamdi made was for a non-suit at the conclusion of the CPSA's case in December 2015. The Tribunal dismissed this application (Interim Decision #6), and an application to reconsider its non-suit decision (Interim Decision #7).

14. When Dr. Al-Ghamdi disagreed with a ruling, he tended to either re-argue it, or just ignore it. For instance, when the Tribunal dismissed Dr. Al-Ghamdi's applications to declare

witnesses hostile, he cross-examined anyway; when the Tribunal ordered Dr. Al-Ghamdi to advise witnesses that the Tribunal had quashed their Notices to Attend, as far as the Tribunal knows, Dr. Al-Ghamdi did not comply with this direction (see for instance March 8, 2016 transcript, pp. 6885-6886).

III. The Charge

15. The allegations against Dr. Al-Ghamdi were set out in the Notice of Hearing (Exhibit 1), as follows:

> It is charged that:
>
> Since 2003, you have demonstrated a pattern of disruptive conduct in your dealings with a number of your medical colleagues and nursing staff at the Queen Elizabeth II Hospital which has resulted in a breakdown of your professional relationship with those colleagues and staff to the detriment of health services at that hospital, with particular acts being in one or more of the following categories of conduct;
>
> a. failing to participate in and follow the on-call schedule and procedures for orthopedic surgery at the hospital;
>
> b. purporting to have a parallel on-call schedule of your own to try to avoid having to deal with the on-call orthopedic surgeon at the hospital when booking a patient for surgery;
>
> c. failing to cooperate with your medical colleagues and nursing staff to ensure surgical cases were performed on the basis of medical need for urgent care;
>
> d. failing to finish your surgical case in a timely manner while another surgeon was in need of the same operating room to deal with an urgent case;
>
> e. failing to replace the safety cap on used needles/sharps and leaving the item for other staff to deal with and putting that staff person at risk of being poked by the uncapped needle /sharp;
>
> f. cultivating a culture of fear and distrust through making complaints to the Alberta Human Rights Commission, the College and Association of Registered Nurses of Alberta or the College of Physicians & Surgeons of Alberta;
>
> g. cultivating a culture of fear and distrust through threatening to start or starting legal action;

h. cultivating a culture of fear and distrust through recording of a conversation without the knowledge of the person in the conversation;

i. cultivating a culture of fear and distrust through making numerous complaints to administration at the hospital and the health authority;

j. failing to follow the issue/dispute resolution processes set out in the bylaws and policies applicable to hospital medical staff;

k. not obtaining consent for the surgery from your patient until immediately before the procedure rather than when booking patient for surgery creating unnecessary stress and delay;

l. advising patients and other doctors that you were able to book patients at the hospital when you did not have active privileges at the time;

m. having nursing staff open sterilized packs of surgical instruments which were not reasonably required for the procedure at hand and thereby making these instruments unavailable for other surgeons until the nursing staff had re-sterilized those instrument packs;

ALL OF WHICH is contrary to your obligation under the Canadian Medical Association Code of Ethics, including in particular section 52, and Standards of Practice No. 3 and No. 28 established under the Health Professions Act, and as such constitutes unprofessional conduct.

IV. Brief Summary of the Background Context

16. Dr. Mohammed Al-Ghamdi was born and educated in Saudi Arabia, where he completed his medical education. Following this, he completed one year of graduate clinical training in Internal Medicine, and one year of General Surgery training. In 1997 he immigrated to Winnipeg, Manitoba to train in orthopedic surgery. Following completion of the orthopedic residency, Dr. Al-Ghamdi completed one year of Fellowship training in spine surgery at the University of Alberta. He completed this training mid-2003 and accepted a position in orthopedic surgery at the Queen Elizabeth Hospital ("QEII") in Grande Prairie, Alberta. Dr. Al-Ghamdi indicated during his cross-examination of the CPSA's witnesses and during the examination of his witnesses, that he had negotiated effectively with Dr. [redacted] (then Facility Medical

Director) for a contract for his services to the Health Region in order to ensure he would have the facilities and resources necessary for him to effectively perform his responsibilities. Dr. Al-Ghamdi interpreted his 'contract' as unique and without a specific term.

17. Dr. Al-Ghamdi was provided with the usual Provisional Medical Staff Privileges at the QEII and he began his work in July of 2003. After a year, there were already concerns about Dr. Al-Ghamdi's behavior and he was not 'promoted' to the category of active privileges (as would be the norm), but rather had his provisional privileges renewed. In 2005, Dr. Al-Ghamdi again applied for active privileges and, after discussion at the Medical Advisory Committee ("MAC"), a decision was made to conduct a review of his performance and behavior. Legal counsel for the Regional Health Authority and legal counsel for Dr. Al-Ghamdi asked Dr. [redacted], then Registrar of the CPSA, to create a committee to carry out this review. Dr. [redacted] arranged to have two orthopedic surgeons join him to visit Grande Prairie to interview Dr. Al-Ghamdi and others and to make recommendations to the QEII and to the legal counsel for both the Regional Health Authority and Dr. Al-Ghamdi. Their review was completed in late 2006 with the recommendation that Dr. Al-Ghamdi not be provided active privileges without agreement to alter his behaviour. Dr. Al-Ghamdi refused to abide by the recommendations included in the Committee's report and initiated a judicial review in the courts; negotiations with the QEII resulted in there being no action taken in relation to his privileges.

18. Because of ongoing concerns within the management of the QEII, Dr. Larry Olhauser – a healthcare consultant – was asked to review the function of the QEII. His 2006 report was critical of the QEII management. Dr. Al-Ghamdi has pointed to this report to confirm his contention that the QEII is dysfunctional and that he had been focused on trying to improve the level of care at the Institution. While the evidence does point to a vacuum of leadership during this turbulent time of constant restructuring of health care in Alberta, this does not excuse Dr. Al-Ghamdi's behaviour which is described in more detail below.

19. In 2009, the MAC requested that Drs. [redacted] (Chief of Orthopedics) and [redacted] (Chief of Surgery) review Dr. Al-Ghamdi's performance for determination of his privilege status. They compiled a list of all of the issues with Dr. Al-Ghamdi that had been brought to their

attention over a one year period and, on that basis, recommended that Dr. Al-Ghamdi's privileges not be renewed. Apparently, because of the upheaval in the healthcare system caused by the establishment of AHS, no action was taken. Conflict continued between Dr. Al-Ghamdi and his physician and nursing colleagues and with officials of AHS.

20. Because of on-going conflict with Dr. Al-Ghamdi regarding the on-call scheduling, in December 2012 the other members of the orthopedic surgery group declared that they were no longer willing to share the on-call schedule with Dr. Al-Ghamdi, nor cover his patients at night when they were on-call. This precipitated a significant problem for Dr. Al-Ghamdi since the rule established for the operating rooms was that the surgeon on 'official' call had the first right of access to the operating rooms after hours.

21. Dr. Al-Ghamdi did arrange with some Emergency Room physicians to accept their referrals to him for surgery. One evening in July of 2013, Dr. Al-Ghamdi attempted to book such a patient for surgery. However, the in-charge nurse, Ms. Tracy Rice refused to book the patient without the approval of Dr. [redacted], the orthopedic surgeon on-call. In a phone conversation with Dr. Al-Ghamdi, Ms. Rice perceived that he threatened her for not followiug his request. Subsequently, the vast majority of the operating room ("OR") nurses and several physicians signed a petition indicating that they feared for their safety and would no longer work with Dr. Al-Ghamdi. This resulted in AHS's imposition of an Immediate Action whereby Dr. Al-Ghamdi was suspended from the QEII as of August 20, 2013, until a hearing could be held under the provisions of the AHS Medical Staff Bylaws. Dr. Al-Ghamdi has not been able to work as a surgeon since that time.

22. During his time in Grande Prairie, Dr. Al-Ghamdi pursued additional education, which has included an MBA and a law degree (with a period of articling time in British Columbia). Subsequently he completed a Master's Degree in Health Law.

23. Before the Immediate Action, the College had received complaints about Dr. Al-Ghamdi's behavior and had started an Investigation, which was broadened in scope, the results of which resulted in the issue being referred to this Tribunal. Dr. Al-Ghamdi takes issue with the

process the CPSA used leading up to the charge, and with the CPSA's conduct throughout the process, including during the hearing.

24. The concerns about Dr. Al-Ghamdi have not related to his clinical judgement or skills, but rather to his pattern of behavior in his interactions with his colleagues at the QEII in Grande Prairie and with AHS.

V. Parties' Submissions

25. Given the length of the hearing and the number of preliminary applications, including a non-suit motion, by the time it came to make final submissions, the Tribunal had already heard many of the final arguments in earlier form. Nevertheless, with Dr. Al-Ghamdi retaining counsel for the last week of this hearing, it is not surprising that his counsel's arguments had a different focus, though there was overlap with the themes and arguments Dr. Al-Ghamdi had presented earlier. Below, in summary form, are the final arguments each party made, following which, this Decision; and Reasons, addresses the arguments substantively.

A. CPSA's Submissions

26. In closing arguments, Mr. Boyer for the CPSA provided extensive written submissions, case authorities, written summaries of evidence, and oral argument. Cases relied upon and which the Tribunal reviewed were: *F.H. v. McDougall*, [2008] 3 SCR 41; *Walsh v. Council for Licensed Practical Nurses*, [2010] NJ no 61 (SCAD); *Faryna v. Chorny,* [1951] BCJ no 152 (CA); *College of Physicians and Surgeons of the Province of Alberta v. J.H.*, [2008] AJ no 463 QB; *Eggertson v. Alberta Teachers' Assn.,* [2001] AJ No 193 (QB); *Litchfield v. College of Physicians and Surgeons of Alberta*, 2005 ABQB 962; Bryan E. Salte, *The Law of Professional Regulation*, (LexisNexis Canada Inc.: Toronto, 2015); *Liberman v. College of Physicians and Surgeons of Ontario*, 2013 ONSC 4066; *Scalpen v. New Brunswick Real Estate Assn.*, 2007 NBQB 45; *Perron v. Guelph General Hospital*, 2014 ONSC 1032; *Re Sogbein*, [2013] OCPSD no 17; *Alghaithy v. University of Ottawa*, 2012 ONSC 142; *Regina Qu'appelle Regional Health Authority v. Dewar*, 2011 SKQB 392; *Re Amer*, [2011] OCPSD no 28; *Khan v. Scarborough General Hospital*, [2009] OJ no 5437 (Sup Ct); *Coffey v. College of Licensed Practical Nurses of Manitoba*, 2008 MBCA 33; *Coffey v. College of Licensed Practical Nurses of Manitoba*, [2008]

SCCA no 247; *Cooper v. Hospital Privileges Appeal Board*, 1999 ABQB 165; *Bermel v. Registered Psychiatric Nurses Association of Manitoba*, 2001 MBQB 223; *Carr v. Nova Scotia (Board of Dispensing Opticians)*, 2006 NSSC 13; *Toronto East General Hospital v. Gopinath*, 2014 ONSC 2731; *Przysuski v. College of Opticians of Ontario*, [1996] OJ no 611 (Div Ct); *Fang v. Law Society of Alberta*, [2000] AJ no 1031 (CA); *Law Society of Upper Canada v. Crozier*, [2005] OJ no 4520 (Div Ct); *Law Society of British Columbia v. Hall*, 2007 LSBC 26; *Law Society of Upper Canada v. Hornwood*, [2009] LSDD no 77; *Law Society of Alberta re: Grosh* – 2009; *Law Society of Alberta v. Broda* – 2010; *Evans v. Society of Notaries Public of British Columbia*, [2010] BCJ no 1735; *Mundulai v. Law Society of Upper Canada*, [2014] OJ no 6292 (Div Ct); *Riad v. Ontario College of Pharmacists*, [2015] OJ no 5676 (Sup Ct); *College of Physicians and Surgeons of Saskatchewan v. Ali*, [2016] SJ no 56 (QB); *College of Physicians and Surgeons of Manitoba re: Emery*, 2006 CanLII 61072 (MB CPSDC); *Al-Ghamdi v. Alberta*, 2016 ABQB 424; *White Burgess Langille Inman v. Abbott and Halliburton Co.*, [2015] 2 SCR 182; *R. v. Mohan*, [1994] 2 SCR 9; *R. v. Abbey*, (2009), 97 OR (3d) 330; *R. v. Abbey*, [2010] SCCA no 125; *Doré v. Barreau du Québec*, [2012] 1 SCR 395; *Rocket v. Royal College of Dental Surgeons of Ontario*, [1990] 2 SCR 232.

27. After setting some of the legal principles, including the standard of proof being on a balance of probabilities (*F.H. v. McDougall*, [2008] 3 SCR 41), the analytical framework (*Walsh v. Council for Licensed Practical Nurses* [2010] NJ no 61) and how to assess credibility (*Faryna and Chorny*), the CPSA addressed a number of issues Dr. Al-Ghamdi raised throughout the hearing process, including: the nature and specificity of the charge; the sufficiency of and alleged bias of the Investigation; and the sufficiency of the pre-hearing disclosure.

28. After highlighting cases related to expert evidence (*White Burgess Langille Inman v. Abbott and Halliburton Co.*, [2015] 2 SCR 182; *R v Mohan*, [1994] 2 SCR 9), the CPSA began a review of the evidence, and argued that the Tribunal should give little weight to the experts Dr. Al-Ghamdi called, Dr. [redacted] and Dr. [redacted]. The CPSA questioned these witnesses' expertise and independence, and argued that both experts had become advocates for Dr. Al-Ghamdi and were not sufficiently independent.

29. The CPSA then reviewed the evidence and submitted it demonstrated a pattern of conduct and a complete breakdown in the working relationship between Dr. Al-Ghamdi and other healthcare professionals including:

- nurses refusing to work with Dr. Al-Ghamdi in July 2013;
- the orthopedic call group with whom he had practiced refusing to work with him anymore as of December 2012;
- an anesthesiologist refusing to work with Dr. Al-Ghamdi as of December 2012;
- Dr. Al-Ghamdi impugning his colleagues' reputation;
- Dr. Al-Ghamdi not collaborating with his colleagues; and
- Dr. Al-Ghamdi failing to treat his colleagues with dignity and respect.

30. Mr. Boyer noted the similarities between Dr. Al-Ghamdi's conduct and that of Dr. Cooper who was determined to be ungovernable and lost his privileges (*Cooper v. Hospital Privilege Appeal Board*, 1999 ABQB 165).

31. Lastly, the CPSA reviewed the particulars of the charge and acknowledged (properly) where no evidence had been led by the CPSA.

B. Dr. Al-Ghamdi's Submissions

32. Mr. Chak, counsel for Dr. Al-Ghamdi, presented the Tribunal with the following case authorities, which the Tribunal reviewed: *Doron Gersten v. College of Physicians and Surgeons of Alberta*, 2004 AHRC 16; *Fitzpatrick v. Alberta College of Physical Therapists*, 2012 ABCA 207; Research Paper on Charge Sheet Under Administrative Law; *Bharati Law Review*, April – June, 2014; *Visconti v. College of Physicians and Surgeons of Alberta*, 2010 ABCA 250; *Calgary (City) v. Alberta Human Rights and Citizenship Commission*, 2011 ABCA 65; *David Candler v. Capital Health*, 2012 AHRC 5; *Canadian Medical Association Code of Ethics; Peel Law Association v. Selwyn Pieters*, 2013 ONCA 396; *Dr. James Irwin v. Alberta Veterinary Medical Association*, 2015 ABCA 396; *Dr. Ian Macdonald v. Mineral Springs Hospital*, 2008 ABCA 273; *Dr. Henry Swart v. College of Physicians and Surgeons of Prince Edward Island*, 2014 PECA 20; College of Physicians and Surgeons of Manitoba Investigation Committee

Decision – Dr. Christopher Emery (2006); *Dr. Graham Hunter v. College of Physicians and Surgeons of Alberta*, 2014 ABCA 262; *Ontario College of Physicians and Surgeons v. Dr. Stephen Rose James*, 2016 ONCPSD 6.

33. Mr. Chak made oral submissions and referred to a letter he sent the Tribunal dated September 5, 2016, which identified some legal issues and contained a Charter notice alleging breaches of freedom of expression and the right to life, liberty, and security of the person as protected in sections 2(b) and 7 of the *Canadian Charter of Rights and Freedoms*. He raised a number of objections to the Tribunal's jurisdiction to hear the charge against Dr. Al-Ghamdi, and requested that the case be dismissed on this basis. The objections to jurisdiction can be distilled into the following points:

- Because the HPA only took effect in relation to the medical profession in 2009, the Tribunal has no jurisdiction to hear evidence about anything predating 2009, and a charge relating to a pattern of conduct since 2003 was largely statute barred.

- There was no application to formally bifurcate this hearing; therefore the CPSA was obliged by statute to set out what remedy it was seeking against Dr. Al-Ghamdi. Its failure to do so results in a loss of jurisdiction.

- There were three original complaints made to the CPSA, each of which was very specific and narrow. None of them were a complaint about disruptive conduct as set out in the charge. Therefore the Tribunal can only address what was raised in the complaints.

- The investigation process, the pre-hearing process, and the hearing process itself has been an abusive process, with the CPSA abusing its power, as prohibited in the leading case of *Roncarelli v. Duplessis*.
    - The investigation was biased as the investigator had a "closed mind", and because of this breach of procedural fairness, the Tribunal did not have the jurisdiction to proceed with the hearing.

- The charge is vague and overly broad and does not meet the specificity required in *Fitzpatrick v. Alberta College of Physical Therapists*, 2012 ABCA 207, and there was a failure to provide reasonable particulars or timely or adequate disclosure.

- Lastly, "a pattern of disruptive conduct...leading to a breakdown in professional relationships...to the detriment of health services" is not a standard of practice that could give rise to a charge of unprofessional conduct under the HPA.

34. Dr. Al-Ghamdi's counsel also argued that the Tribunal had to respect the other administrative law process in which Dr. Al-Ghamdi was engaged under the *Medical Staff Bylaws* with respect to his privileges. That is, he argued the Tribunal could not reconsider issues that had been litigated in that process as to do so would be an abuse of process and engage the principles of *issue estoppel* and/or *res judicata*.

35. With respect to the evidence, Mr. Chak urged the Tribunal to consider the testimony of Dr. Westhues who gave evidence on the social phenomena of workplace mobbing. In light of his evidence, the facts had to be considered in a different light – that the medical and nursing professionals at the QEII in Grande Prairie were 'out to get' Dr. Al-Ghamdi. He argued that, when the particulars are considered from that perspective, it is clear that Dr. Al-Ghamdi is a victim of unprofessional conduct by his colleagues:

- the on-call schedule situation is one of his colleagues refusing to work with him because they want to marginalize him;

- the parallel on-call was suggested by administration and he tried it once (on July 26, 2013) and after the hassle it caused he did not try it again, but somehow he is the one that is blamed for the situation;

- Dr. Al-Ghamdi is aware of his legal rights and obligations and tends to view the world legalistically, but that does not mean he is cultivating a culture of fear by threatening or starting legal action, he is just protecting himself and his rights that are under attack by others.

36. With respect to some of the other particulars, Mr. Chak pointed out that the question of whether Dr. Al-Ghamdi failed to follow medical staff by-laws was outside the Tribunal's jurisdiction. He also argued that Particular (e) was inappropriate because it is not good medical practice to recap sharps.

37. Lastly, returning to the charge, Mr. Chak argued that there had been no evidence of any detriment to the health services at the QEII as a result of the allegations against Dr. Al-Ghamdi; or if there was any detriment, the other health professionals were responsible because it was they who were ganging up on Dr. Al-Ghamdi. While he urged the Tribunal not to make any findings on the discrimination claims, he asserted that Islamophobia was a fact in Grande Prairie and a relevant factor in understanding the mobbing that has occurred against Dr. Al-Ghamdi.

VI. Conclusion on Applicable Legal Principles

A. Charter Issues

38. Mr. Chak acknowledged that this Tribunal has no jurisdiction to address Charter claims. He then argued that the Tribunal must apply Charter values. While Mr. Chak did not fully develop the argument as to how Charter values apply in this case, the Tribunal takes no issue with the general proposition that in interpreting legislation it must keep in mind Charter values. The Tribunal does not find any inconsistency between Charter values and its conclusions on jurisdictional issues set out below.

B. Objections to the Hearing Tribunal's Jurisdiction

39. As set out above, Dr. Al-Ghamdi has raised a number of objections to the Tribunal dealing with the issues before it. Dr. Al-Ghamdi's Counsel characterized these as jurisdictional objections, and they will be addressed that way.

a) No retroactivity of HPA beyond 2009

40. As noted above, Dr. Al-Ghamdi's Counsel argued the Tribunal has no jurisdiction to deal with any alleged conduct prior to 2009 when the HPA came in to force. This claim is without merit. Section 19 of Schedule 21 of the HPA is a complete answer. This transitional provision provides that any complaint made after the coming into force of the HPA that "relates to conduct that occurred all or partly before the coming into force of this Schedule, must be dealt with under this Act" (s. 19(1)). Section 19(2) makes it clear that the Act applies to Dr. Al-Ghamdi's pre-2009 conduct.

b) Bifurcation of Hearing

41. The Tribunal was not pointed to any authority in the HPA, or otherwise, that requires the CPSA to request a sanction at this stage of the proceedings, or that results in a loss of jurisdiction when it chooses to await the outcome of a Hearing Tribunal's decision before deciding what kind of remedy or sanction it will seek against an investigated member.

42. Section 80(1) of the HPA addresses the Tribunal's decision and states that,

> The hearing tribunal may decide that the conduct of an investigated person does or does not constitute unprofessional conduct.

43. Section 80 does not require a finding on the sanction at the same time. Further, s. 82(1) states, "*If* the hearing tribunal decides the conduct of an investigated person constitutes unprofessional conduct, the hearing tribunal may make one or more of the following orders" (emphasis added). While this section does not mandate the bifurcation of proceedings, since a sanction order cannot flow until a finding of unprofessional conduct is made, bifurcating the proceedings is a logical and practical step. In any event, this Tribunal finds the bifurcation of these proceedings does not raise a jurisdictional issue.

c) Complaints Narrower than the Charge

44. Mr. Chak also argues that the Tribunal only has jurisdiction to hear evidence related to the three original complaints, none of which alleged a pattern of disruptive conduct. The three original complaints as set out in the investigation report were: Dr. [redacted] letter of December

12, 2012; Tracy Rice's letter of September 3, 2013; and Dr. [redacted] letter of August 30, 2013. Mr. Chak argues that the *investigation* could only relate to those letters, and the Tribunal is confined to dealing with these complaints during the *hearing*.

45. The Tribunal rejects this argument. It is necessary to consider the structure of the HPA. Section 54 of the HPA addresses the making of a complaint. A complaint can be made in writing (s. 54(1)), or it can arise by operation of the HPA (s. 54(5)). Section 55 sets out a number of options for the complaints director when deciding what to do with a complaint, one of which is to appoint an investigator (s. 55(2)(d)).

46. The complaints director has a wide scope to go beyond an initial complaint. Section 56 states:

> Despite not receiving a complaint under section 54…if the complaints director has reasonable grounds to believe that the conduct of a regulated member… constitutes unprofessional conduct…the complaints director may treat the information…as a complaint and act on it under section 55.

47. Section 57 also provides for a complaint to arise under a specific set of circumstances in an employment relationship. Specifically, if an employer is of the opinion that an employee has engaged in unprofessional conduct, and that employee is suspended, terminated, or resigns because of that conduct, the employer *must* notify the complaints director.

48. Therefore, the HPA is not solely a complaints driven process. The complaints director has the ability to initiate a complaint based on information that the complaints director reasonably believes could constitute unprofessional conduct, (s. 56), or that an employer believes constitutes unprofessional conduct (s. 57).

49. If a complaint, from a third party or initiated by the complaints director, is referred to investigation, then the scope of the investigation is defined in s. 62 of the HPA. By virtue of s. 62(2), there is no requirement that an investigation be limited to the complaint:

> 62 (1) An investigator may investigate a complaint.

> 62(2) In the course of an investigation under subsection (1), an investigator may investigate matters that are related to the conduct of the investigated person that could give rise to a finding of unprofessional conduct.

50. When an investigation is complete, the complaints director must either refer the matter to a hearing, or dismiss the complaint (s. 66(3)). If referred to hearing, the hearings director must give the investigated person a notice to attend and reasonable particulars of the subject matter of the hearing at least 30 days prior to the hearing (s.77).

51. On a plain reading of the HPA, there is no merit to the argument that an investigation or hearing is confined by the contents of an original complaint by a third party.

52. In this case, the Tribunal heard evidence that the complaints director became the complainant during the course of the investigation. The investigation proceeded to examine whether Dr. Al-Ghamdi had engaged in a pattern of disruptive conduct. Based on the investigation report and the decision to refer the matter to hearing, the hearings director prepared the charge that is before the Tribunal. The Tribunal concluded that it had jurisdiction to hear evidence related to the charge.

d) Abuse of Power/Lack of Fairness in Investigation, Particulars, Pre-Hearing Disclosure

53. A hearing tribunal obtains its jurisdiction when the complaints director refers a matter to hearing under s. 66(3)(a) of the HPA and the hearings director schedules the hearing before a specific hearing tribunal under s. 69 of the HPA. At a hearing, a hearing tribunal receives the Notice of Hearing, and then has jurisdiction to hear evidence relevant to the issues in the Notice of Hearing.

54. During the first day of hearing, the Tribunal was advised that an application in Court of Queen's Bench (Action No. 1404 00589, Judicial Centre Grand Prairie) had been brought by Dr. Al-Ghamdi to, among other things, prohibit the Tribunal from proceeding. A copy of the Originating Notice was entered into evidence and it is apparent that the issues raised here were among the issues raised in that application. The Tribunal was advised that the application was

adjourned, and it never beard about the application again. The Tribunal has not been provided with a Court Order prohibiting the Tribunal from proceeding.

55. Normally, a hearing tribunal would have no knowledge of the investigation process and investigation report unless a party leads evidence about it. As the CPSA noted, it was not relying on the investigation report to prove its case; rather, the report provided notice to Dr. Al-Ghamdi of the case the CPSA would be making. However, during the last week of hearing, Dr. Al-Ghamdi's Counsel entered into evidence a thumb drive which contained the investigation report and other documents (amounting to several hundreds of pages).

56. There are important differences between what occurs during an investigation and what might be presented at a hearing. In this case, when Mr. Chak put the investigation report into evidence, the Tribunal learned that Tracy Rice had made a complaint to the CPSA on September 3, 2013, regarding Dr. Al-Ghamdi, yet, the charge did not include an allegation related to her complaint. Ms. Rice's complaint is therefore not before this Tribunal as the question before it is whether the CPSA has proved, on a balance of probabilities, the charge that is before it.

57. As will be set out below, the Tribunal rejects the argument that there has been an abuse of power or bad faith in the investigation, or pre-hearing procedures in this case.

e) Biased Investigation

58. Dr. Al-Ghamdi argues that the investigation was biased and unfair. He alleges the investigator had a "closed mind" in that he had made up his mind that Dr. Al-Ghamdi was guilty of disruptive conduct and set out to collect information to support this conclusion.

59. The Tribunal's first interim decision dated December 1, 2014 addressed this issue:

> The Tribunal is guided by the principles set out in *College of Physicians and Surgeons of the Province of Alberta v. J.H.*, 2008 ABQB 205. That case concerned a Court application brought by some physicians who were under investigation by the College of Physicians and Surgeons. The physicians sought to stop the investigation because of an alleged unfairness, including bias, in how the investigation was being conducted. In that case, unlike this one, the investigation had yet to be concluded. The Court

> surveyed a number of decisions in this area and the one that seems most applicable is the Manitoba Court of Appeal's decision in *Mondesir v. Manitoba Association of Optometrists*, [1998] MJ 336 (CA). That case concerned a Court application to prohibit a disciplinary hearing from proceeding because of bias during the investigation stage. The Court pointed out that the extent of the duty of fairness fluctuates in relation to the power the administrative body has over the individual. The greater the power of the administrative body over the individual, the greater the duty to act fairly. As an investigator does not make a final decision with respect to discipline, it may not have the same duty to act fairly as a disciplinary hearing body. Further, the Court noted that courts have generally concluded that mistakes made by a first stage investigation can be remedied or addressed at the second stage hearing before a discipline committee. Thus, even if there was some kind of bias during the investigation stage, that did not preclude a fair hearing before a discipline committee (Para 24).

60. As the Court notes in *JH*, the limited duty of open-mindedness at the investigative stage might be breached if the investigator's mind is so closed that any submissions would be futile in that no evidence would change the investigator's mind. However, the Court also noted that, "the concept of 'bias' engages a whole new context when applied to investigators who are not barred from forming an opinion about the case, or from feeling sorry for the complainant or the accused" (paras 80-81). Or as Mr. Boyer argued, it is the investigator's job to form an opinion and to make recommendations arising from the investigation.

61. Early in these proceedings Dr. Al-Ghamdi alleged the investigation was biased because the investigator did not interview witnesses whose statements Dr. Al-Ghamdi believes may have supported him. As a result of a conference call, the Tribunal directed,

> Dr. Al-Ghamdi is to identify in writing to Mr. Boyer any witnesses he thinks are relevant to the issues in these proceedings that should be interviewed by the College but have not been interviewed by the College thus far. He is to provide this no later than January 30, 2015. (Interim Decision #2 dated January 25, 2015).

At that point the hearing was not to resume until April 20, 2015, so there was sufficient time for further investigation. The Tribunal heard nothing further on this point.

62. Further, investigators from the CPSA, Mr. West and Ms. Ivans (who assisted Mr. West), both testified. Dr. Al-Ghamdi extensively cross-examined both. Further, Dr. Al-Ghamdi examined the following additional other representatives of the CPSA involved in the

investigation and referral to: Drs. [redacted], [redacted], and [redacted] He was afforded the opportunity to explore with them the issue of whether the whole CPSA process was biased against him.

63. Even if there were problems with the investigation process as Dr. Al-Ghamdi alleges, which the Tribunal is not deciding, any deficiencies have been cured during this hearing. Dr. Al-Ghamdi had every opportunity to explore with witnesses from the CPSA his defence theory about bias and bad faith. Indeed, he relied on the evidence he obtained to support his argument that he had been the victim of workplace mobbing and that the CPSA had (improperly) been part of the mob out to get him.

f) Vagueness of Charge, Reasonable Particulars and Pre-Hearing Disclosure

64. Dr. Al-Ghamdi raised these issues throughout the hearing and the Tribunal addressed them in the interim rulings. In Interim Decision #1 the Tribunal stated at paras 22-23:

> The Hearing Tribunal heard evidence from the College about its attempts to meet its obligation to provide reasonable particulars to Dr. Al-Ghamdi and/or his counsel by trying to provide the investigation report and the 1880 pages in appendices when requested to do so. It heard evidence from Dr. Al-Ghamdi about his perspective that the College was not responsive and avoiding providing the particulars in that he had not received the appendices to the Investigation Report in a timely manner.
>
> What is clear, and without assigning responsibility, is that when Dr. Al-Ghamdi received the complete Investigation Report with its over 1800 pages in appendices there were less than thirty (30) days until the hearing date of October 17, 2014. Section 77 of the HPA is clear that the Hearings Director must "at least 30 days before the hearing, give the investigated person a Notice to Attend and give reasonable particulars of the subject matter of the hearing". The 128 page Investigation Report was in the possession of Dr. Al-Ghamdi's counsel in April 2014 but the approximately 1800 pages in appendices were not. Dr. Al-Ghamdi received a CD with the appendices on September 26, 2014 but it was password protected and he did not receive the password until a couple of days later. As such, the Hearing Tribunal agrees with this objection raised by Dr. Al-Ghamdi that he did not receive the appendices at least 30 days before October 17, 2014.
>
> As a remedy, at the conclusion of the hearing, the Hearing Tribunal ordered that the hearing be rescheduled for a time period not less than thirty (30) days from October 17, 2014, to ensure that Dr. Al-Ghamdi had ample time to review all of the documentation he has received prior to this hearing resuming.

> The College provided the Hearing Tribunal with some authorities about the nature of the obligation to disclose particulars, and what is required to be disclosed. The Hearing Tribunal agreed that the obligation to provide "reasonable particulars" means that a complainant must receive sufficient disclosure to ensure she or he can properly prepare a defense to the allegations, but does not require disclosure of all evidence to be relied on: *Eggerston v. Alberta Teachers' Assn.*, 2001 ABQB 116 at para 29-31; adopted in *Litchfield v. College of Physicians and Surgeons of Alberta,* 2005 ABQB 962 at para 69. At this stage the Tribunal understands that Dr. Al-Ghamdi's issue related to the receipt of the appendices of the investigation report and that issue has been resolved by the Hearing Tribunal's order regarding the rescheduling of the hearing.

65. As a result of Dr. Al-Ghamdi's further interim application relating to, among other things, further particulars, the Tribunal noted the following on April 20, 2015 during the hearing:

> With respect to the request 1 and 2 for full disclosure and more detail in the charges, the Hearing Tribunal has two responses. First we would note that this Hearing Tribunal has already decided on the issue of disclosure. In our preliminary decision dated December the 1st, 2014, paragraph 23, we stated that we believe that the obligation to provide reasonable particulars means that a complainant must receive sufficient disclosure to ensure he or she can properly prepare a defence to the allegation, but does not require disclosure of all evidence to be relied on.
>
> We remain satisfied that this is an accurate statement of the obligations of the College for disclosure. We understand from the exchange of correspondence reviewed and the record already before us that Dr. Al-Ghamdi has received the following: The complete investigation report and all appendices; a letter from Mr. Boyer dated January the 27th, 2015, which specifies which sections of the Canadian Medical Association Code of Ethics and Standards of Practice established under the HPA, are engaged by the allegations in the Notice of Hearing; a letter from Mr. Boyer dated March 26th, 2015, which provides notice of the witnesses scheduled for the week of April 20th to 24th, 2015; a letter from Mr. Boyer dated April the 8th, 2015, containing an overview of the anticipated evidence from each of the witnesses scheduled to testify the week of April the 20th, 2015; and finally a letter from Mr. Boyer dated April the 13th, 2015, providing a breakdown of which paragraph numbers from the investigation report relate to which particulars in the Notice of hearing.
>
> The Hearing Tribunal takes no position as to whether the level of detail provided is required by law. It is satisfied that Dr. Al-Ghamdi has received sufficient disclosure in these proceedings. As such, for all the reasons set out above, Dr. Al-Ghamdi's request was rejected by the Hearing Tribunal, and we now ask the College to open its case.

66. The Tribunal again addressed these and related issues in Interim Decision #3, August 17, 2015, at paragraphs 20-23.

67. In addition, charges of unprofessional conduct do not have to meet the standard of a criminal indictment (*Lieberman v. College of Physicians of Ontario* 2013 ONSC 4066; *Sealpen v. New Brunswick Real Estate Association*, 2007 NBQB 45).

68. Mr. Chak pointed to the Alberta Court of Appeal's decision in *Fitzpatrick and Alberta College of Physical Therapists,* 2012 ABCA 207, to support his argument that a charge must be specific:

> The need to prove the specific allegations set forth in a charge of misconduct comes from the nature of the proceedings. While disciplinary proceedings of professionals are civil in nature, and the civil burden of proof applies, the fact that a charged member may face serious consequences from a finding of misconduct has prompted the courts to be rigorous in relation to such charges. First, the charge of citation alleging misconduct must be specific so that the charged member knows the case that must be met: *Visconti v. College of Physicians and Surgeons of Alberta*, 2010 ABCA 250. Second, all of the elements of the charge must be strictly proven. -
>
> ...
>
> To emphasize the rigor with which the second principle is applied, misconduct discovered during the disciplinary hearing, but does not fall within the charge, will not provide a basis for sanction. (paras 17 and 19).

69. In addition, the Court made the following observation with respect to the particulars of a charge:

> The case stands for the proposition that it is not necessary to prove all of the particulars alleged to support a finding of misconduct. It is enough to prove a sufficient number of particulars that support the charge when considered in their totality. The same logic applies here (para 35).

70. The Tribunal finds that the charge and the disclosure of reasonable particulars were specific enough to give sufficient notice to Dr. Al-Ghamdi. This will be demonstrated when the evidence in relation to the charge and the particulars is reviewed. Dr. Al-Ghamdi was able to put in a defence to the charge.

g) Charge of Disruptive Conduct not found in HPA

71. The main thrust of Dr. Al-Ghamdi's argument in this regard was that the HPA does not contemplate the charge. According to Mr. Chak, the HPA defines unprofessional conduct in s. 1(pp)(ii). Section 1(pp) defines unprofessional conduct as: "one or more of the following, whether or not it is disgraceful or dishonourable". There are numerous subsections of (pp) illustrating examples of unprofessional conduct; specifically (ii) states: "contravention of this Act, a code of ethics or standards of practice". Mr. Chak submits that, since a prohibition on disruptive conduct is not found in the code of ethics or standards of practice, there is no basis for making a finding of unprofessional conduct in this case. In support of this argument, Mr. Chak points to *Walsh v. Counsel for Licensed Practical Nurses,* 2010 NLCA 11, which suggests that the following steps apply when determining whether there has been unprofessional conduct:

1. make findings of fact in relation to the conduct that must be placed under the professional misconduct microscope;
2. identify the standard of conduct that is expected of the professional in the factual circumstances at issue; and
3. apply that identified standard to the established events that have occurred.

72. The Tribunal agrees that it is important to identify the standard of conduct expected of the professional. In *Walsh,* the Court observed that the standards can come from a written code of conduct, or evidence of common understandings within the profession as to what is expected of a reasonable professional in the circumstances, or by way of logical deduction from the fundamental values of the professional body itself. The Court observes:

> Professional standards by their nature are designed to influence behaviour to ensure professional competence and consistency. Adherence to establish standards is the essence of a profession. To achieve that purpose, the standards must be known or ascertainable, or at least capable of being deduced in advance. That can be accomplished either by the professional body exercising its rule making authority to establish written standards of practice, or by reference to the "professional culture" itself. A discipline tribunal must therefore search for a source of standards external to itself; the personal opinions of the members of the tribunal are not necessarily the same as the common expectations of the profession (para 41).

73. In this case, the CPSA identified in the original charge some of the standards of practice that it says were engaged. Further, it provided a letter to Dr. Al-Ghamdi dated January 27, 2015 (Exhibit 270) which expanded on which elements of the Code of Ethics and Standards of Practice were engaged.

74. Fundamentally however, the Tribunal disagrees with the assertion that only s. 1 (pp)(ii) of the HPA defines unprofessional conduct. Section 1(pp) as a whole offers many examples of what can amount to unprofessional conduct. Specifically, s. 1(pp)(xii) refers to "conduct that harms the integrity of the profession". It seems that such a broad definition leaves scope for what the Court of Appeal in *Walsh* described as "professional culture" itself – and it would be fair to say that it is well accepted in the professional culture in Alberta that disruptive conduct can amount to unprofessional conduct.

75. The CPSA provided cases on the topic of disruptive conduct and ungovernable conduct, and presented cases demonstrating the kind of conduct that various adjudicative bodies have concluded amounts to a disruptive pattern of conduct:

Perron v. Guelph General Hospital, 2014 ONSC 1032
Re Sogbein, [2013] OCPSD no 17
Alghaithy v. University of Ottawa, 2012 ONSC 142
Regina Qu'appelle Regional Health Authority v. Dewar, 2011 SKQB 392
Re Amer, [2011] OCPSD no 28
Khan v. Scarborough General Hospital, [2009] OJ no 5437 (Sup Ct)
Coffey v. College of Licensed Practical Nurses of Manitoba, 2008 MBCA 33
Coffey v. College of Licensed Practical Nurses of Manitoba, [2008] SCCA no 247
Cooper v. Hospital Privileges Appeal Board, 1999 ABQB 165
Bermel v. Registered Psychiatric Nurses Association of Manitoba, 2001 MBQB 223
Carr v. Nova Scotia (Board of Dispensing Opticians), 2006 NSSC 13
Toronto East General Hospital v. Gopinath, 2014 ONSC 2731
Przysuski v. College of Opticians of Ontario, [1996] OJ no 611 (Div Ct)

Or an ungovernable pattern of conduct:

Fang v. Law Society of Alberta, [2000] AJ no 1031(CA)

Law Society of Upper Canada v. Crozier, [2005] OJ no 4520 (Div Ct)

Law Society of British Columbia v. Hall, 2007 LSBC 26

Law Society of Upper Canada v. Hornwood, [2009] LSDD no 77

Law Society of Alberta re: Grosh – 2009

Law Society of Alberta v. Broda – 2010

Evans v. Society of Notaries Public of British Columbia, [2010] BCJ no 1735 (SC)

Mundulai v. Law Society of Upper Canada, [2014] OJ no 6292 (Div Ct)

Riad v. Ontario College of Pharmacists, [2015] OJ no 5676 (Sup Ct)

College of Physicians and Surgeons of Saskatchewan v. Ali, [2016] SJ no 56 (QB)

76. The cases provide examples of disruptive conduct, including:

- Behaviour that continues even when advised that it is inappropriate;
- Lawsuits against colleagues and complaints against colleagues;
- A professional's complaints about their colleagues' abilities and competence, making it difficult to work with the professional;
- A professional's pattern of deflecting responsibility by blaming colleagues;
- A professional's failure to respect the administration's authority to deal with issues affecting physicians, and by implication, patients;
- A professional's constant attempts to undermine practices at a hospital, creating tension and undermining collegiality.

77. With respect to such conduct, it is not necessary for the specifics of time and place to be set out in the charge if a pattern of behaviour is displayed over time (*Perron v. Guelph General Hospital*, 2014 ONSC 1032; *Alghaithy v. University of Ottawa*, 2012 ONSC 142; *Sogbein* [2013] OCPSD no 17).

78. In addition, in the fall of 2010 the CPSA published a Guidance Document, "Managing Disruptive Behaviour in the Healthcare Workplace". This Guidance Document is an explicit reflection of the professional culture in Alberta in terms of what is acceptable or unacceptable conduct. It offers the following relevant illustrations of disruptive conduct, which can be passive and difficult to identify:

- An enduring pattern of conduct that disturbs the work environment;
- Behaviour that is uncooperative, contentious, or litigious;
- Refusals to comply with known and accepted practice standards;
- Chronic refusal to work collaboratively with colleagues, staff and patients; and
- Failure to respond to calls for assistance and persistent lateness.

79. In conclusion, unprofessional conduct defined in s.1(pp), references standards of practice or codes of ethics, and conduct, which harms the integrity of the profession. The Tribunal is satisfied that the charge of disruptive conduct as articulated in this case, engages the definitions of unprofessional conduct. It is against this standard that the evidence will be evaluated.

h) Res Judicata and Issue Estoppel

80. Dr. Al-Ghamdi raised a *res judicata* and *issue estoppel* argument based on other proceedings between himself and AHS in relation to his hospital privileges. He argues that the same facts are at issue before this Tribunal and the Tribunal should not adjudicate on issues that have already been determined by another tribunal. Two cases were referred to in support of this position: *Calgary v. Alberta (Human Rights and Citizenship Commission)*, 2011 ABCA 65, and *BC (Workers' Compensation Board) v. Figliola*, 2011 SCC 52.

81. In *Calgary v. Alberta* the Court reviewed the concepts of *issue estoppel* and *res judicata* and discussed how the two concepts promote finality by preventing the re-litigation of disputes already decided. There are three things that must be shown for *res judicata* or *issue estoppel* to apply:

1. The same question has been decided in earlier proceedings;

2. The earlier judicial decision was final; and
3. The parties to that decision or their privies are the same in both the proceedings.

82. The Court said that once all three preconditions are met, the principles are engaged, although a court has a residual discretion whether to apply the doctrine in a particular case. Usually, the doctrines are invoked when the prior decision is from a court, but it can also be invoked when the prior decision is from another administrative tribunal. The discretion not to apply the doctrine is exercised more broadly in this latter situation.

83. The Court went on to comment about the related concept of abuse of process that can apply if the test for *res judicata* or *issue estoppel* is not strictly met:

> Canadian courts have applied the doctrine of abuse of process to preclude relitigation in circumstances where the strict requirements of issue estoppel (typically the privity/mutuality requirements) are not met, but where allowing the litigation to proceed would nonetheless violate such principles as judicial economy, consistency, finality and the integrity of the administration of justice.
>
> Citing the Supreme Court of Canada in *Toronto (City) v. CUPE* at para 33.

84. The Court of Appeal emphasized that the focus of the inquiry should be on preserving the integrity of the administration of justice.

85. In *Figliola* the Supreme Court of Canada confirmed the three part test noted above, and emphasized the importance of finality in litigation. With respect to the broader concept of abuse of process, the Court noted the principles at play:

- It is in the interests of the public and parties that the finality of a decision can be relied upon;
- Respect for the finality of an administrative decision increases fairness and the integrity of the process; re-litigation undermines fairness and the integrity of the first decision;
- Parties should not circumvent review or appeal mechanisms by using another forum to challenge an administrative decision;
- Avoiding unnecessary re-litigation saves resources (para 34).

86. While this Tribunal has been told on many occasions that there are concurrent proceedings with AHS, it was never provided with any documentation in relation to those proceedings until the final week of hearing. At that time, the Table of Contents for the "Alberta Health Service Medical Staff Bylaws Hearing, Committee Report and Recommendations" was entered as an exhibit in these proceedings. The Tribunal specifically asked counsel for both parties whether it should have available to it the full Decision of this Committee Report and Recommendations, instead of just the table of contents showing there was a 140 page decision. Both parties said they did not want the Tribunal to review this decision.

87. Based on the limited information available to the Tribunal, it finds the doctrines of *res judicata, issue estoppel* and/or abuse of process do not apply in this case to preclude the Tribunal from adjudicating on the charge before it.

88. First, the parties are not the same. In the other matter the parties are AHS and Dr. Al-Ghamdi. In this case the parties are the CPSA and Dr. Al-Ghamdi.

89. Second, the Tribunal does not know if the earlier decision is final. It is a Committee Report and *Recommendation.* The Tribunal does not know if this recommendation is binding.

90. Third, it does not appear that the same question was before both tribunals. If the AHS proceedings were an appeal of the Immediate Action, then the Tribunal is inclined to *presume,* but cannot know without reading the decision, that the questions focused on the event leading to the Immediate Action: the incident and conversation between Dr. Al-Ghamdi and Tracy Rice on July 26, 2013 and the subsequent petition signed by many nurses and doctors saying they would no longer work with Dr. Al-Ghamdi.

91. The question before this Tribunal is whether Dr. Al-Ghamdi engaged in a pattern of disruptive conduct between 2003 and 2013 at the QEII in Grande Prairie. The Tribunal notes that while it heard evidence about the July 26, 2013 conversation between Dr. Al-Ghamdi and Tracy Rice and the subsequent petition signed by many, this incident does not form one of the particulars supporting the charge. In fact, until Mr. Chak raised it in closing argument, this

Tribunal did not know that Tracy Rice had made a complaint to the CPSA about this incident. While the Tribunal does *presume* the evidence in relation to this incident was common to both proceedings, it also heard a lot of other evidence. While the Tribunal has a list of the witnesses who testified in the other proceedings, it has no idea what other evidence the other tribunal heard. In any event, this Tribunal is satisfied that the legal question of whether Dr. Al-Ghamdi is guilty of unprofessional conduct as charged is one that only this Tribunal can determine, and it will proceed to do so.

92. Lastly, from what little the Tribunal understands about the other proceeding, it does not see how these proceedings dealing with the allegation of unprofessional conduct can be seen as undermining the other tribunal or as a collateral attack on the decision of another tribunal. Sometimes the same conduct can be the subject of more than one proceeding (*R. v. Wigglesworth*, [1987] 2 SCR 54). In this case, some of the conduct involving Dr. Al-Ghamdi would have been the same in both cases. But the Tribunal does *presume* that the scope of the pattern of disruptive conduct alleged in this case is broader than the conduct in the other proceeding.

C. Other Legal Issues

a) Exclusion of Exhibit 186

93. Exhibit 186 is the Health Quality Counsel of Alberta ("HQCA"), Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care in Cancer Surgery and the Role and Process of Physician Advocacy, February 2012. Dr. Al-Ghamdi originally tendered this exhibit during the examination of his witness, Janet Loseph. The CPSA objected to the admissibility of this report based on the *Alberta Evidence Act.*

94. In light of the fact that the HQCA report is made under the auspices of Section 9 of the *Alberta Evidence Act*, the quality assurance provisions, the Tribunal agreed to exclude Exhibit 186 and said it would provide reasons for its decisions afterwards.

95. Section 9 of the *Alberta Evidence Act* creates an exclusionary rule for certain categories of information. The type of information that is excluded is information gathered to improve

quality of care. During investigations to improve that quality, parties are encouraged to share information and be frank about what has happened and how matters can be improved. To facilitate that process, the Legislature provides this protection to the collection of that type of information.

96. What was clear in the document previously marked as Exhibit 186 was that the investigation was to be "by an appointed Quality Assurance Committee" ("QAC") of the Health Quality Counsel of Alberta, and was conducted in accordance with section 9 of the *Alberta Evidence Act"* (p. 146).

97. Further, the Tribunal regarded the Alberta Court of Queen's Bench's interpretation of s. 9 in *Bruce Estate*, 2010 ABQB 21, in which the Court held that s. 9(2) prohibits quality assurance records from being admitted into evidence whether or not the document had previously been made public. It became clear that, while this report had initially been accepted as Exhibit 186, it was inadmissible by law and the Tribunal ordered it removed from the record.

b) Expert Witnesses

98. The CPSA objected to Dr. Al-Ghamdi's expert witnesses. The CPSA objected when Dr. Al-Ghamdi sought to qualify a compelled witness, Dr. [redacted] as an expert without speaking to him first and without notice to the CPSA. However, the primary objection was to Drs. [redacted] and [redacted], in that they were not neutral experts, but advocates for Dr. Al-Ghamdi in the sense by the Supreme Court of Canada disapproved of in *White Burgess Langille Inman v. Abbott and Haliburton Co.*

99. While Dr. Al-Ghamdi did not have Dr. [redacted] confirm that he would be objective and do his best to give an unbiased opinion, Dr. [redacted] did make such statements on cross-examination. The CPSA's more significant argument is that Dr. [redacted] evidence should be excluded because he is Dr. Al-Ghamdi's friend and Dr. Al-Ghamdi is his agent in a court proceeding against the Canadian Medical Protective Association ("CMPA"). Indeed, Dr. [redacted] referred to himself, Dr. Al-Ghamdi, and one other as the three musketeers in a fight against the CMPA.

100. The CPSA challenged Dr. [redacted] expertise in workplace mobbing and his impartiality as he only reviewed the materials Dr. Al-Ghamdi provided, and he testified that he only agrees to be an expert when he believes someone has been the victim of workplace mobbing.

101. In *White Burgess,* the Supreme Court of Canada required tribunals to consider the nature and extent of the interest or connection between the proposed expert and the party tendering the expert, and whether this relationship would interfere with the expert's primary duty to provide a fair and non-partisan objective opinion.

102. Ultimately, the Tribunal accepted Dr. [redacted] as an expert in being a hospitalist and as a family physician with expertise in emergency care, and as a family physician with an interest in geriatrics. The Tribunal also accepted Dr. [redacted] as an academic sociologist qualified to give evidence on the social phenomenon of workplace mobbing, its definition, its culture, its descriptions and symptoms and how to remedy it. He was also qualified to comment on the alleged charge of disruptive behaviour, assuming the proper factual foundation had been established. Lastly; the Tribunal noted Dr. [redacted] experience is primarily in workplace mobbing in academia, and that he has less experience in the healthcare setting, particularly regulated health professionals.

103. The concerns the CPSA raised about the impartiality of the witnesses, or lack thereof, are considered in the weight given to the experts' evidence.

VII. Decision

104. On the balance of probabilities, the Tribunal finds Dr. Al-Ghamdi guilty of engaging in a pattern of disruptive conduct in his dealings with medical and nursing colleagues at the QEII. This pattern of disruptive conduct resulted in a breakdown of his professional relationships with those colleagues, to the detriment of the health services at that hospital .....all of which is contrary to his obligations under the Canadian Medical Association Code of Ethics, including in

particular section 52, and the CPSA's Standards of Practice; *Collaboration in Patient Care; Standard 3)* and *Job Action; Standard 28* established under the HPA, and harms the integrity of the profession, and as such constitutes unprofessional conduct.

105. To explain its conclusion, the Tribunal begins by addressing the evidence in relation to each of the Particulars of the charge and then in relation to the disruptive conduct allegation. Then, the Tribunal provides its Reasons for finding Dr. Al-Ghamdi guilty of disruptive conduct, and lastly addresses how this amounts to unprofessional conduct.

A. The Particulars

106. As was set out above, Dr. Al-Ghamdi is charged with disruptive conduct. The charge sets out 13 particular examples of disruptive conduct. Below, the Tribunal reviews the evidence with respect to each of these particulars and determines which particulars have been established.

(a) Failing to participate in and follow the on-call schedule and procedures for orthopedic surgery at the hospital

(i) CPSA's Evidence

107. "On-call" is a system to ensure physician coverage of their own patients as well as physician coverage of patients presenting at the Emergency Department who are "unattached" to a physician or specialist and who may require specialty physician services. The principle of "on-call" is that these services are shared between a group of physicians so that, individually, they can be assured that their patients will be cared for when they themselves are not available, and, collectively, the workload can be equitably shared and each of the physicians in the group can have equitable access to new patients who enter the hospital through the Emergency Department.

108. Dr. Al-Ghamdi's own contract with the Health Region required him to "comply with all reasonable on-call requirements of the QEII, the Region and Medical Staff, such not to exceed 1 day in 4 including two days of weekend coverage in 4 weeks, unless otherwise agreed by the parties."

109. The Tribunal heard testimony that all of the orthopedic surgeons except Dr. Al-Ghamdi wanted an on-call schedule that was simple, equitable and predictable. It was Dr. Al-Ghamdi's view that the on-call schedule should be established quarterly on the basis of his and others' available and unavailable dates.

110. Dr. [redacted] told the Tribunal that, prior to 2010, the on-call schedule required each surgeon to be on-call on a rotating "one-in-four weeks" basis. In 2010 the system was changed so that each surgeon would provide on-call duties on a rotating "one-in-four days and every fourth weekend" basis. Each surgeon was assigned a specific day each week to be on-call. Although Dr. Al-Ghamdi approved of the one-day-in-four rotation, he did not approve of the fixed day per week rotation, but rather wanted to have each day of each week scheduled according to availability. However, this new scheduling arrangement, with the fixed day per week for each participant, was acceptable to the other orthopedic surgeons in the group and to Dr. Al-Ghamdi on those months when he had no disagreement.

111. The Tribunal heard that, while there were some conflicts over the years regarding Dr. Al-Ghamdi's involvement in the on-call system, the conflicts increased following his commencement of law school in 2008. Dr. Al-Ghamdi did not inform the other surgeons in the group that he was attending law school, and that this would make him unavailable for his on-call coverage from time to time (he testified that this was none of his colleagues' business).

112. After beginning his law studies, Dr. Al-Ghamdi initially did his slate of surgical patients on his assigned day (Wednesday) and then asked Dr. [redacted] to care for these patients post-operatively while he went to Edmonton to attend Law School. When it became clear that this was becoming a standard procedure, Dr. [redacted] objected. After this, Dr. Al-Ghamdi asked a Family Physician to care for his patients post-operatively. Much of the time this seemed satisfactory but on occasion one of Dr. Al-Ghamdi's patients would develop complications, requiring one of the other orthopedic surgeons to be called.

113. When Dr. Al-Ghamdi was on-call, however, he objected to seeing the patients of the other orthopedic surgeons unless they formally handed over care to him, a step they refused to take.

114. According to the testimony of Drs. [redacted] and [redacted], the other orthopedic surgeons were of the view that each individual physician is obligated to arrange coverage if they are unable to meet their on-call schedule responsibilities. This was also the view of most of the other physicians who testified before the Tribunal. In spite of these requirements and obligations, Dr. Al-Ghamdi was of the view that if he could not be available for his on-call schedule, he simply had to advise his colleagues, the Medical Staff Office at the Hospital, and / or the Departmental Clinical Chief, and it would then be their responsibility to arrange the necessary changes to the on-call schedule to ensure coverage. Dr. [redacted] testified that Dr. Al-Ghamdi wanted to submit the days he would be available to work rather than advising which days he needed to be away and making arrangements with others to cover those days. Testimony and documents show that other practitioners in the group did not accept Dr. Al-Ghamdi's position and that they made it clear to him that arranging coverage was his responsibility.

115. Dr. [redacted] testified that, by late 2012, the other orthopedic surgeons had reached the conclusion that they did not trust Dr. Al-Ghamdi's professional integrity or anything that he said with respect to the on-call schedule, or any other matter.

116. Dr. Al-Ghamdi attempted to have conflicts over on-call schedules resolved by the clinical chief or others at a higher level in the organization, including Dr. [redacted] as Facility Medical Director at the QEII, Dr. [redacted] as Chief of Surgery and even senior individuals in AHS. These individuals refused to become involved in resolving such conflicts on the basis that it was up to the group of surgeons to do so, and in particular it was the individual surgeon's responsibility to contact his colleagues to arrange coverage when he would not be available. The AHS Medical Staff Bylaws and the AHS Medical Staff Rules both require the individual practitioner to be responsible for ensuring coverage.

117. On July 19, 2010, Dr. Al-Ghamdi refused to provide on-call services for that week based on his position that he had not agreed to the change in schedule which resulted in his week being changed. This sudden refusal by Dr. Al-Ghamdi to be on-call required Dr. [redacted] to take that week of call, despite the fact that he was in the process of retiring and had not been on-call for over a year.

118. The conflicts over on-call came to a head in December 2012 when Dr. Al Ghamdi was again accused of "abandoning his call". Dr. [redacted] testified that, in an email to Dr. [redacted] CEO of AHS, Dr. Al-Ghamdi refused to fulfill his on-call obligation for the month of December, 2012. Dr. [redacted] confirmed this in his testimony. This resulted in the other surgeons having to cover for him, and for two of the surgeons this meant cancelling planned holidays. The four orthopedic colleagues (including Dr. [redacted] who was in the process of retiring) signed a letter sent to Dr. Al-Ghamdi, with a copy to Dr. [redacted], indicating that they would no longer participate in an on-call schedule with him. On December 12, 2012, Dr. [redacted] sent a letter to the CPSA accusing Dr. Al-Ghamdi of unprofessional conduct for his sudden cancellation of his on-call obligations.

(ii) Dr. Al-Ghamdi's Evidence

119. Dr. Al-Ghamdi testified that, in his view, *if* he agreed to a schedule, then he was responsible for providing on-call coverage, and that *if* he had not agreed to the schedule then he was not obligated to ensure coverage should he be unavailable. Moreover, Dr. Al-Ghamdi took the position that if he notified the Medical Staff Office well in advance that he was unavailable (Dr. Away Notification), he had discharged his responsibility.

120. Dr. Al-Ghamdi also referred to a 2010 complaint to the CPSA that Dr. [redacted] had brought against him relating to the call schedule, which the CPSA dismissed.

121. The evidence was that there was not a process to ensure that all of the surgeons formally agreed to every on-call schedule, and the Tribunal heard evidence that the on-call schedules were not always communicated well in advance.

122. Dr. Al-Ghamdi accused the other surgeons in the group of conspiring to make things difficult for him. He pointed out that the other three orthopedic surgeons all worked together in one office where they could meet frequently and make decisions that excluded him. However, Dr. [redacted] testified that the office meetings dealt only with issues related to the office practice and not those involving the QEII.

123. Dr. Al-Ghamdi also pointed out that there were no regular meetings of the Orthopedic Department members and argued that there should have been regular meetings to discuss the on-call schedule and other issues. Dr. [redacted] and Dr. [redacted] both testified that having such meetings were difficult; frequently Dr. Al-Ghamdi would indicate that he was not available for such a meeting and would request a date change. When such meetings did occur, agreement was usually not reached with Dr. Al-Ghamdi.

124. Dr. Al-Ghamdi called Dr. [redacted] who described the on-call system for pediatrics. There are four physicians in the Pediatrics group, all visible minorities, and they work one night in four and every fourth weekend. If someone needs time away, that person will switch on-call schedules with another person in the group. This on-call system works for that group. This indicates that the call schedule called for by the orthopedic surgeons can work efficiently.

125. Regarding the on-call schedule for September of 2012, Dr. Al-Ghamdi had indicated that he would not be available. He saw a draft of the schedule and he was not listed for call on the respective Wednesdays. However, a revised schedule was produced on September 5 that indicated that Dr. Al-Ghamdi was scheduled to be on-call for three Wednesdays that month (his usual on-call day). Dr. Al-Ghamdi contacted Dr. [redacted] and Dr. [redacted] to complain about this.

126. The on-call schedule for October 2012 included Dr. Al-Ghamdi and he agreed with this so he completed his days of on-call as scheduled. When the December on-call schedule was discussed, Dr. Al-Ghamdi indicated that he was unavailable for December 20 and for January 1-3 of 2013. But when the on-call schedule appeared, Dr. Al-Ghamdi was scheduled to work on

December 20. Additionally, a locum physician had been arranged to work for much of the last two weeks of December when Dr. Al-Ghamdi had indicated that he was available and had planned to work.

(iii) Decision and Reasons

127. The Tribunal finds that this particular has been established on the balance of probabilities.

128. While it may be reasonable for a physician not to be obligated to ensure on-call coverage for specific dates for which they did not know he or she were on-call, the Tribunal rejects the argument that a physician does not have an obligation to ensure on-call coverage just because he or she did not formally agree to the on-call schedule.

129. Furthermore, while the evidence suggested that the QEII did not have a process to ensure formal agreement by all physicians to every on-call schedule, there was also no evidence presented that the process of setting and communicating the on-call schedules posed problems for the other physicians at the QEII or for the other surgeons in the orthopedics group.

130. Although Dr. Al-Ghamdi testified that he had notified others that he would not be available in September and for certain dates in December of 2012, the physicians who testified (including physicians from other disciplines) were unanimous in their belief that it was Dr. Al-Ghamdi's responsibility to arrange among his colleagues for coverage of his assigned days if he was not available. If such coverage was not possible, this would justify asking to have a locum assigned for the days at issue. Dr. Al-Ghamdi refused to accept this responsibility; rather, he believed that if he had provided notification to the Medical Staff Office of his absence, then it was someone else's responsibility to assure that there was coverage. The Tribunal rejects this position of Dr. Al-Ghamdi's.

131. Dr. [redacted] testified that other surgeons frequently had conflicts between their on-call commitments and other activities, but always asked another colleague to trade days or otherwise

cover for them. Dr. [redacted] pointed out that, as far as he knew, every time that Dr. Al-Ghamdi asked to trade a day, his request was granted.

132. Although conflicting evidence was provided about the details surrounding the development and operation of the on-call schedule for the orthopedic surgery group (and specifically for September and December of 2012), the Tribunal found the testimonies of Dr. [redacted] and [redacted] more credible than that of Dr. Al-Ghamdi. Their evidence was consistent with the evidence from other physicians at the QEII, and elsewhere as to how on-call schedules are developed and operate in various practice groups. Furthermore, Dr. Al-Ghamdi did not "work collaboratively to resolve issues" with the on-call system, as is required by the Alberta Health Services Medical Staff Rules.

133. The 2010 complaint to the College brought by Dr. [redacted] against Dr. Al-Ghamdi in relation to an on-call schedule, related to a narrow and specific incident in which Dr. Al-Ghamdi agreed to an on-call schedule which was later unilaterally changed. That complaint was dismissed. In this case, the charge is broad and underlying it is the failure to collaborate with colleagues in relation to establishing the on-call schedule.

(b) Purporting to have a parallel on-call schedule of his own to try to avoid having to deal with the on-call orthopedic surgeon at the hospital when booking a patient for surgery

(i) CPSA's Evidence

134. The Tribunal heard evidence from Drs. [redacted] and [redacted] and was provided with copies of letters written during December of 2012 indicating that Dr. Al-Ghamdi was then removed from the other orthopedic surgeons' on-call schedule.

135. Dr. Al-Ghamdi attempted to get back on the on-call schedule, notably through requests to senior managers of AHS, including Dr. [redacted] and Dr. [redacted]. Dr. Al-Ghamdi was concerned about a loss of income as a result of his exclusion from the on-call schedule, and he engaged a lawyer to pursue getting restored to the on-call schedule.

136. There is uncertainty as to where the idea for a "parallel on-call system" initially arose. Dr. Al-Ghamdi testified that it came from Dr. [redacted] while Dr. [redacted] testified that it came from Dr. Al-Ghamdi and his lawyer. Nevertheless, the evidence is clear that Dr. [redacted] advised Dr. Al-Ghamdi that a parallel system could not be introduced unilaterally, that it could not be used by a single physician, and that if it was to be introduced it would require collaboration with, and the agreement of, other stakeholders, notably the other orthopedic surgeons. Dr. [redacted] testified that Dr. Al-Ghamdi did not approach the group of orthopedic surgeons to seek collaboration for a parallel on-call system.

137. Dr. Al-Ghamdi did speak to individual members of the Emergency Department Physicians group and indicated that he was available for consultation as required. Dr. Al-Ghamdi also asked the QEII administration to circulate a memo that he would be continuously on call. This request was not honored and Dr. Al-Ghamdi was advised that if he wished such a memo to be circulated, it should originate from Dr. Al-Ghamdi's office. Dr. Al-Ghamdi did continue to see patients referred from the Emergency Department and to compete with other surgeons for OR time.

138. The Tribunal heard testimony that on July 27, 2013 Dr. Al-Ghamdi attempted to book surgery for a patient with a hip fracture. The OR nurse, Tracy Rice, advised Dr. Al-Ghamdi that he was not the on-call surgeon and that she could not put the patient on the surgical schedule unless Dr. Al-Ghamdi first discussed it with Dr. [redacted] who was the on-call surgeon at that time. That was consistent with hospital policies.

139. Dr. Al-Ghamdi told Nurse Rice that he did not have to talk to Dr. [redacted], advising her "No. We have double call system. We have two surgeons". Nurse Rice refused to send for Dr. Al-Ghamdi's patient until she had approval from Dr. [redacted] to do so.

140. Dr. Al-Ghamdi implied that he had approval for this double call system from AHS and advised her to contact Dr. [redacted], then CEO of AHS. The Tribunal heard evidence from Dr. [redacted], the Facility Medical Director, that Dr. Al-Ghamdi had not been given approval to have a

parallel on-call system. Furthermore, Dr. [redacted] testified before the Tribunal that he never authorized such a system.

(ii) Dr. Al-Ghamdi's Evidence

141. Dr. Al-Ghamdi's position was that he had not initiated or suggested the parallel on-call; rather, AHS (Dr. [redacted]) had proposed it, and he was just following AHS's suggestions. He further pointed out that there are instances where there are parallel on-call systems and pointed to the department of Family Medicine at the QEII as an example. He also said there were times when there were two orthopedic surgeons working in the emergency department seeing patients at the same time.

(iii) Decision and Reasons

142. The Tribunal finds that this particular has been established on the balance of probabilities.

143. The Hearing Tribunal finds that the evidence is clear that Dr. Al Ghamdi did purport to have a parallel on-call system; attempt to have a patient booked for surgery on the basis that he was the on-call surgeon for that patient; and tried to avoid dealing with the legitimate on-call surgeon in this regard.

(c) Failing to cooperate with your medical colleagues and nursing staff to ensure surgical cases were performed on the basis of medical need for urgent care

(i) CPSA's Evidence

144. The CPSA provided considerable evidence on this issue from a number of witnesses.

145. Several witnesses described the system in place in Grande Prairie to deal with urgent/emergent cases: the surgeon with the urgent patient was to speak to the surgeon whose case was being bumped and, if there was disagreement, the anesthetist on duty had the final say.

146. The CPSA called Dr. [redacted] who described his interactions with Dr. Al-Ghamdi as always being a battle. As an obstetrician, his urgent cases are usually caesarian sections but Dr. Al-Ghamdi always questioned him in an attempt to determine if, in his (Dr. Al-Ghamdi's) opinion the case was urgent. Dr. [redacted] described a case of a prolapsed umbilical cord for which he needed to bump Dr. Al-Ghamdi's case, but Dr. Al-Ghamdi did not accept that the cord was prolapsed and wrote a letter of complaint because Dr. [redacted] did not speak to him before the procedure, even though Dr. [redacted] explained that he was occupied with holding the cord 'up' to prevent interference in blood supply to the baby. Dr. Al-Ghamdi accused him of lying. Nurse Kerianne Dunlop's evidence corroborated Dr. [redacted] account.

147. Dr. [redacted] (anesthetist) described a case which Dr. Al-Ghamdi booked as not urgent, that is, it could be done in the order booked. Later Dr. Al-Ghamdi spoke to the Unit Clerk and indicated that he needed to bump all of the other cases so he could do his case promptly because of fear of paralysis for his patient secondary to a tumour on the spine. Dr. [redacted] believed that Dr. Al-Ghamdi lied about the change in urgency of the case. Later Dr. Al-Ghamdi complained to the CPSA about this because a case that went before his case was an RCMP officer and Dr. Al-Ghamdi considered the officer to be receiving preferential treatment.

148. Dr [redacted] testified about his patient, Mr. [redacted] who was admitted with recurrent bleeding from a gastric lesion. On the day before the one in question, Dr. [redacted] (colleague of Dr. [redacted] had performed a gastroscopy but had been unable to identify the bleeding site. The following morning, Dr. [redacted] saw the patient in the Intensive Care Unit ("ICU") and decided that a gastrectomy was needed. He noted that the patient was *reasonably* stable at that time and decided to schedule surgery for the afternoon. When things deteriorated that afternoon, Dr. [redacted] spoke to Dr. [redacted] who was the surgeon on-call for orthopedics and told him about Mr. [redacted] Dr. [redacted] agreed that Dr. [redacted] should go first. Dr [redacted] s did not know that Dr. Al-Ghamdi had a case to do as well. The anesthetist, Dr. [redacted], also assessed the patient [redacted], declared him to be very ill, and had the patient taken to the OR and prepared for surgery. However, Dr. Al-Ghamdi was upset because Dr. [redacted] had not called him and Dr. Al-Ghamdi indicated that since his patient was booked first, he thought he should go first. Dr. [redacted] then spoke to Dr. Al-Ghamdi on the phone and 'pleaded' with him to allow surgery on Mr.

[redacted] to proceed but Dr. Al-Ghamdi refused. The anesthetist (Dr. [redacted]) also testified that he told Dr. Al-Ghamdi that Dr. [redacted] patient was very ill and needed urgent surgery. Despite all this, Dr. Al-Ghamdi insisted that he do his case first. There was disagreement as to who instructed the nurses to take Mr. [redacted] back to the ICU; the nurse's note indicated that it was as ordered by Dr. [redacted], however, Dr. [redacted] was emphatic that it was Dr. Al-Ghamdi who had called into the OR and insisted that the patient be taken from the OR so that Dr. Al-Ghamdi could do his surgery. In her testimony, Ms. Rita Young corroborated this and stated that Dr. Al-Ghamdi had instructed the nurses to take the patient back to the ICU. In any event, surgery for Mr. [redacted] was delayed. When he did eventually get to the OR, there was a further delay because some instrument trays had been opened earlier (in anticipation that surgery would proceed) and had to be re-sterilized. Moreover, platelets that were available in the early evening expired and were not available for use during surgery. As it turned out, the patient had suffered a perforation of the stomach, probably associated with the gastroscopy the previous night, which made him even more ill. Dr. [redacted] did not recognize that until after the surgery began.

149. Dr. [redacted] testified for the CPSA that, because of Dr. Al-Ghamdi, he too had experienced difficulty having the OR run smoothly. He particularly described one day when he had two short cases to do so that they could be discharged to free up hospital beds. However, Dr. Al-Ghamdi tried to insert into the schedule his patient who had been delayed from the previous day because of an abnormal blood test. This resulted in considerable discussion and eventually involved the anesthetist. Dr. [redacted] was able to proceed with the two minor cases but the next day received a letter from Dr. Al-Ghamdi claiming that Dr. [redacted] activity had compromised the safety of his patient.

150. Dr. [redacted] also described an instance where it appeared that Dr. Al-Ghamdi had changed the priority (E rating) of his patient in order that he could operate sooner. The Surgical Services Committee investigated this and invited Dr. Al-Ghamdi to attend a meeting and present his side of this issue; however, Dr. Al-Ghamdi refused to attend. In his absence, the Committee decided that Dr. Al-Ghamdi had inappropriately changed the priority rating on one of his patients. This matter was eventually referred to Dr. [redacted] but, in Dr. [redacted] opinion, was

never satisfactorily resolved. It was never clear to the Tribunal whether the patient referred to here is the same patient described by Dr. [redacted] above.

151. Ms. Gail Coristine (OR nurse) testified that it was her impression that if another surgeon had an urgent case, Dr. Al-Ghamdi would not allow them to bump his case because this would result in a delay for him.

152. Ms. Kerianne Dunlap, an OR nurse, corroborated the above testimony concerning Dr. [redacted] case. Indeed, Ms. Dunlap testified that Dr. Al-Ghamdi actually slowed down his closure to delay Dr. [redacted] even more.

(ii) Dr. Al-Ghamdi's Evidence

153. In providing his defence, Dr. Al-Ghamdi claimed that witnesses had lied. Specifically, he pointed out that Kerianne Dunlap had no detailed memory of the case Dr. Al-Ghamdi was doing when Dr. [redacted] came to the door. He suggested that the conversation that he had held with Ms. Dunlap while he was closing was not about politics (as suggested by Ms. Dunlap) but about the need to do an incident report on the fact that Dr. [redacted] had entered the OR while dressed in street clothes and therefore contaminated some instruments. He maintained that he was taking appropriate caution in the closing of the incision.

154. Regarding the patient of Dr. [redacted] (Mr. [redacted]), Dr. Al-Ghamdi maintained that it was not he who had ordered the patient be returned to the ICU so that Dr. Al-Ghamdi could proceed with his case. He also seemed to attempt to justify his actions by pointing out that Dr. [redacted] had written in the hospital record that the patient was stable. However, the record actually said "reasonably stable" and it had been written eight hours earlier; the patient had clearly become unstable when he was brought to the OR by the anesthetist, Dr. [redacted]. Finally, in relation to Mr. [redacted], Dr. Al-Ghamdi implied that Dr. [redacted] was not providing an acceptable quality of care since he did not really know how sick his patient was and did not even know that a perforation of the stomach had occurred, something that would have been evident had Dr. [redacted] reviewed the chest radiographic report from that morning. Dr. Al-Ghamdi suggested that Dr.

[redacted] should have operated on Mr. [redacted] earlier in the day but did not because he was busy with other cases.

155. Dr. Al-Ghamdi called Dr. [redacted] and attempted to have him accepted as an expert witness in surgery, among several other disciplines. After hearing arguments, the Tribunal accepted Dr. [redacted] as an expert in being a Hospitalist, and as a family physician with expertise in emergency care and as a family physician with an interest in geriatrics. However, Dr. Al-Ghamdi did proceed to question Dr. [redacted] extensively on the diagnosis and management of patients with a bowel perforation. Dr. [redacted] speculated that if the stomach perforation of Mr. [redacted] occurred secondary to the gastroscopy, he (Mr. [redacted]) would be expected to develop an acute abdomen and if that occurred, he should have been taken to the OR within an hour. He did acknowledge that Mr. [redacted] was very ill and needed to have surgery urgently.

(iii) Decision and Reasons

156. The Tribunal finds that this particular has been established on the balance of probabilities.

157. The policy at the QEII aimed at assuring that ill patients in urgent need of surgery could be accommodated was clear and generally seems to have been effective. The rule was that a surgeon with a patient who needed urgent surgery would speak to the surgeon with a patient previously booked. Usually this resulted in agreement on whether the 'urgent' patient' was in the greatest need of surgery and that patient's surgery would proceed. If there was disagreement between the surgeons, the anesthetist would be consulted and would make the final decision. The Tribunal heard that with Dr. Al-Ghamdi, this process rarely went smoothly. If someone attempted to bump in a case, Dr. Al-Ghamdi would question the surgeon extensively about clinical details, even if the medical issue was not in Dr. Al-Ghamdi's discipline, in order to be convinced that the other case was more urgent than his. However, if he was wanting to bump in a case, he often asked the nurses to speak to the operating surgeon and advise that Dr. Al-Ghamdi had a case to bump-in, rather than follow the practice as outlined. In the incident involving Nurse Rice, although Dr. Al-Ghamdi eventually did speak to Dr. [redacted], Dr. Al-Ghamdi initially

refused to speak to Dr. [redacted] who was the designated surgeon on-call and had cases waiting to proceed (this case is admittedly somewhat different than others but reflects the same principle).

158. The incident involving Dr. [redacted]' patient, Mr. [redacted] was the best documented example of Dr. Al-Ghamdi refusing to allow a seriously ill patient to precede his own less urgent case. The urgency of this case was well-documented by Dr. [redacted] as well as by Dr. [redacted] yet Dr. Al-Ghamdi refused to abide by the rule established for such cases at the QEII. His defence was based on denigrating Dr. [redacted] capabilities and the quality of care he provided. The delay resulted in Mr. [redacted] condition worsening, and platelets that had been obtained became outdated. Based on his review of the medical record, Dr. Al-Ghamdi challenged Dr. [redacted] about whether platelets had been ordered for this patient. However, there was independent corroboration that platelets had been ordered but had expired by the time Mr. [redacted] got to the OR. This could have had serious implications to the operative risk to Mr. [redacted] since, if needed, platelets had to be requisitioned from Edmonton. Finally, the Tribunal heard conflicting evidence as to who ordered that Mr. [redacted] be returned to the ICU so that Dr. Al-Ghamdi could proceed with his case. Dr. Al-Ghamdi maintained that only the "most responsible physician," Dr. [redacted] could write an order for this to occur. The Tribunal has determined that who instructed the nurses to return the patient to the ICU was immaterial, since it clearly was the result of Dr. Al-Ghamdi's insistence that his case proceed first.

159. Based on the evidence of Drs. [redacted] and [redacted], it seems very likely that Dr. Al-Ghamdi did inappropriately change the urgency rating for his patient with the spinal tumour, an act not related to a worsening of the patient's condition.

160. Dr. [redacted] testimony did not strengthen Dr. Al-Ghamdi's case. The Tribunal refused to approve Dr. [redacted] as an expert in surgical care and there was also considerable indication that Dr. [redacted] was testifying to help Dr. Al-Ghamdi and therefore was not independent. Moreover, Dr. [redacted] testimony was simply that Mr. [redacted] was sick and should have been operated on as soon as possible, the implication being that he should have received surgery before the evening in question. Although this may be true, overall Dr. [redacted] was deemed not to be a

particularly credible witness. Importantly, Dr. [redacted] had his own 'issues' with the QEII in Grand Prairie. These included recurring difficulties with the QEII staff which eventually resulted in him leaving Grande Prairie with considerable bitterness. Moreover, he stated that he was testifying as a friend of Dr. Al-Ghamdi and wanted to help him. It also became clear that Dr. [redacted] had been helping Dr. Al-Ghamdi file and serve documents. For all of these reasons, the Tribunal did not consider Dr. [redacted] to be independent or unbiased.

(d) Failing to Finish Your Surgical Case In A Timely Manner While Another Surgeon Was In Need Of The Same Operating Room To Deal With An Urgent Case

(i) CPSA's Evidence

161. The CPSA witness, Nurse Kerianne Dunlap, described an instance when Dr. Al-Ghamdi was doing surgery and Dr. [redacted] opened the OR door to indicate that he had an urgent case and wanted to know how long Dr. Al-Ghamdi would be. Dr. Al-Ghamdi told Dr. [redacted] that it would take approximately 20 minutes, but Dr. [redacted] returned twice more to ask when Dr. Al-Ghamdi would finish. Nurse Dunlap stated that Dr. Al-Ghamdi noticeably slowed down and even stopped to make conversation about other – non-patient related - issues. She believes that the time Dr. Al-Ghamdi took was more than 20 minutes but had no documentation to substantiate this.

162. Nurse Dunlap also testified that she observed other times when she thought that Dr. Al-Ghamdi had deliberately *slowed* down – apparently to cause problems for other surgeons. Again there was no documentation to support this.

163. Dr [redacted] testified that he observed Dr. Al-Ghamdi purposefully slowing down when he was closing an incision. He indicated that he had even observed Dr. Al-Ghamdi close an incision in seven layers and was convinced that this was intended to be disruptive.

164. The College's counsel did not question Ms. Gail Coristine on this issue. However, during Dr. Al-Ghamdi's cross-examination of Nurse Coristine, he produced a transcript of Ms. Coristine's statements to the CPSA Investigator concerning this issue. Nurse Coristine told the Investigator that Dr. Al-Ghamdi believed that his patients always deserved priority over any

other patients and she believed that he would purposefully slow down incision closures so as to delay other surgeons. There was no documentary evidence to support the accuracy of these statements.

165. Mr. Shane Ray also testified that he had witnessed Dr. Al-Ghamdi slowing down when Dr. [redacted] patient was waiting.

(ii) Dr. Al-Ghamdi's Evidence

166. Dr. Al-Ghamdi denied these allegations. In his cross-examination of Nurse Dunlap, Dr. Al-Ghamdi questioned her about their reported conversation in the OR when he was completing the case while Dr. [redacted] waited for the OR. Dr. Al-Ghamdi suggested that the conversation was about the need to do an incident report about Dr. [redacted] coming into the OR area in street clothes and thereby contaminating opened instruments. Nurse Dunlap had no recollection of this but, rather, believed the topic of discussion was politics.

167. Dr. Al-Ghamdi suggested that Nurse Dunlap exaggerated her estimate of the time he took to complete the case, since, after he had finished, Dr. [redacted] was another 20 minutes before starting. Nurse Dunlap pointed out that this would be expected, given that the anesthetist needed to allow Dr. Al-Ghamdi's patient to awake and take her/him to the recovery room before attending to Dr. [redacted] patient.

(iii) Decision and Reasons

168. The Tribunal finds that this particular has *not* been established on the balance of probabilities.

169. Although these witnesses were credible, there was no documentation that substantiated their accusations. Dr. Al-Ghamdi emphatically denied that he would slow down a surgery just to delay other surgeons.

170. To prove such an accusation would require documentation of the amount of time Dr. Al-Ghamdi took in closing compared to other surgeons; it would also require a comparison of Dr. Al-Ghamdi's closing times when another surgeon was waiting for the OR compared to when Dr. Al-Ghamdi was doing the next case himself. Such evidence was not presented.

(e) Failing To Replace The Safety Cap On Used Needles/Sharps And Leaving The Item For Other Staff To Deal With And Putting That Staff Person At Risk Of Being Poked By The Uncapped Needle/Sharp

(i) CPSA's Evidence

171. The CPSA presented no evidence on this particular.

(ii) Dr. Al-Ghamdi's Evidence

172. Dr. Al-Ghamdi presented evidence to show that the standard of practice was, in fact, that sharps should not be re-capped as this process increases the risk of being 'poked' and thereby being infected by particular blood borne viruses. Even the CPSA has a policy on this issue which is consistent with the standards of other organization.

(iii) Decision and Reasons

173. The Tribunal finds that this particular has *not* been established on the balance of probabilities.

174. Dr. Al-Ghamdi provided sufficient evidence that the CPSA erred in making this accusation. The standard of practice is that health care workers should never re-cap used needles/sharps in order to avoid accidental punctures of the skin – with the associated risk of transmitting blood-borne viruses.

(f) Cultivating A Culture Of Fear And Distrust Through Making Complaints To The Alberta Human Rights Commission, The College And Association Of Registered Nurses Of Alberta Or The College Of Physicians & Surgeons Of Alberta

(i) CPSA's Evidence

175. Dr. Al-Ghamdi complained frequently and to multiple levels of the QEII, AHS, the Profession and other regulatory bodies. In so doing, Dr. Al-Ghamdi expected that once he raised a concern, others were obligated to resolve the issue despite his frequent failure to provide requested follow-up information.

176. Dr. Al-Ghamdi reported his colleagues to the CPSA on numerous occasions because of his assessment that their patient care was below his expectation, or that their behavior toward him was unprofessional. Some examples include: reporting Dr. [redacted] to the CPSA regarding the handling of a patient who had suffered an open fracture from a motorcycle injury, which complaint was ultimately dismissed; reporting Dr. [redacted] twice, once for failing to wear a mask in the OR, and once for using profanity in the workplace; and reporting Dr. [redacted] for failing to complete charts in a timely manner. Dr. Al-Ghamdi had first raised his concern about Dr. [redacted] to the Medical Advisory Committee ("MAC"). When he perceived that the MAC failed to take appropriate action against Dr. [redacted] Dr. Al-Ghamdi reported all of the members of the MAC to the CPSA. Eventually Dr. [redacted] was sanctioned by the CPSA for this and was suspended for three months (in abeyance).

177. Indeed, Dr. Al-Ghamdi reported Dr. [redacted] to the CPSA five times. Dr. Al-Ghamdi also threatened to report colleagues to the CPSA as a means to intimidate individuals and obtain his desired outcome. In particular, Dr [redacted] provided the Tribunal with an email from Dr. Al-Ghamdi threatening that if Dr. [redacted] did not agree to a call schedule for medical examiner duties, Dr. Al-Ghamdi would report him to the CPSA for unprofessional conduct. Other physicians expressed their fear and embarrassment at being reported to the CPSA.

178. Dr. [redacted]n also testified about Dr. Al-Ghamdi reporting him to the CPSA for breaching Dr. Al-Ghamdi's privacy when Dr. [redacted] looked at Dr. Al-Ghamdi's papers on a communal printer in the doctors' lounge. Dr. Al-Ghamdi also reported Dr. [redacted] regarding an incident

between Dr. [redacted] and Dr. [redacted]. Dr. [redacted] testified that he and Dr. [redacted] later talked and solved their issue, which was settled with a handshake. Yet, Dr. Al-Ghamdi used this incident, in which he was not involved, as a basis for a complaint.

179. Dr. Al-Ghamdi also reported a number of nurses to the College and Association of Registered Nurses of Alberta (CARNA). In most instances, these nurses worked in the ORs at the QEII and were very troubled by such reports. Indeed, the Tribunal heard from a number of nurses for whom the fear of being reported was significant enough that they wished not to work with Dr. Al-Ghamdi. A number of nurses testified that they had ongoing anxiety because of the fear that if they committed even a minor error when working with Dr. Al-Ghamdi, he would 'write them up' and report them to either their supervisor or to CARNA. Ms. Nasedkin testified that, on the advice of her physician, she took seven weeks of stress leave after Dr. Al-Ghamdi's second complaint about her to CARNA (she believes there was a third one but was unable to remember the details). Dr. Al-Ghamdi also complained to CARNA that Ms. Gail Coristine deliberately withheld requested equipment from him. Dr. Al-Ghamdi then also requested the QEII administration to prevent her from working in his room. Ms. Kerianne Dunlap also testified that before she had worked with Dr. Al-Ghamdi, she had heard from other nurses that they were afraid that whatever they did in Dr. Al-Ghamdi's room might be used to generate a report to their supervisor. The situation was described as being like walking a tightrope. The magnitude of this concern was demonstrated by the fact that 37 of 40 nurses who worked in the OR signed a 'petition' refusing to work with Dr. Al-Ghamdi after they believed that Dr. Al-Ghamdi had threatened a colleague, Nurse Tracy Rice.

180. Dr. Al-Ghamdi made a complaint to the Alberta Human Rights Commission in 2008 concerning his belief that Grande Prairie, particularly the QEII, had a racially charged environment and that he was being discriminated against because of his ethnicity, skin color and religion. In a 66 page report, the Commission's Investigators found no evidence of discrimination against Dr. Al-Ghamdi. His request for review by the Commission, a subsequent judicial review to the Court of Queen's Bench (2015 ABQB 155) and an appeal to the Court of Appeal (2017 ABCA 31) were all dismissed. Witnesses did note that having to defend themselves against claims of racial prejudice was very stressful and at least two physicians, Dr.

[redacted] and Dr. [redacted], stated they felt that they were the defendants in Dr. Al-Ghamdi's complaint to the Human Rights Commission.

(ii) Dr. Al-Ghamdi's Evidence

181. Dr. Al-Ghamdi claimed that one of his major goals was to improve the quality of care in Grande Prairie and that he expressed this by being a patient advocate. He stated that he firmly believed that foremost among his professional responsibilities was the need to report any example of what might appear to him to represent care or conduct that was deficient enough to constitute unprofessional conduct.

182. Dr. Al-Ghamdi maintained that the education and qualifications of the nursing staff was limited by the fact that many of them had never worked outside of the ORs in Grande Prairie. He certainly reported nurses to their supervisor, Ms. Rita Young, because of their apparent lack of knowledge or experience. (However, it was their behavior that he usually interpreted as being unprofessional.) Dr. Al-Ghamdi also believed that a number of his nursing colleagues were biased against visible minorities, and particularly targeted those who were Arab and Muslim. He pointed out that a number of his Arab and Muslim surgical colleagues also had difficulty functioning in the ORs at the QEII. Certainly Dr. Al-Ghamdi called witnesses who provided evidence that a number of the nurses, particularly Gail Coristine, made prejudicial comments toward him. Specifically, Dr. Al-Ghamdi was called "Dr. Al-Qaeda", "shit-for-brains" and other names that are clearly derogatory and/or reflect racial profiling.

183. In relation to his medical colleagues, he described his education as being substantially greater and much broader than that of others in Grande Prairie; indeed, he expressed his belief that others (particularly Dr. [redacted] and Dr. [redacted]) had inferior training to him and to other Canadian trained orthopedic surgeons. Dr. Al-Ghamdi challenged Dr. [redacted]s during his testimony, stating that Dr. [redacted] did not even possess the LMCC qualification for practice in Canada. Dr. [redacted] provided documentation that he did possess this qualification, although it had not been recorded on the CPSA website.

184. Dr. Al-Ghamdi's observations regarding the quality of care his colleagues provided was perhaps explained by the fact that he functioned as a medical examiner for the region. When he did notice what he considered to be less than optimal care, he did not hesitate to report this to administrators in the QEII or in AHS, and he reported a number of incidences to the CPSA as professional misconduct. Again, he interpreted the Code of Ethics and the Code of Conduct for Physicians in Alberta required him to do so, or he too, would be guilty of professional misconduct.

185. Dr. Al-Ghamdi was also critical of the qualifications and performance of General Surgeons in Grande Prairie and was particularly critical because of his belief that certain surgeons did surgical procedures for which they were not adequately trained. Dr. [redacted] was a particular focus of these concerns and the Tribunal heard a great deal of testimony from Dr. Al-Ghamdi's witnesses, as well as from the CPSA witnesses during cross-examination, about specific cases of Dr. [redacted] in which, in Dr. Al-Ghamdi's opinion, the care had not met acceptable standard.

186. In addition to criticizing their patient care, Dr. Al-Ghamdi criticized the behavior of certain physicians with whom he worked. This included his criticism of Dr. [redacted], an anesthetist, for failing to wear a mask when he provided anesthesia services to Dr. Al-Ghamdi's patients. Dr. Al-Ghamdi also reported Dr. [redacted] and Dr. [redacted] for unprofessional conduct for using what Dr. Al-Ghamdi considered to be abusive and obscene language, often delivered in a loud voice. Dr. Al-Ghamdi prided himself for never shouting or using foul language. Moreover, Dr. Al-Ghamdi called witnesses such as Ms. Denise Beaudin, Ms. Janet Loseth, Ms. Beverley Peters and Ms. Wendy Dumais who all described Dr. Al-Ghamdi as always being professional, calm and polite, even when he was under attack by others.

(iii) Decision and Reasons

187. The Tribunal finds that this particular has been established on the balance of probabilities.

188. Although Dr. Al-Ghamdi repeatedly maintained that he was merely advocating for his patients and trying to improve the quality of patient care, his approach caused much distress among his medical, nursing and administrative colleagues. Indeed, several witnesses expressed that Dr. Al-Ghamdi was merely advocating for himself.

189. Despite Dr. Al-Ghamdi's claims that he was always polite and respectful, others found him threatening. This was clear from the testimony of several nurses who feared working with him because of his propensity to report them to their supervisor or worse, to CARNA. The Tribunal concludes Dr. Al-Ghamdi did create fear and distrust among his nursing colleagues.

190. Whereas it is a physician's professional responsibility to note instances of unprofessional conduct among clinical colleagues, the expectation is that the physician seeks to help the other physician understand the perceived transgression and improve their quality of care. One would reasonably only report a professional to his or her regulatory body following serious attempts to understand the professional's behavior and to ensure that there were no extenuating circumstances explaining the observed behavior. However, Dr. Al-Ghamdi reported his colleagues without considering any potential extenuating circumstances and was distressed that this could not be done secretly. It seems that he believed that it was the fault of the QEII, AHS or his Nursing or Physician Colleges when there was anger against him when it became known that he had reported someone to a superior or to their governing College.

191. Dr. Al-Ghamdi increased some of his colleagues' fear by reporting a large number of individuals to the CPSA because they knew – or ought to have known - that a certain physician had committed what Dr. Al-Ghamdi considered to be unprofessional conduct. For instance, Dr. Al-Ghamdi reported Dr. [redacted] to the CPSA for not completing his medical records in a timely fashion and reported all members of the MAC in the QEII, claiming that they were guilty of professional misconduct because they failed to enforce the Medical Staff Bylaw regarding medical records and failed to suspend Dr. [redacted]. Although Dr. Al-Ghamdi was correct to complain about Dr. [redacted] conduct, to report this group of senior leaders reflects an insensitive view of how institutions work. Dr. Al-Ghamdi's inflexible attitude certainly contributed to his increasing isolation within the workplace. Even when Dr. [redacted] was

subjected to a hearing at the CPSA, found guilty and punished with a suspension, Dr. Al-Ghamdi complained that the penalty was too light.

192. Dr. Al-Ghamdi relies on a College of Physicians and Surgeons of Manitoba Investigation Committee decision regarding Dr. Emery, which censured Dr. Emery for failing to report a complaint received regarding the inappropriate touching of a patient by a physician in his employ. The Committee Decision notes that the obligation to report is not premised on the reporting physician having evidence that the allegation is true; rather, the physician must report if, in the event the allegation is true, the public would be at risk.

193. It is important to note that Dr. Emery had received a similar complaint that the same physician had inappropriately touched a patient, and Dr. Emery had not reported it to the College. At that time, the College told Dr. Emery he should have reported it. When he failed to report a similar allegation six years later, he was censured. Even this case illustrates that the College itself tried to problem solve the first time before censuring Dr. Emery.

194. Despite the dismissal of Dr. Al-Ghamdi's complaint to the Human Rights Commission, Dr. Al-Ghamdi continued to complain about racial prejudice and discrimination at the QEII in Grande Prairie. Indeed, Dr. Al-Ghamdi presented a number of witnesses who supported his claims. Even Dr. [redacted] testified that, whereas he did not like Dr. Al-Ghamdi, he did believe there was racial bias at the QEII. Dr. [redacted] believed that persons of foreign birth, particularly if they have dark skin, were subjected to unfair treatment. Dr. [redacted] had many additional complaints about the system, not all of them related to racial discrimination.

195. Dr. Al-Ghamdi called Dr. [redacted] who, although black and from Africa, did not sense that he had been unfairly treated at the QEII. Indeed, Dr. [redacted] stated he got along with everyone and described having a wonderful time in Grande Prairie.

(g) Cultivating A Culture Of Fear And Distrust Through Threatening To Start Or Starting Legal Action

(i) CPSA's Evidence

196. Dr. Al-Ghamdi has initiated several legal actions during the period of time being considered. He initially brought suit against the Northern Zone of AHS for breach of contract. Other physicians in the North Zone had contracts that can best be described as a 'Return of Service'; usually these contracts were for three years and then expired. It was clear that Dr. Al-Ghamdi negotiated extensively with Dr. [redacted] who was Medical Director at the QEII in 2003 when Dr. Al-Ghamdi was recruited. His contract, therefore, did not have a clear expiry date and stated that he was entitled to 1.5 days of operating time per week for elective cases and access to resources for emergency cases as required. Dr. Al-Ghamdi claimed that he was not receiving the OR time to which he was entitled and therefore he sued for a significant amount of money to reflect his lost income. Dr. Al-Ghamdi's human rights complaint also referenced a lawsuit started June 30, 2008, but it is not known if this is the same one. Whether Dr. Al-Ghamdi's contract provisions had not been met was unclear from the testimony provided. Dr. [redacted] did testify that he had maintained a record of his own hours lost from nominal OR time and Dr. Al-Ghamdi had actually suffered fewer hours of lost OR time than his colleagues.

197. Dr. [redacted] testified that Dr. Al-Ghamdi had threatened legal action against him for loss of income associated with Dr. [redacted] 'failure' to ensure that Dr. Al-Ghamdi had his operating resources intact. This threat came during 2012 when Dr. [redacted] suddenly withdrew his anesthesia services from Dr. Al-Ghamdi; this threatened to result in Dr. Al-Ghamdi's patients for that day being cancelled. In fact, Dr. [redacted] worked hard to find an alternative anesthesia provider for the day in question so that Dr. Al-Ghamdi's patients were not cancelled. However, Dr. Al-Ghamdi did threaten Dr. [redacted] that he would hold Dr. [redacted] responsible for his lost income. This was clearly distressing to Dr. [redacted]

198. Dr. [redacted] testified that on one occasion he 'teased' Dr. Al-Ghamdi for being late coming to the Physician Lounge after completing a case and Dr. Al-Ghamdi told him that if he ever did that again he would be sued for defamation.

199. Dr. [redacted] acknowledged that he found working with Dr. Al-Ghamdi stressful and admitted that he had taken at least one day off work because of this. He did fear a lawsuit. In his December 10, 2012 letter to Dr. [redacted] advising he would no longer work with Dr. Al-Ghamdi, Dr. [redacted] stated:

> I recognize that this may delay the elective treatment of some of the patients on the waiting list, and I inconvenience my anesthesia colleagues but feel that I have no other choice in the matter. Dr. Al-Ghamdi's ongoing disruptive behaviour has resulted in immeasurable harm to the work environment at the QEII, and his implied and overt threats of medico-legal action, combined with regular formal complaints to the College of Physicians and Surgeons has caused me to focus more on ***him*** (sic) in the operating room than I do on my patients. From a patient safety perspective and, indeed with my own career in mind, I cannot, in good conscience, allow this to continue.

200. During this hearing, Dr. Al-Ghamdi filed a lawsuit against more than 50 of his QEII colleagues. The Tribunal was not informed of the details of this lawsuit, but was left with the impression that this was primarily against those individuals who had signed the petition supporting Ms. Tracy Rice that led to the Immediate Action and the suspension of Dr. Al-Ghamdi's privileges in 2013. Indeed, Dr. Al-Ghamdi attempted to serve the notice of this legal action on a number of these individuals when they came to the Hearing to testify. The fact that Dr. Al-Ghamdi was suing them was clearly upsetting to these individuals and this was frequently demonstrated by their demeanor when testifying.

201. One physician, Dr. [redacted] refused to testify for the CPSA on the basis that his lawyer had advised him against it once he had been served with the notice of the lawsuit against him. He was subsequently called by Dr. Al-Ghamdi and he did testify.

202. Dr. [redacted] testified about a patient (Ms. [redacted] he had seen for Dr. [redacted] and took to the OR for debridement of severe necrotizing pressure sores over the buttock. Later the patient (who was taking anticoagulants and had an elevated INR) began to hemorrhage and later expired. This was reported to the Medical Examiner in Edmonton but when Dr. Al-Ghamdi learned of this, he sought to take over the case as Medical Examiner. Although Dr. [redacted] refused to be 'interviewed', Dr. Al-Ghamdi did locate the body and initiated his examination. He involved the RCMP and although details were not clear, it appears that he suggested criminal charges be brought against Dr. [redacted]. Dr. [redacted] believed that this was all an attempt to 'get back'

at him because of multiple conflicts with Dr. Al-Ghamdi in the past. Since this seemed to represent a conflict of interest on the part of Dr. Al-Ghamdi, Dr. [redacted] contacted the Chief Medical Examiner in Edmonton and Dr. Al-Ghamdi was removed from the case.

(ii) Dr. Al-Ghamdi's Evidence

203. Dr. Al-Ghamdi acknowledged that he had brought a number of legal actions since he has practiced in Grand Prairie. However, he maintained that this was his right – if he experienced things that were negative to his interests, it was within his rights to bring legal action.

204. Dr. Al-Ghamdi denied that he had threatened anyone with legal action.

(iii) Decision and Reasons

205. The Tribunal finds that this particular has been established on the balance of probabilities.

206. It is clear that Dr. Al-Ghamdi did not hesitate to use the legal system to defend what he considered his rights. In addition to the suit against the Regional Health Authority for breach of contract, he has brought suits against other people and organizations and, since the Tracy Rice event in 2013, has sued more than 50 people at the QEII, members of AHS and others.

207. The Tribunal heard a number of witnesses describe how emotionally upset they were with being sued by Dr. Al-Ghamdi.

208. Dr. [redacted] clearly expressed the anxiety he felt with being threatened with legal action by Dr. Al-Ghamdi and the fear that he might be personally responsible to pay Dr. Al-Ghamdi for lost income.

209. Based on the evidence heard, the Tribunal finds that Dr. Al-Ghamdi did create an atmosphere of fear among other physicians and colleagues at the QEII because of the real or perceived threat of being subjected to a lawsuit by Dr. Al-Ghamdi.

(h) Cultivating A Culture Of Fear And Distrust Through Recording Of Conversation Without The Knowledge Of The Person In The Conversation

(i) CPSA's Evidence

210. Dr. Al-Ghamdi provided evidence that he had recorded a number of conversations between himself and others without the knowledge or consent of the other individuals.

211. The Tribunal heard a recording of the conversation between Dr. Al-Ghamdi and Dr. [redacted] during which Dr. [redacted] shouted at Dr. Al-Ghamdi and used vulgar language. This recorded conversation was the basis for Dr. Al-Ghamdi's complaint to the CPSA about Dr. [redacted] unprofessional conduct. It was unclear; however, whether the recording constituted the entire conversation on that occasion. Dr. Al-Ghamdi claimed that this was the entire conversation and that it had occurred in the Physician Lounge. However, Dr. [redacted] testified that there had been an earlier conversation in the hallway outside the operating theatres which was about deciding the priority of surgical cases in which there had been significant disagreement. Indeed, Dr. [redacted] stated that Dr. Al-Ghamdi had inappropriately changed the name of the responsible surgeon on the surgical list from the on-call surgeon to himself.

212. Dr. Al-Ghamdi also recorded his telephone conversation with Tracy Rice in July 2013 during which Nurse Rice accused him of threatening her. Dr. Al-Ghamdi submitted this recording to prove that he had not threatened Ms. Rice. Mr. Boyer noted that the wording of Dr. Al-Ghamdi's statement during that conversation could be perceived as threatening.

(ii) Dr. Al-Ghamdi's Evidence

213. Dr. Al-Ghamdi pointed out that it is not illegal in Alberta to record the conversation between two people as long as one party was consenting. He also pointed out that the Emergency call line for the North Zone routinely recorded the conversations of the callers without indicating that they were doing so or asking for permission.

(iii) Decision and Reasons

214. The Tribunal finds that this particular has *not* been established on the balance of probabilities.

215. The Tribunal agrees with Dr. Al-Ghamdi that it is not illegal to record the conversations that he presented as evidence. However, the charge against Dr. Al-Ghamdi is not one of legality – rather, it is that by recording conversations without the knowledge or consent of the other parties; Dr. Al-Ghamdi created a culture of fear and distrust.

216. The Tribunal sees how this practice would undermine positive working relationships that rely on collaboration and trust, but no direct evidence on this subject was provided by witnesses.

217. Dr. [redacted] testimony suggested that Dr. Al-Ghamdi actually produced an incomplete recording of the conversation between them and used this to report Dr. [redacted] to the CPSA for unprofessional conduct. If true, such behaviour could create mistrust among those affected. However, the Tribunal heard no evidence that the recording of conversations by Dr. Al-Ghamdi created fear and mistrust among colleagues.

(i) Cultivating A Culture Of Fear And Distrust Through Making Numerous Complaints To Administration At The Hospital And The Health Authority

(i) CPSA's Evidence

218. Many of the witnesses the CPSA called reported that they had been the subject of a complaint by Dr. Al-Ghamdi, or of multiple complaints, to their supervisors at the QEII, to administrative persons at the QEII or to administrators at AHS.

219. Within the operating room environment, Dr. Al-Ghamdi complained many times to the OR supervisor, Ms. Rita Young, about nurses or other staff. Ms. Young commented that she had a file with 170 letters in it, most of which were complaints by Dr. Al-Ghamdi and responses to his complaints. Ms. Young noted that between June and September of 2005, she received nine complaints from Dr. Al-Ghamdi. Indeed, she filed a harassment and abuse complaint with the

QEII about Dr. Al-Ghamdi because of this, although nothing was done. As noted previously, some of the nurses expressed fear of working in Dr. Al-Ghamdi's room because he might report them to Ms. Young. Ms. Kerianne Dunlap indicated that it was her prediction that if Dr. Al-Ghamdi came back to the QEII now, he would not have any nurses; she indicated that if he did come back, she would quit.

220. Dr. Al-Ghamdi reported Ms. Young on many occasions to her superiors within the QEII, complaining that Ms. Young did not provide him with sufficient resources to meet the terms of his contract, that she provided equipment that did not meet his needs, and that she was prejudiced against him.

221. Dr. Al-Ghamdi reported his colleagues frequently to Dr. [redacted], the Chief of Staff at the QEII. These reports included criticism of Dr. [redacted] for using improper language, Dr. [redacted] for using the OR after hours, and Rita Young for being involved in the cancellation of his patients. In turn, Dr. Al-Ghamdi notified Dr. Pope that if he recruited another orthopedic surgeon, that he (Dr. [redacted]) would be held personally responsible for Dr. Al-Ghamdi's loss of income. Finally, Dr. Al-Ghamdi reported Dr. [redacted], along with others, for allegedly being in a conflict of interest because they were quoted in the newspaper as being opposed to the closing of the Edmonton Municipal Airport because the closure would prolong the time it would take to have patients from Grande Prairie reach specialty care at Edmonton Hospitals. Dr. Al-Ghamdi pointed out that Dr. [redacted] had his own plane and used the Municipal Airport for personal reasons.

222. Dr. [redacted] discussed the vast administrative resources used to deal with Dr. Al-Ghamdi's concerns.

223. Dr. Al-Ghamdi reported many of his colleagues to Dr. [redacted], AHS's Medical Director for the North Zone. These included complaints about Dr. [redacted] involvement in recruiting another orthopedic surgeon, about the referral practice in the region being racially biased, and about two of the orthopedic surgeons, Drs. [redacted] and [redacted], having only provisional licenses and thus being expected to stay in a community only while a shortage exists and then being asked to move to another community. Dr. Al-Ghamdi raised other issues with Dr.

[redacted], including Dr. Al-Ghamdi's desire to have a central intake for orthopedic patients, and his concern that general surgeons in Grande Prairie were practicing beyond the scope of their training (this allegation applied particularly to Dr. [redacted]).

224. With time, Dr. Al-Ghamdi began directing his complaints to higher levels of the AHS administration, including to Drs. [redacted], [redacted] and [redacted]. His belief was that Dr. [redacted] did not bother to respond to his complaints, but if he copied Dr. [redacted] or others in senior administration, then he did obtain results. Dr. [redacted] began to refer correspondence from Dr. Al-Ghamdi to Dr. [redacted] who, in turn, asked Dr. [redacted] to deal with the issues. However, after Dr. Al-Ghamdi complained about Dr. [redacted] being a significant part of the problem, Dr. [redacted] involved Dr. [redacted]. At the time of her testimony, Dr. [redacted] had a list of 68 letters from or about Dr. Al-Ghamdi that had been addressed to, or copied to, Dr. [redacted], between April 2010 and October 2013. In many instances, Dr. Al-Ghamdi did not provide the signed letter or additional information requested in order for his concerns to be dealt with according to the Medical Staff Bylaws. In an effort to manage the volume of emails from Dr. Al-Ghamdi, Dr. [redacted] directed him to send everything to Dr. [redacted] and was told the AHS legal department would respond once a week to all his emails of that week.

(ii) Dr. Al-Ghamdi's Evidence

225. Dr. Al-Ghamdi did not deny that he complained frequently to the many levels of administration in the QEII and AHS. However, he indicated that his complaints to the QEII or AHS leaders were always based on his desire to advocate for the best care of his patients. He also complained because, in his view, the environment in the ORs and generally in the QEII was heavily biased against him and others who were of different ethnicity, skin color, or religion. He did not comment on whether he believed that his actions would result in fear and distrust among his colleagues.

(iii) Decision and Reasons

226. The Tribunal finds that this particular has been established on the balance of probabilities.

227. The Tribunal heard of many times that Dr. Al-Ghamdi reported his medical and nursing colleagues in the operating rooms or within the QEII to their supervisor or senior official. Dr. Al-Ghamdi did not deny that this occurred.

228. The Tribunal did conclude that Dr. Al-Ghamdi made many complaints and that these complaints were upsetting to his colleagues. The Tribunal acknowledges that it is not adjudicating the complaints, however it heard enough evidence to conclude that a great many of the complaints were unjustified.

229. Therefore, the Tribunal's decision is that Dr. Al-Ghamdi's reporting of his colleagues to the QEII and to AHS administrations contributed to a culture of fear and distrust, much as did Dr. Al-Ghamdi's conduct at issue in Particulars (f) and (g).

(j) Failing To Follow The Issue/Dispute Resolution Process Set Out In The Bylaws And Policies Applicable To Hospital Medical Staff

(i) CPSA's Evidence

230. The CPSA called a number of witnesses to address this particular. The first witness was Dr. [redacted] who, since 2009, has been AHS's Medical Director for the Northern Zone. He received many emails from Dr. Al-Ghamdi with complaints about other practitioners or about the medical administration at the QEII in Grande Prairie. He stated that in most instances he relied on the procedures in the Medical Staff Bylaws to resolve these issues. Among other things, these procedures involve informing the complainant that, if they wish to pursue resolution of a concern through the provisions of the bylaws, they have seven days to provide a signed letter requesting the same, accompanied by sufficient supporting documentation to allow the complaint to be investigated. If no reply was received from the complainant within seven days, he considered the issue closed.

231. Dr. [redacted] described the many letters he received from Dr. Al-Ghamdi containing complaints about colleagues or the administration with respect to which Dr. Al-Ghamdi did not follow-up with the necessary documentation which would have allowed the issue to be

investigated using the Bylaws. Exhibit 23 contains many emails (more than 90) from and about Dr. Al-Ghamdi that Dr. [redacted] received and dealt with over the years. Although Dr. [redacted] dealt with many issues raised by Dr. A-Ghamdi, because Dr. Al-Ghamdi perceived that Dr. [redacted] was not taking sufficient action, Dr. Al-Ghamdi increasingly chose to direct his correspondence containing complaints to Dr. [redacted] superiors, including Dr. [redacted], CEO of AHS.

232. One of the many issues Dr. Al-Ghamdi complained about was physician recruitment. He maintained that if another orthopedic surgeon was recruited from South Africa, it would negatively impact his practice since referrals in the area were along ethnic and racial lines. He pointed out that already his waiting list was less than he desired.

233. Dr. Al-Ghamdi also expressed concerns about the training and qualifications of surgeons practicing in Grande Prairie. Dr. Al-Ghamdi frequently pointed out that he was the only properly qualified orthopedic surgeon in Grande Prairie. He assumed (incorrectly) that Drs. [redacted] and [redacted] were practicing with provisional licensure.

234. Dr. Al-Ghamdi had advocated for a central intake of orthopedic referrals which would support more equitable distribution of workload among the surgeons. His colleagues did not support this.

235. Dr. Al-Ghamdi complained that certain surgeons in Grande Prairie provided preferential access to patients. AHS investigated this and found it not to be meritorious.

236. Dr. Al-Ghamdi complained repeatedly about the on-call schedule for orthopedic surgery and that it was not fairly developed and did not respect his need to be away.

237. Dr. Al-Ghamdi complained about the failure of some anesthetists to wear a mask when in his OR.

238. The CPSA called Dr. [redacted], AHS's Associate Chief Medical Officer. In this role he serves as Chair of the Bylaws Committee and has a role in investigating senior medical

administration persons when there are accusations of behavior problems. He began interacting with Dr. Al-Ghamdi in March of 2012 because of concerns Dr. Al-Ghamdi raised about Dr. [redacted] There had been many communications from Dr. Al-Ghamdi to Dr. [redacted] as well as to Dr. [redacted]; Dr. [redacted] was asked to deal with these concerns.

239. Dr. Nichol described Dr. Al-Ghamdi's many complaints about: his medical colleagues; the administration at the QEII in Grande Prairie; the failure to meet the terms of his contract; his surgical cases being bumped by other surgeons; the surgical booking policy; an unfair on-call system; and Dr. [redacted]

240. Regarding the on-call system, Dr. [redacted] explained to Dr. Al-Ghamdi that the Bylaws did not provide AHS with the ability to force physicians to practice with other physicians; rather, a call schedule represents a group of physicians agreeing to work together to provide services to the community, the emergency department, or patients in the QEII.

241. Dr. [redacted] testified that he had advised Dr. Al-Ghamdi (before his privileges had been suspended) that he could notify the emergency department that he would be available for consultation; however, this did not imply that Dr. Al-Ghamdi would have unfettered access to the ORs, or to nursing and support staff. Dr. [redacted] had not intended this to be a parallel on-call system.

242. Dr. Verna Yiu, then Chief Medical Officer, testified that Dr. Al-Ghamdi wrote to Dr. [redacted], CEO of AHS, with many concerns about colleagues and processes at the QEII. Dr. [redacted] referred these emails and letters to Dr. [redacted] who referred them to Dr. [redacted]. Although Dr. Al-Ghamdi repeatedly complained that Dr. [redacted] did not deal with his issues, Dr. [redacted] was confident that Dr. [redacted] had dealt with at least some of these matters. She referred specifically to an issue regarding the purchase of a Jackson Table for spine surgery cases at the QEII which Dr. Al-Ghamdi had vigorously opposed because of his concerns regarding safety. Another issue which she knew that Dr. [redacted] had addressed related to Dr. Al-Ghamdi's complaint that one of his OR days had been cancelled.

243. It was then that she received further correspondence from Dr. Al-Ghamdi indicating that Drs. [redacted] and [redacted] were part of the problem and that it was inappropriate for Dr. [redacted] to be dealing with the issues relating to Dr. Al-Ghamdi. It was then that she involved Dr. [redacted]

244. Dr. [redacted] provided a long list of emails from or about Dr. Al-Ghamdi between 2010 and 2013 with a summary of each concern raised and how it was handled. She noted that many of these complaints from Dr. Al-Ghamdi did not proceed because Dr. Al-Ghamdi failed to provide the documentation required under the Bylaws in order to investigate the complaint.

245. Ms. Rita Young (OR manager) testified that she had a file with 170 letters relating to complaints from Dr. Al-Ghamdi or responses to his letters. In many instances, Dr. Al-Ghamdi did not follow-up his letter with the documentation that would have allowed the QEII Administration to deal with the issue.

(ii) Dr. Al-Ghamdi's Evidence

246. In his defence, Dr. Al-Ghamdi denied; or did not respond to, the accusations that he had not followed the Bylaws process for initiating a complaint against a colleague. He implied that it was his expectation that if he raised a concern, then it would be resolved. In addition to not providing a signed letter or the documentation necessary for an accusation to be dealt with, Dr. Al-Ghamdi did not think it was appropriate, as provided in the Bylaw, that the subjects of his complaints were notified about his complaints. Rather, Dr. Al-Ghamdi believed that the complaint should be handled in private until the investigation was complete and that advising the individual named in his complaint was a breach of Dr. Al-Ghamdi's privacy and resulted in anger against Dr. Al-Ghamdi.

247. Under cross-examination, Dr. [redacted] acknowledged that he had instructed Drs. [redacted] and [redacted] to communicate with Dr. Al-Ghamdi concerning the Immediate Action taken because of concerns about staff safety, despite the fact that Dr. Al-Ghamdi had complained about both of these persons.

248. Dr. [redacted] also described to Dr. Al-Ghamdi the process outlined in the Bylaws for dealing with concerns. He testified that on many occasions Dr. Al-Ghamdi did not sufficiently follow the process that would have allowed his concerns to be managed as an official complaint under the Bylaws.

249. Dr. [redacted] explained that if he received a letter from a medical staff member who described a number of 'issues' concerning another physician – not a complaint, just for information - he probably would just file it. However, depending on the nature of the concerns expressed in the letter, he might take the opportunity to speak to the subject physician about the expressed concern. In such cases, it would, therefore, not be dealt with under the Bylaw procedures.

250. Dr. Al-Ghamdi asked why he had not been given an opportunity to respond to the Immediate Action against him. Dr. [redacted] responded that Dr. Al-Ghamdi had been provided such an opportunity but had ignored it.

251. Finally, Dr. [redacted] reminded Dr. Al-Ghamdi that local hospital administration was designed to look after the vast majority of the types of issues Dr. Al-Ghamdi raised. Particularly, AHS did not get involved with local matters such as OR booking procedures.

(iii) Decision and Reasons

252. The Tribunal finds that this particular has been established on the balance of probabilities.

253. There was sufficient evidence that Dr. Al-Ghamdi submitted numerous complaints to AHS officials about colleagues and processes at the QEII in Grande Prairie. In doing so, he referred to the Medical Staff Bylaws and Rules to point out what would be the accepted behavior.

254. The AHS officials did (at least usually) respond to Dr. Al-Ghamdi's complaints by indicating that if he wished to have the complaint dealt with under the Bylaws, then he was

required to submit a signed letter along with sufficient documentation to allow the complaint to be investigated. The witnesses testified that Dr. Al-Ghamdi did not respond to these requests and therefore the file was closed.

255. Although Dr. Al-Ghamdi used the Bylaws as the basis for his complaints, the evidence was that he did not follow the process as outlined and did not provide the requested documentation. Nor did he agree with the Bylaw stipulation that the respondents for his complaints must be notified and be given an opportunity to respond. Dr. Al-Ghamdi maintained that this violated his right to privacy. Despite this, Dr. Al-Ghamdi continued to make complaints against colleagues and clearly expected AHS to deal with them using the mechanisms provided in the Bylaws. This Tribunal is aware that it is not adjudicating under the Bylaws, rather it is making findings based on the evidence heard regarding Dr. Al-Ghamdi's frequent attempts to use the Bylaws.

(k) Not Obtaining Consent For Surgery From Your Patient Until Immediately Before The Procedure Rather Than When Booking Patient For Surgery Creating Unnecessary Stress And Delay

(i) CPSA's Evidence

256. The CPSA called several witnesses who testified about this issue.

257. Ms. Rita Young acknowledged that Dr. Al-Ghamdi liked to consent his patients in the Holding Area but did not agree that this was an agreed-to safety matter. Ms. Young did write a letter of apology to Dr. Al-Ghamdi because a patient was taken to the OR before Dr. Al-Ghamdi had a chance to witness the consent.

258. Ms. Kerianne Dunlap testified that Dr. Al-Ghamdi lacked empathy for his patients in that, even with older individuals, Dr. Al-Ghamdi had them repeat to him all the potential complications, including death, that might occur with surgery. All this was just before entering the OR.

259. Nurse Mary Nasedkin described one instance in which Dr. Al-Ghamdi's patient was taken to the OR and anesthetized before Dr. Al-Ghamdi was called. When he arrived, he wanted the patient awakened. Ms. Nasedkin thought this might be to check the circulation of the affected limb but Dr. Al-Ghamdi proceeded to seek consent for the surgery, including for possible amputation. The patient was confused and consent was not provided.

(i) Dr. Al-Ghamdi's Evidence

260. Dr. Al-Ghamdi called a number of witnesses who testified about his practice. On questioning his witnesses and cross-examining those of the CPSA, he acknowledged that in the beginning he obtained consent for the specific surgery in question from the patient before the procedure was submitted for booking. However, after he had a patient taken to the OR and anesthetized before he was called to do the surgery, he stopped witnessing the consent form until he interviewed the patient in the Holding Area. He was not the only surgeon to do this as Dr. Wiens had the same procedure. Dr. Al-Ghamdi maintained that this was for safety reasons so that he could check to be sure the patient's status had not changed and that the patient had not changed their mind just before proceeding with surgery.

(ii) Decision and Reasons

261. The Tribunal finds that this particular has *not* been established on the balance of probabilities.

262. It was clear from the testimony that by following this procedure, Dr. Al-Ghamdi slowed the process in the ORs to some extent. However, the Tribunal accepted Dr. Al-Ghamdi's argument that this was a safety precaution for him.

263. There seemed to be some confusion about the nature of what Dr. Al-Ghamdi did in the Holding Area. The consent had been explained to, and signed by, the patient before the booking request had been submitted. However, the consent is not complete until the physician performing the procedure has witnessed the signature of the patient. It was the witnessing of the consent that Dr. Al-Ghamdi withheld until he interviewed the patient in the Holding Area.

264. The need to do this seems to have resulted from one of Dr. Al-Ghamdi's patients having been taken into the OR and anesthetized before Dr. Al-Ghamdi had interviewed the patient. Not witnessing the consent until just before surgery was his way to ensure that he had the opportunity to interview the patient just prior to surgery. The way he did this was distressing to the staff but does not constitute unprofessional conduct.

(l) Advising Patients And Other Doctors That You Were Able To Book Patients For Surgery At The Hospital When You Did Not Have Active Privilege At The Time

(i) CPSA's Evidence

265. The CPSA did not call any evidence on this matter.

(ii) Dr. Al-Ghamdi's Evidence

266. Dr. Al-Ghamdi made no mention of this particular.

(iii) Decision and Reasons

267. The Tribunal finds that this Particular has *not* been established on the balance of probabilities as no evidence on this Particular was presented by either the CPSA or Dr. Al-Ghamdi.

(m) Having Nursing Staff Open Sterilized Packs Of Surgical Instruments Which Were Not Reasonably Required For The Procedure At Hand And Thereby Making These Instruments Unavailable For Other Surgeons Until The Nursing Staff Had Re-Sterilized Those Instrument Packs

(i) CPSA's Evidence

268. Kerianne Dunlap, a nurse in the OR who worked with Dr. Al-Ghamdi from time to time, testified that Dr. Al-Ghamdi would ask for more trays to be opened than were, in the nursing staff's opinion, required. She told the Tribunal that she had personal experience with Dr. Al-Ghamdi booking cases and requesting the usual instruments. However, he would arrive and ask for additional instrument sets and demand that they be opened. She described this as a make-work project.

269. The Tribunal heard evidence that in November 2012 Dr. Al-Ghamdi performed emergency surgery on a patient who had had a total knee replacement that had become infected. Theresa Jordan, a nurse working in the OR at that time, testified that Dr. Al-Ghamdi told her and others involved in this particular surgical procedure that it was going to be a debridement, which would require few instruments. However, according to Ms. Jordan, Dr. Al-Ghamdi ordered trays that would be appropriate for a total knee replacement rather than just for a debridement. Ms. Jordan stated that Dr. Al-Ghamdi demanded that the trays all be opened.

270. Witness Stephanie Malekoff, who was also involved in this case in the OR, testified that she also believed the intended procedure was a debridement and that she was frustrated that Dr. Al-Ghamdi did not advise all of the staff that he might be performing a total knee replacement. Ms. Malekoff testified to the effect that emotions were running high in the OR during this procedure, particularly when Dr. Al-Ghamdi did not use any of the added trays.

271. Mr. Shane Ray, called by Dr. Al-Ghamdi, testified that Dr. Al-Ghamdi asked for eight pans of instruments (required for a knee replacement) to be opened to merely do an exchange of liner, which normally did not even require one pan.

272. Dr. [redacted] testified that Dr. Al-Ghamdi asked to have more trays opened than he needed.

(ii) Dr. Al-Ghamdi's Evidence

273. Dr. Al-Ghamdi denied these accusations. Indeed, he stated that he only wanted the instrument packs to be ready, not opened.

274. During his testimony, Dr. Al-Ghamdi explained that it could be harmful to a patient if the operation was started and then it was recognized that another instrument was required, only to find that there was not one available. Moreover, searching for an instrument causes delay in the procedure. He described a case in which he needed a long plate and screws, however when the box was opened during surgery, there was only a short plate and he was forced to compromise the patient's care. Therefore, he stated that his procedure is to have all potentially required

instruments present and opened in the OR before the procedure begins. This is a different statement than his initial denial that he had insisted on the additional trays being opened.

(iii) Decision and Reasons

275. The Tribunal finds that this particular has been established on the balance of probabilities.

276. This conduct is indicative of Dr. Al-Ghamdi's disregard for the hospital's resources and the potential needs of other patients. Once the trays are opened they cannot be used again. There is a limited supply of sterilized equipment.

277. The two nurses who testified that they were in the room during the surgery on the man with the infected knee prosthesis were insistent that Dr. Al-Ghamdi had requested the additional trays and that he had also insisted that they be opened.

278. Other witnesses also agreed that Dr. Al-Ghamdi requested instrument trays to be opened that were not needed.

279. Although the Tribunal agrees that the surgeon is in the best position to know what instruments will be required for specific cases and acknowledges that Dr. Al-Ghamdi denied this accusation, there were no witnesses who agreed with Dr. Al-Ghamdi's statements concerning this particular. Moreover, during his testimony, Dr. Al-Ghamdi contradicted his earlier denial when he indicated that he always asked for all the trays to be open so he could be certain that everything that he might need was available. Overall, the Tribunal found the other witnesses more credible than Dr. Al-Ghamdi regarding this issue as they were consistent in their observations in this regard.

B. Conclusion on Particulars

280. The Tribunal finds that, on the balance of probabilities, the College has established 8 of 13 particulars listed in the charge. As noted in *Fitzpatrick v. Alberta College of Physical*

Therapists, not all particulars need to be established in order for the charge to be proven. Before deciding whether Dr. Al-Ghamdi is guilty of the charge that he demonstrated a pattern of disruptive conduct which has resulted in a breakdown of his professional relationship with colleagues and staff at the QEII, and that this breakdown has had a negative impact on health services at the QEII, below the Tribunal first considers other evidence heard in testimony during the Hearing.

C. Evidence in Relation to Disruptive Conduct

281. As noted above, having completed a review of the evidence in relation to the particulars, now a review of the evidence in relation to disruptive conduct will be undertaken. While some of the evidence reviewed below was touched on in the review of the particulars, it is necessary to consider whether the evidence before the Tribunal, beyond the particulars, establishes on a balance of probabilities a pattern of disruptive conduct as set out in the charge.

a) Disruptive Conduct in On-Call

282. The Tribunal heard a number of witnesses describe Dr. Al-Ghamdi as passive-aggressive and "two-faced" after he pointed out that he never yelled or used profane language within the QEII. However, none of the witnesses testified that Dr. Al-Ghamdi yelled or used inappropriate language during interactions with them.

283. We also heard Dr. Al-Ghamdi's behavior described as un-governable by his fellow clinicians. It was clear that he frequently refused to conform to procedures and processes considered normal or usual by others.

284. Perhaps the best detailed example of this was his refusal to agree to the development and implementation of an on-call schedule for orthopedic surgery at the QEII, at least using a process described as 'normal' or 'usual' by many witnesses from other disciplines within the QEII and from elsewhere. The orthopedic surgeons had elected as a group (including Dr. Al-Ghamdi) that, since there was four of them, they would be on-call one day in four during the week and one weekend per month. Dr. Al-Ghamdi did not agree to have the weekday on-call fixed for each

individual (Dr. Al-Ghamdi was on-call each Wednesday) which facilitated a simple and repetitive call schedule.

285. Regarding the creation of the on-call schedule, Dr. Al-Ghamdi literally interpreted the Medical Staff Bylaws to mean that the on-call schedule should reflect the agreement of all involved; if this was not possible then AHS officials should be involved. Dr. Al-Ghamdi unsuccessfully attempted to involve such individuals but agreement was impossible. Dr. Al-Ghamdi wanted to advise his colleagues when he would be available to be on-call and expected the others to accommodate his wishes by scheduling themselves to fill the gaps. During the hearing, Dr. Al-Ghamdi indicated he would also find it acceptable if he (and others) were to advise the Department Chief of what days they were not available, with the Department Chief then having the responsibility to create an on-call schedule acceptable to all. Of course, both of these approaches defeat the purpose of having a simple and predictable on-call rotation with which everyone becomes familiar. Even when the on-call schedule was to his satisfaction, Dr. Al-Ghamdi did not consider it official until he had approved it.

286. It became apparent later why Dr. Al-Ghamdi wished to have such a flexible on-call schedule. In 2008, Dr. Al-Ghamdi enrolled for full-time studies in the Faculty of Law at the University of Alberta. He wished to be able to arrange his on-call responsibilities around his time-table for classes. He complicated the situation by failing to inform his orthopedic surgeon colleagues that he was attending law school, stating emphatically during testimony that it was none of their business. He objected to being on-call each Wednesday since, after performing surgery on patients all that day, he would occasionally have to leave the next day to go to Edmonton to attend classes. This meant that he was not available to care for his patients in the hospital if the need arose. Initially Dr. Al-Ghamdi managed this by asking Dr. [redacted] (another orthopedic surgeon) to care for these patients. However, Dr. [redacted] eventually refused to do this on an ongoing basis and Dr. Al-Ghamdi then 'signed out' to a family physician to care for his patients, with his help by phone as needed. Arguably, this did not provide the best care for these patients and the Administrative personnel at the QEII may not have approved it had they been aware.

287. After graduation from law school, Dr. Al-Ghamdi did his articling requirements over a two-year period in British Columbia. Again, his surgical colleagues had not been informed that he was studying law nor that he was an articling student in British Columbia. The articling requirements were such that Dr. Al-Ghamdi needed to be away for longer blocks of time. The many disputes over the on-call schedule in September and December of 2012 reflected Dr. Al-Ghamdi's need to be away from Grande Prairie for up to a month at a time. And still this was done without making any arrangement for his on-call responsibilities other than sending a note (Dr. Away notification) to the Medical Staff Office months in advance.

288. During all this time, Dr. Al-Ghamdi wanted to do as much surgery as possible when he was in Grande Prairie but then needed to have as much time away as possible to complete his legal education. The Tribunal heard testimony that even when his colleagues suspected that Dr. Al-Ghamdi was studying law, it was difficult to ascertain this since Dr. Al-Ghamdi went to lengths to avoid being identified as a student at the University of Alberta. Only when Dr. [redacted] found a photograph on the internet of Dr. Al-Ghamdi with a number of attendees at a legal conference, did it become clear that Dr. Al-Ghamdi was, indeed, attending law school.

289. After years of frustration with this situation, in 2012, his colleagues refused to share on-call with Dr. Al-Ghamdi, which he (Dr. Al-Ghamdi) claimed was an act that interfered with his hospital privileges.

b) Disruptive Conduct in the area of priority for access to OR

290. Perhaps even more serious was Dr. Al-Ghamdi's resistance to having a patient (judged by another physician to be more ill that Dr. Al-Ghamdi's patient) precede his patient to the OR. The most blatant example of this concerned Dr. [redacted]' patient, Mr. [redacted], referred to in particular (c). Dr. [redacted] also described an occasion when he wished to bump Dr. Al-Ghamdi's patient in order to perform an urgent caesarian section. Dr. [redacted] described how Dr. Al-Ghamdi questioned him about the signs and symptoms of Dr. [redacted] patient, as if he was the most qualified to judge the urgency of the case.

291. The agreed procedure when the two surgeons could not agree as to whose patient should go first was to have the patient in question assessed by the anesthetist, whose ruling was to be final. But Dr. Al-Ghamdi was not prepared to accept this, as illustrated in Mr. [redacted] case. Dr. [redacted] the anesthetist, evaluated this patient and was distressed enough by the seriousness of his condition that he personally took the patient to the OR and began preparing him for surgery. However, Dr. Al-Ghamdi would not accept this opinion and insisted that his patient was to be operated on first, because he had booked the patient first.

c) Disruptive Conduct on the Mask Issue

292. Dr. Al-Ghamdi's insistence that everyone in his OR wear a mask also frustrated his colleagues. The issue of health care workers wearing masks has been the subject of research to determine if wearing masks is associated with a reduced risk of infection. The Tribunal heard from a number of witnesses about this issue, with the dominant opinion being that the available evidence is inconclusive. Dr. Al-Ghamdi was particularly obsessed that Dr. [redacted] an anesthetist, did not wear a mask except in specified situations when he believed there was evidence that it made a difference. Dr. Al-Ghamdi was unable to accept this position and stated several times during the Hearing that there was evidence that wearing a mask decreased the incidence of infection; however, he did not provide this evidence to the Tribunal. Dr. Al-Ghamdi called Dr. [redacted] an infectious disease expert, who testified that the research evidence was not conclusive. Dr. [redacted] acknowledged that for patients having orthopedic surgery with the insertion of hardware, or patients having vascular surgery, the situation might be different. However, this specific situation has not been studied. Despite this lack of evidence, Dr. Al-Ghamdi insisted that he knew best and reported Dr. [redacted] to the CPSA. He also reported nurses who entered his OR without a mask and complained enough that the QEII did eventually develop a dress code for the ORs which included wearing a mask. This applied to staff (nursing and technical) but not to physicians.

d) Disruptive Conduct re parallel call

293. The Tribunal heard considerable testimony concerning whether it was proper for Dr. Al-Ghamdi to operate a parallel on-call system once the other orthopedic surgeons refused to share a call system with him. Because of his rigid interpretation of the Medical Staff Bylaws and a letter

from Dr. [redacted] to Dr. Al-Ghamdi's lawyer, Dr. Al-Ghamdi believed he was entitled to be on-call all the time to receive consultations from the emergency department at the QEII. Unfortunately, in order to treat the patients referred to him, Dr. Al-Ghamdi needed access to the OR facilities. But the Operating Room policy developed by the Surgical Services Committee specified that first call on the OR resources after hours was the surgeon who was officially on-call for each specialty service. Therefore, Dr. Al-Ghamdi had to speak to; and negotiate with, the on-call orthopedic surgeon in order to have his patient booked. This was the situation on the evening in July 2013 when Dr. Al-Ghamdi spoke to Nurse Rice on the phone and requested that she call for his patient so that he could proceed with surgery. Ms. Rice refused to call for Dr. Al-Ghamdi's patient without the approval of Dr. [redacted] who was the official on-call surgeon for orthopedics that evening. Dr. Al-Ghamdi initially refused to speak with Dr. [redacted] and insisted that he had approval for a parallel on-call system and that Ms. Rice should call Dr. [redacted], CEO of AHS, to confirm this. Based on all the evidence presented to the Tribunal on this issue, Dr. Al-Ghamdi's assertion that he had approval for a parallel on-call system was not true.

e) Disruptive Conduct in terms of dispute resolution structures and processes

294. As noted in Particular (j), The Medical Staff Bylaws and Rules of Alberta Health Services outline procedures for medical staff to follow if there is reason to believe that they have not been treated fairly or if they have identified changes which, if implemented, might improve patient care. The medical staff is organized into Departments and/or Divisions – each of which has a Clinical Head charged with administering the affairs of the group. It is expected that the vast majority of concerns encountered by a clinician would be resolved by the Clinical Head. Because Dr. Al-Ghamdi did not get along with his clinical department colleagues, he chose to take his problems to persons with positions senior to the departmental level. At the QEII, this was the Facility Medical Director, a position occupied by Dr. [redacted] until 2006, and subsequently by Dr. [redacted]. With the advent of AHS in 2008/09, there was also a clinician with regional responsibility and Dr. [redacted] has served as Medical Director for the North Zone. Dr. Al-Ghamdi made many complaints to these individuals and when he perceived that Dr. [redacted] was not effective in resolving his issues, he began sending his complaints directly to Dr. [redacted], then CEO of Alberta Health Services. Dr. Al-Ghamdi complained to Dr. [redacted] that Dr. [redacted] did not resolve the issues that he (Dr. Al-Ghamdi) had raised and therefore requested that Dr. [redacted]

resolve them. This included complaints that his OR day had been cancelled or that his patient's surgery had been postponed. Dr. [redacted] began referring this correspondence to Dr. [redacted] (Chief Medical Officer) to resolve. She initially referred them to Dr[redacted] since these were issues for the North Zone, but when Dr. Al-Ghamdi complained that Dr. [redacted] was part of the problem, the issues were referred to Dr. [redacted], an Associate Chief Medical Officer who also chaired the Bylaws Committee. Although Dr. Al-Ghamdi sent many complaints to these individuals, he frequently failed to provide the information required for his complaints to be dealt with under the Bylaws. AHS has approximately 100,000 employees and interacts with approximately 10,000 physicians licensed to practice in Alberta. Despite the fact that these senior officials dealt with numerous complaints from Dr. Al-Ghamdi, he reported all of them to their superiors for not doing their jobs properly – this included Dr. [redacted] who was reported to the Minister of Health.

295. Most of the issues the administration and medical staff at the QEII raised were normally dealt with by the QEII with reference to the Medical Staff Bylaws. When Dr. Al-Ghamdi joined the medical staff at the QEII, he was awarded temporary (provisional) privileges, the same as all other new members. The expectation would be that he would be awarded full medical staff privileges after successfully completing his first year. However, at the end of that first year, there were concerns about Dr. Al-Ghamdi; subsequently, his provisional privileges were renewed. In 2006, the Credentials Subcommittee of the Medical Advisory Committee at the QEII asked Dr. [redacted] (who was Registrar of the CPSA) to form a Committee and evaluate Dr. Al-Ghamdi's suitability for full privileges. Dr. [redacted], with co-operation from Dr. Al-Ghamdi's lawyer, arranged for two orthopedic surgeons to join him for an on-site visit. The CPSA entered the report of this visit as evidence in this hearing. The committee's assessment of Dr. Al-Ghamdi was negative and the recommendation was that his privileges not be renewed. Dr. Al-Ghamdi filed for judicial review, and the QEII pledged not to act on the Theman report if this application was withdrawn. In 2009, the Credentials Subcommittee asked Dr. [redacted] and Dr[redacted] to prepare a report for MAC concerning Dr. Al-Ghamdi's privileges. The two surgeons created a list of all the issues with Dr. Al-Ghamdi over a one-year period. On the basis of this, they recommended that Dr. Al-Ghamdi's privileges at the QEII be terminated. According to testimony from Dr. [redacted], because of the turmoil ongoing at that time; as AHS was being established and the Bylaws re-written, the decision was made not to accept the recommendation.

Therefore, Dr. Al-Ghamdi continued to have his 'temporary' or 'provisional' hospital privileges. Because of on-going issues in the ORs, in 2013 the Surgical Services Committee attempted to have Dr. Al-Ghamdi's privileges suspended. Dr. [redacted] was involved in the meeting but he indicated to the Tribunal that he was careful to assure that others carried this forward because he realized that he had a potential conflict of interest. The QEII subsequently advised the Committee that it did not have the authority to do this.

f) Disruptive Conduct as evidenced by Dr. Al-Ghamdi's views of himself and others

296. Dr. Al-Ghamdi is justifiably proud of his educational achievements. However, his arrogance affected his relationships with his colleagues and was apparent throughout the Hearing. On several occasions during the Hearing, Dr. Al-Ghamdi indicated that, as reflected by his many 'degrees', he was brighter than others in Grande Prairie. Indeed, Dr. Al-Ghamdi told one witness that he has thirteen degrees (it appears that he has four degrees and many certificates). During his own testimony, he stated that, because he has a Masters of Health Law degree, he knew more about ethics in medicine than anyone else in the room. While this may be true, it does not mean he is more ethical. His sense of 'superiority' extended to his orthopedic colleagues in Grande Prairie. He noted on several occasions that the 'older' surgeons there when he arrived were not familiar with the newer techniques that he used. Moreover, he believed that the 2006 recruits, Drs. [redacted] and [redacted], who were both from South Africa, had lesser quality training than he had received in the Canadian system. Indeed, he believed that both had only some form of provisional license which allowed surgeons to practice in more remote areas where there was a lack of services. He also believed that once further recruitment had occurred in Grande Prairie, these two surgeons would be asked to leave to go to another under-serviced area. Dr. Al-Ghamdi actually asked Dr. [redacted] during cross-examination if he was allowed to see patients without supervision (because of a license restriction). Drs. [redacted] and [redacted] have met all the requirements of the CPSA and have full licenses to practice in Alberta.

297. During his examination-in-chief or cross-examination of witnesses who were physicians, Dr. Al-Ghamdi often asked medical questions, again implying that he was better educated, or more intelligent, than they were.

298. Dr. Al-Ghamdi was also critical of general surgery in Grande Prairie, and particularly of Dr. [redacted] who has been Chief of Surgery at the QEII. Dr. [redacted] is also from South Africa but did his surgical training in Canada. However, Dr. Al-Ghamdi seems to believe that Dr. [redacted] does some surgical procedures for which he is not qualified and that his clinical judgment is suboptimal. In Particular (c), details were provided about a patient of Dr [redacted] Mr. [redacted] whom Dr. Al-Ghamdi refused to allow to precede his case of a fractured leg. But during this hearing, Dr. Al-Ghamdi questioned many witnesses about other cases of Dr. [redacted]. Of particular interest was that of a woman with an un-diagnosed condition who was immobile and developed large areas of pressure-induced necrosis (gangrene) of the tissue, particularly over her buttocks. Both Dr. [redacted] (another General Surgeon) and Dr. [redacted] had seen this patient and recommended palliative treatment consisting of debridement of the dead tissue. Dr. [redacted] took this patient to the OR, Dr. Al-Ghamdi accused Dr. [redacted] of bumping his case in order to take this non-urgent patient to surgery. Dr. [redacted] denied that he had bumped Dr. Al-Ghamdi's patient on that occasion, explaining that cases proceeded in the order they were booked. After the surgery was complete, and Dr. Al-Ghamdi was operating on his case, Dr [redacted] patient (who had been taking anti-coagulants and was known to have a high INR), began to bleed and subsequently died. Dr. [redacted] and/or the anesthetist notified the Medical Examiner (ME) in Edmonton about the death, but Dr. Al-Ghamdi found out and attempted to have the case assigned to him, as he was a ME for that region. He claimed that the death was preventable since Dr. [redacted] should not have operated on someone who had such a high INR – or at least he should have reversed the anti-coagulant before surgery. Dr. Al-Ghamdi even involved the RCMP to try and locate the body so that he could conduct his examination, and may have suggested that Dr [redacted] be criminally charged. Dr. [redacted] testified that he believed that this was an attempt by Dr. Al-Ghamdi to retaliate against Dr. [redacted] for previous interactions with which Dr. Al-Ghamdi was not happy. In any event, this became a very unpleasant event and significantly increased the animosity between Dr. Al-Ghamdi and Dr. [redacted]

299. Another case of Dr. [redacted] was that of Mr. [redacted], an elderly patient referred to Dr. [redacted] with the diagnosis of necrotizing fasciitis. Dr. [redacted] proceeded to do fasciotomies and minimal debridement. Unfortunately, the patient's condition worsened and he died in hospital. Dr. Al-Ghamdi believed that Dr. [redacted] had not properly treated this condition and suggested that

amputation should have been performed. During cross-examination he questioned Dr. [redacted] on whether he had been trained or had approval to do amputations. Dr. [redacted] confirmed that he had been trained and had approval to do such procedures. Dr. Al-Ghamdi called Mr. [redacted] daughter as a witness during this hearing; she travelled a significant distance to testify because it was her understanding from her conversation with Dr. Al-Ghamdi that this was a hearing into Mr. [redacted] death and she would find out why he died. The Tribunal questions Dr. Al-Ghamdi's ethics for misrepresenting the purpose of this hearing to Mr. [redacted] daughter.

g) Disruptive Conduct as demonstrated in Dr. Al-Ghamdi's working relationships with others

300. Dr. [redacted] relayed complaints about Dr. Al-Ghamdi not answering his pager when he was on-call. Dr. Al-Ghamdi pointed out that he made himself available for spinal cases for many years without special recognition or compensation, but did not specifically deny that he sometimes did not answer his pager.

301. The orthopedic surgeons also pointed out that Dr. Al-Ghamdi refused to accept patients in transfer from locum physicians after these individuals had been on call but were leaving the community. Another surgeon had to do this since locum physicians were not resident in Grande Prairie and could not therefore accept responsibility for in-hospital care of patients after their rotation was completed.

302. Another understanding among the orthopedic surgeons was that after a 24-hour period on call, each would transfer any un-operated patients they had admitted during their call to the person on-call for the subsequent 24-hour period for the needed surgery. Dr. Al-Ghamdi refused to transfer his patients after his 24-hour on-call period ended and this placed himself in the position of competing with the next on-call surgeon for OR time.

303. Dr. Al-Ghamdi complained extensively that the Orthopedic Department did not regularly meet to deal with the call schedule and other matters. However, Dr. [redacted] testified that whenever a meeting was called, Dr. Al-Ghamdi would send an email requesting a date change.

304. Dr. Al-Ghamdi complained repeatedly that the QEII and AHS were not honoring the contract he had signed. Indeed, Dr. Al-Ghamdi has brought a lawsuit against AHS regarding his contract. However, Dr. Al-Ghamdi has not shown his contract to others; even [redacted], Chief of Orthopedics, had not seen Dr. Al-Ghamdi's contract despite the fact that Dr. Al-Ghamdi repeatedly accused Dr. [redacted] of not providing him with the amount of OR time that is called for in his contract.

305. Dr. [redacted] explained that some of the correspondence from Dr. Al-Ghamdi was copied to his then lawyer. After noting this, Drs. [redacted] and [redacted] decided to refer all correspondence from Dr. Al-Ghamdi to the legal department at AHS. Dr. Al-Ghamdi then complained that Dr. [redacted] stopped responding to his emails.

306. According to Nurse Nasedkin, Dr. Al-Ghamdi wrote a letter to the QEII, threatening to charge the QEII for lost income when one of his patient's surgery was cancelled. Ms. Nasedkin testified that this caused her considerable stress as she assumed that others thought that she was making errors. Dr. Al-Ghamdi had stated that his contract provided him with seven OR days per month and when he was only booked for six days, he sent an invoice for lost income and blamed Nurse Nasedkin. Dr. [redacted] confirmed that this happened.

307. When Dr. Al-Ghamdi asked Dr. [redacted] to care for his patients after he had performed surgery on Wednesdays, Dr. [redacted] pressed him as to why he was to be away so many Thursdays. Dr. Al-Ghamdi indicated to him that he was on holiday. This got worse in 2012 when Dr. Al-Ghamdi indicated that he would be away all of September and December. It was only in retrospect that Dr. [redacted] understood that these requests were because Dr. Al-Ghamdi had studied law in Edmonton and was now articling in Northern BC.

308. Dr. Al-Ghamdi had many problems in accessing surgical assistants for specific surgical cases. Dr. Al-Ghamdi 'fired' one of the Assistants, Dr. [redacted]; however, the next day when no surgical assist was available for his case, he tried to have Dr. [redacted] help him. She refused. Dr. Al-Ghamdi also asked a nurse to leave his room because 'she was slowing him down'.

309. Ms. Rita Young described a patient who came to her crying because, although he had paid Dr. Al-Ghamdi to complete Workers Compensation Forms, this had not been done. The patient was desperate and could not pay his bills. Ms. Young asked another surgeon to complete the forms.

310. Dr. [redacted], an anesthetist, described working with Dr. Al-Ghamdi when he (Dr. Al-Ghamdi) received a phone call from a family physician in Grimshaw about a patient with a fracture through a joint containing a prosthesis. According to Dr. [redacted], Dr. Al-Ghamdi advised the physician to send the patient to Grande Prairie and he would see him. However, when the patient arrived in the Emergency Room at the QEII with a consultation form addressed to Dr. Al-Ghamdi, he refused to see the patient and instructed the Emergency Department to send the patient back to Grimshaw. Eventually, the physician in Grimshaw was able to arrange for the patient to be seen in Edmonton. Dr. Al-Ghamdi denied these accusations.

311. Dr. Al-Ghamdi wrote to Dr. [redacted] requesting that Dr. [redacted], Dr. [redacted], Dr. [redacted] and others be investigated for abuse of authority.

312. Ms. Kerianne Dunlap testified that if Dr. Al-Ghamdi came back to work at the QEII, she would quit and predicted that many other nurses would as well.

313. Dr. [redacted] who was the Facility Medical Director between 2003 and 2006, described physicians from surrounding communities wanting to know who was on-call for orthopedics before sending their patients to Grande Prairie. If Dr. Al-Ghamdi was on-call, they would send the patient elsewhere. This was because, on occasion, patients would arrive in Grande Prairie and wait in the ER for many hours to be seen by Dr. Al-Ghamdi who might then send them back to their community, costing another ambulance trip.

314. Dr. Al-Ghamdi wrote a letter to the Minister of Health suggesting that several anesthetists were over-billing for certain procedures. This was investigated but the Tribunal does not know the result of the investigation.

315. Dr. Al-Ghamdi sent an email to Dr. St. Germaine about the call schedule for the Medical Examiner for the Grande Prairie region and indicated that if Dr. [redacted] did not agree to the on-call schedule Dr. Al-Ghamdi proposed, Dr. [redacted] would be reported to the CPSA for unprofessional conduct.

316. During the course of the CPSA investigation and this hearing, Dr. Al-Ghamdi filed a lawsuit against many of his administration, nursing and medical colleagues at the QEII as well as against AHS and even the CPSA. More than 50 individuals have been named in this suit. Several witnesses acknowledged during their testimony that they were being sued by Dr. Al-Ghamdi, but were not aware of the reason(s).

317. Nurse Jordan wrote a letter of complaint about Dr. Al-Ghamdi following an incident in the OR. Dr. Al-Ghamdi was waiting for the results of an X-ray on a patient with a broken leg and booked the patient for surgery. According to Ms. Jordan, she did not know about the X-ray and when the anesthetist called for the patient, he was taken into the OR. The patient had been drinking and was heavily sedated, so Ms. Jordan did not think that discussing the consent with the patient would be meaningful, if even possible. Dr. Al-Ghamdi was very upset and accused Ms. Jordan of not doing her job properly.

318. Dr. [redacted] testified that as Chief of Surgery, he noticed that whenever Dr. Al-Ghamdi was on-call there was a conflict in the OR.

319. Dr. Al-Ghamdi called Ms. Deborah Magusin, a nurse in the OR for 30 years. When asked what she thought of Rita Young, she answered that Rita was a good nurse with a tough job. At this point, Dr. Al-Ghamdi provided her with an unsigned letter that Ms. Magusin had written (but not sent) some time before. Ms. Magusin testified that she had been upset at the time and wrote the letter in support of Dr. [redacted]. She wished she had never written the letter and was obviously distressed that Dr. Al-Ghamdi had obtained it, apparently from Dr. [redacted]. This witness also had no idea why Dr. Al-Ghamdi had sued her.

320. Dr. Al-Ghamdi called Ms. Ginger Krause, who had worked in the Recovery Room for 10 years and the OR for the past 1.5 years. She described an instance when Dr. Al-Ghamdi removed the Halo collar from a patient with an unstable cervical fracture and asked for a hard collar, although he must have known that this would take some time to obtain. While waiting, Dr. Al-Ghamdi asked Ms. Krause to apply traction to the neck; she refused on the basis that this was a procedure which was outside her scope of practice although Dr. Al-Ghamdi did report her to her supervisor. This witness also complained that Dr. Al-Ghamdi would ask her to get up from her chair in the recovery room so that he could sit and dictate his operative note. On occasion, he would just stand beside her chair and stare until she got up. She also had no idea why she was being sued by Dr. Al-Ghamdi.

321. Although Dr. Al-Ghamdi maintained on several occasions that the visible minority physicians were being driven out of Grande Prairie, Dr. [redacted] (called by Dr. Al-Ghamdi) testified that there are a lot more visible minorities in the Grande Prairie medical community now than when he first arrived in 1998.

322. Dr. Al-Ghamdi called a number of witnesses, who worked in the OR at Grande Prairie (these included Nurses Dorcheid, Halwa, Hobbs, Parsons, Malekoff and Hanson). All are being sued by Dr. Al-Ghamdi but they do not understand why. Ms. Holly Ljuden made this same comment.

D. Dr. Al-Ghamdi's Defence to the Charge of Disruptive Conduct

a) Advocate for Quality of Care

323. Dr. Al-Ghamdi's defence to these accusations of unprofessional behavior fell into a number of categories. Dr. Al-Ghamdi believes that he has been labelled a troublemaker rather than a concerned practitioner. He stated that his extensive background as a surgeon and lawyer with an MBA and a Master's Degree in Health Law made him more skilled than others in detecting shortcomings in the healthcare system. Pointing out these shortcomings was upsetting to the people working in the system.

324. Dr. Al-Ghamdi pointed out to the Tribunal that there were problems with the quality of care in Grand Prairie. He particularly referred to Dr [redacted] but he also made comments about Drs. [redacted] and [redacted]. Dr. [redacted] did not complete his medical records which certainly interfered with Dr. Al-Ghamdi's ability to care for patients previously seen by Dr. [redacted]. For this, Dr. Al-Ghamdi reported Dr. [redacted]k twice to the CPSA. He also reported others, including Drs. [redacted] and [redacted], who in his view, engaged in unprofessional behavior. He felt it was his professional obligation to report these shortcomings to the CPSA or to senior officials at AHS and it was because of his reporting of these individuals (as he was obliged to do), that people complained about him; he stated he was only doing his job. He also acknowledged that he reported a number of the medical leaders at the QEII in Grande Prairie and at AHS, often because they failed to take action against those about whom he complained.

325. Dr. Al-Ghamdi called Dr. [redacted], a physician from Africa who spent considerable time in South Africa (seemingly in a medical leadership position) before coming to Canada. Although Dr. Al-Ghamdi attempted to confirm Dr. [redacted]n as an expert in surgery, medicine, ICU, emergency medicine, pre and post-operative care and geriatrics, Dr. [redacted] qualifications in Canada were as a family physician with a special interest in geriatrics and he had worked in Grande Prairie for approximately 3.5 years as a Hospitalist. After considering the evidence presented, the Tribunal did accept him as a family physician with expertise in emergency care, as a family physician with a special interest in geriatrics, and as a Family Physician with expertise as a Hospitalist. Dr. [redacted] stated that the quality of care at the QEII was abysmal. Dr. [redacted] believes that he was also penalized for trying to improve things.

326. Dr. Al-Ghamdi called Dr. [redacted] who testified in-camera. She was educated in Argentina but has done training in Obstetrics and Gynecology in North America. She testified that when she had to bump Dr. Al-Ghamdi's patient, she did not experience more difficulty than with other surgeons. She also noted that when she arrived, a colleague told her that the QEII was small with only one problem: Dr. Al-Ghamdi. Dr. [redacted] did not get along with one of the nursing administrators, stating that she was rude to Dr. [redacted] staff. She described Dr. [redacted] as having an anger management problem and stated that she had heard lots of negative comments about Dr. Al-Ghamdi.

327. Dr. Al-Ghamdi called Ms. Holly Ljuden, who had worked for many years in the Medical Records Department. She described the process for notifying physicians of the charts to be completed. If the records were not completed within two weeks, the Facility Medical Director was notified. She stated that some physicians were suspended because of their failure to complete records (she could only name two – one was Dr. [redacted]). In her new position, she helps senior medical leaders by giving advice about complaints concerning physicians. She indicated that since 2012 there had been complaints about Dr. Al-Ghamdi which she sent to him for response; she does not recall receiving any responses from him, but if she had she would have forwarded them to Dr. [redacted]. In response to questioning, she reminded Dr. Al-Ghamdi that concerns over safety (such as the concern following the threat Tracy Rice perceived Dr. Al-Ghamdi to have made) are dealt with through the legislation on Workplace Health and Safety, not through the Medical Staff Bylaws. Dr. Al-Ghamdi made it clear again that he believed that all interactions between AHS and physicians should be dealt with through the Bylaws. Ms. Ljuden also does not understand why she is being sued by Dr. A-Ghamdi.

b) Racism and Islamophobia

328. Dr. Al-Ghamdi claimed that many of his problems in Grande Prairie have been because of racism and Islamophobia. He stated that he and other visible minority surgeons were treated differently than other (white) surgeons. In support of this he called a number of witnesses:

329. Ms. Janet Loseth, a nurse in the operating rooms at the QEII, testified that, in her experience, Dr. Al-Ghamdi was always professional, polite and clearly a patient advocate. She thought that a lot of Dr. Al-Ghamdi's problems stemmed from the fact that Gail Coristine and Rita Young did not like him. According to her testimony, other visible minorities were treated just like Dr. Al-Ghamdi. She described some nurses' behaviour as obstructing Dr. Al-Ghamdi. She gave examples such as Gail Coristine not providing Dr. Al-Ghamdi with the instruments he needed, nurses not speaking to Dr. Al-Ghamdi for long periods of time, and Ms. Coristine slowing down so that Dr. Al-Ghamdi's next case would be cancelled. She also claimed that if a nurse called in sick, it would be Dr. Al-Ghamdi's or Dr. [redacted] room that would be cancelled. She described Ms. Coristine as disruptive and said she called Dr. Al-Ghamdi "shit-for-brains". Ms. Coristine was also heard saying that Dr. Al-Ghamdi disliked women, Christians, and

Christmas. According to Ms. Loseth, Ms. Coristine did not like Dr. Al-Ghamdi because he was Arab and a Muslim. Ms. Loseth did acknowledge that Dr. [redacted] was not treated differently than the white surgeons, but stated that he has lived in Canada for a long time and has become Canadianized. Ms. Loseth indicated that she did not sign the Tracy Rice petition and has noticed that she has been treated differently since then. Ms. Loseth had sworn an affidavit for Dr. Al-Ghamdi with respect to his claim with the Human Rights Commission. This was entered as an exhibit.

330. Dr. [redacted] is a physician from Lebanon who has practiced in Grande Prairie for many years as a Urologist. He is an Arab and, although Christian, he believes that he has suffered discrimination because of his ethnicity. Initially he believed he was treated well, but ascribed the beginning of his troubles to the influx of a lot of South Africans, after which he felt marginalized. He complained to the Hospital Administration about discrimination after that his referrals slowed and he became less busy to the point that his OR time was decreased. A new Urologist has been recruited and Dr. [redacted] feels isolated and his patients and resources are decreasing. He described physicians in Grande Prairie as greedy and only interested in making money. Although he does not like Dr. Al-Ghamdi, he feels that Dr. Al-Ghamdi has been a victim of discrimination and now is not allowed to work *or* to move away from Grande Prairie. Dr. [redacted] believes that Dr. [redacted] makes a lot of decisions; but not without Dr. [redacted] input. Dr. [redacted] described Dr. [redacted] as "a full-blown idiot and a racist". When he told Dr. [redacted] that he would testify for Dr. Al-Ghamdi, Dr. Pope became angry and no longer refers patients to him. Dr. [redacted] believes that he and Dr. Al-Ghamdi have been treated differently than others; he also believes that Drs. [redacted] [redacted] and [redacted] were treated badly. According to Dr. [redacted] the lucky ones moved. Dr. [redacted] stated that he advised the medical staff not to recruit Drs. Al-Ghamdi and [redacted] because they were Muslim and very rigid and would not fit into the environment. Dr. [redacted] expressed no confidence in the QEII Administration, AHS, or the CPSA. He stated that he did observe nurses being disrespectful of Dr. Al-Ghamdi. He also acknowledged that he had been reported to the CPSA and had recently gone through a hearing process.

331. Dr. Al-Ghamdi called Ms. Yvonne Vos (wife of Dr. [redacted] who had shared his office with Dr. Al-Ghamdi). She was from South Africa and had been friends with the [redacted] and [redacted]. However, these relationships faltered after Dr. [redacted] allowed Dr. Al-Ghamdi to work in his office. Ms. Vos has a high opinion of Dr. Al-Ghamdi, his knowledge, skills, and interpersonal relationship abilities.

332. Ms. Denise Beaudin worked as an OR attendant and was largely responsible for portering patients to and from the operating rooms. More recently, she took an OR processing course. She also 'picks' the instrument trays for cases. She has not noticed that Dr. Al-Ghamdi uses more instruments than other surgeons. Ms. Beaudin stated that she did not hear nurses talking negatively about Dr. Al-Ghamdi, or that they did not want to work with him. Ms. Beaudin thinks that things are better in the OR since Ms. Young has left and she believes that Tracy Rice is doing a good job. According to Dr. Al-Ghamdi, this testimony was very different than that provided by this witness at the AHS hearing.

333. Ms. Beverley Peters works in the ORs as the Unit Clerk. She testified that she heard nurses refer to Dr. Al-Ghamdi as Dr. Al-Qaeda and state that he does not like women or Christmas. She believed that Ms. Young did not like Dr. Al-Ghamdi because he was Muslim. She stated that she believed that Drs. Al-Ghamdi, [redacted] and [redacted] were treated differently because of their skin color and religion. She also maintained that Gail Coristine made lots of derogatory comments about Dr. Al-Ghamdi. She also stated that Dr. Al-Ghamdi was always nice to her and always answered his pager. She described non-white and non-Christian physicians as being treated differently. She signed an affidavit for Dr. Al-Ghamdi but was not aware that it was for his Human Rights case. She admitted that Dr. Al-Ghamdi had prepared it and she had just signed it.

334. Ms. Wendy Dumais is a Central Service Technician mostly responsible for cleaning and sterilizing instruments for the ORs. She also checked the 'preference' cards and 'picked' the instruments needed for cases. She noted that Dr. Al-Ghamdi did not have a preference card and she believed this was because he is a Muslim and does not fit in. She has overheard others say that Dr. Al-Ghamdi does not like Christians or women and that Muslims prefer to keep women

in the barn and goats in the house. She always found Dr. Al-Ghamdi to be professional and pleasant. However, she acknowledged that no one likes her in the ORs. She had signed an affidavit Dr. Al-Ghamdi prepared for his Human Rights case. However, she did not know why she was asked to sign it.

335. Dr. Al-Ghamdi called Ms. Sheila Dorcheid, an OR nurse for 20 years. She did not get along well with Ms. Young or with Gail Coristine. However, she testified that she never heard Ms. Young say negative things about Dr. Al-Ghamdi, although it was clear that Ms. Coristine did not like him. Ms. Dorcheid stated that she saw Gail leave instruments outside the OR and only bring them in when Dr. Al-Ghamdi asked for them. She indicated that she did not know why Dr. Al-Ghamdi was suing her.

336. Dr. Al-Ghamdi called Ms. Heather Halwa, an OR nurse in Grande Prairie for 10 years. She noted that she never had any trouble working with Dr. Al-Ghamdi but did acknowledge that the relationship between Dr. Al-Ghamdi and some of her colleagues was toxic. She had no idea why Dr. Al-Ghamdi was suing her.

337. Dr. Al-Ghamdi called Mr. Allan Hanson, an OR nurse at the QEII. When he started work there in 2012, pretty much everyone told him negative things about Dr. Al-Ghamdi. Mr. Hanson said that Dr. Al-Ghamdi was always polite, but unprofessional. He stated that he could sense the tension as soon as he went into Dr. Al-Ghamdi's room. He also does not know why Dr. Al-Ghamdi is suing him.

338. Dr. Al-Ghamdi called Dr. [redacted] and asked him about Dr. [redacted], a visible minority physician who, according to Dr. Al-Ghamdi, lost his license to practice because he failed to complete his medical records. He compared this penalty to the suspension in abeyance which Dr. [redacted] received; Dr. Al-Ghamdi considered this penalty to be a slap on the wrist. However, Dr. [redacted] recalled that the issue with Dr. [redacted] was not about incomplete records; rather, Dr. [redacted] was suspended with conditions because of a lack of knowledge and skills. When Dr. [redacted] failed to meet the conditions he was removed from the Register.

339. Dr. Al-Ghamdi called Ms. Jennifer Power who completed the LPN program but has also done the peri-operative program at Grant McEwan and now functions as a scrub nurse in the OR. She believes it was difficult for her to obtain this position because of Ms. Young's negative view of LPN training. Dr. Al-Ghamdi reached out to her when she was having a particularly rough time at work and she appreciated it. She heard about the Rice petition but did not sign it. She currently has a complaint against Dr. [redacted] for his dismissive behavior.

c) Workplace Mobbing

340. Dr. Al-Ghamdi claimed that he has been a victim of workplace mobbing and Mr. Cbak, Counsel to Dr. Al-Ghamdi beginning in May of 2016, called Dr. [redacted] as an expert witness. Dr. [redacted] testified via a video link. He indicated that he was trained as a Sociologist and had spent much of his academic career at the University of Waterloo, having retired in 2010. He described workplace mobbing as ganging up on a peer or workmate to make that person's life miserable and ultimately to drive that person out of the workplace. He pointed out that workplace mobbing is most likely to occur in an environment with a poisonous culture. His scholarly work has been on the 'difficult professor' and the 'disruptive physician'. He stated that he was familiar with the case law on disruptive physicians, but was unable to name any cases. He acknowledged that he did not know about the privileging of physicians, on-call scheduling, and how physicians are compensated in Alberta. He has only been an expert witness in one court case and in that case his evidence was in-admissible. He also acknowledged that he only comments on cases in which he is convinced workplace mobbing had occurred. Based on this evidence, the Tribunal accepted Dr. [redacted] as an expert witness qualified to give evidence as an academic sociologist on the social phenomenon of workplace mobbing, its definition, its description and symptoms, and how to remedy it. Assuming the proper factual foundation was established, the Tribunal indicated that Dr. [redacted] could provide an opinion on the charge of disruptive behaviour. At the time of accepting his qualifications, the Tribunal noted that Dr. [redacted] experience on this issue related to academia, and he had little experience in health care, and with regulated healthcare professionals in particular.

341. Mr. Chak questioned Dr. [redacted] about a large number of issues:

- Dr. [redacted] stated that he had interviewed Dr. Al-Ghamdi and read Mr. West's Investigation Report, some thousands of pages of transcript, 241 exhibits, the affidavits signed in support of Dr. Al-Ghamdi, and the Harmes notification regarding Workplace Safety.

- In Dr. [redacted] view, the situation at the QEII in Grande Prairie fit the diagnosis of workplace mobbing.

- He has developed a checklist of 15 indicators of workplace mobbing. One that is very important is a formal expression of collective negative sentiment toward the target, such as with signatures on a petition or the holding of special meetings to discuss what to do about the target. The signing of the Petition concerning the Rice incident meant that there were more than 50 people denouncing the target, such that diversity of opinion no longer existed.

- He described the Nurse Rice incident as the critical event in this mobbing. He recognized that the Rice incident was not part of the charge for this hearing but noted that this merely created the situation where a list of 'fuzzy charges had to be concocted to keep the mobbing going'.

- Dr. [redacted] pointed to several significant events in the mobbing of Dr. Al-Ghamdi. These included the Theman review, the letter by Drs. [redacted] and [redacted] regarding Dr. Al-Ghamdi's privileges, and Dr. [redacted] refusal to work with Dr. Al-Ghamdi.

- Dr. [redacted] pointed out that it is typical that the charges against the target go well back in time. This helps explain why the charge for this hearing is 'a pattern of behaviour'. In his opinion, there is also a pattern of accusations against Dr. Al-Ghamdi over time.

- Dr. [redacted] acknowledged that, whereas it is clear that Dr. Al-Ghamdi has been subjected to workplace mobbing, it is not clear as to whether it is deserved.

- Most cases of workplace mobbing are initiated by a pre-disposing condition such as ethnicity, skin color, sexual orientation, etc.

- In commenting on the outcomes of mobbing, Dr. [redacted] noted that the target's suicide is relatively uncommon at reported rates of 5-7%. More common is the target leaving the place of the mobbing.

- Name calling is an important part of mobbing. Dr. Al-Ghamdi has been called disruptive (a very discrediting label) by the QEII and now by the CPSA. Workers in the operating rooms and other physicians have referred to him in unpleasant terms.

- In the history of workplace mobbing, sometimes the accusations are proven to be false – or they may be true but of minor significance. This usually does not stop the mobbing.

- Dr. [redacted] considers the environment at the QEII to be poisonous and considers the Olhauser report to be proof of this. He noted that, in his experience, the target is never completely innocent and apologies from the target do not work.

- Dr. [redacted] assessed the QEII administration as ineffective and said it allowed the surgical department to continue to mob Dr. Al-Ghamdi. In this regard, for an administrative action to have been effective, it would have had to have been implemented well before 2013.

- For mobbing to be successful, the target must be expelled from the environment. Dr. Westhues quoted a prominent researcher as stating that targets never get re-integrated into the environment.

- In his view, this is clearly an example of workplace mobbing, Dr. [redacted] questions why the CPSA hearing was ever initiated.

342. On cross-examination by Mr. Boyer, Dr. [redacted] testified that:

- He believes that Mr. West, the CPSA Investigator, exceeded his area of competence. In the workplace mobbing literature, there is frequently some authority figure who writes a report which gives credence to the mobbing. He believes that Mr. West's report does this.

- He knows less about the healthcare environment (than that of a University) and he realizes that the staff in the health system, where the object is patient care, must work more closely together than the staff at a University.

- It is common in organizations to make exceptions for individuals who do not conform with expected behavior, such as Dr. [redacted] and his poor record keeping. He also admitted that it is possible for an organization to make exception after exception until something must be done.

- He has not seen any evidence of professional misconduct by Dr. Al-Ghamdi and therefore questions why this hearing exists.

- Dr. [redacted] does not understand the importance of people in the workplace (those involved in generating complaints about others) providing requested information to Administration personnel so that issues can be resolved. However, he stated that he was only aware of one instance when Dr. Al-Ghamdi failed to provide requested information. Mr. Boyer pointed out that the Tribunal was

informed of numerous incidences when Dr. Al-Ghamdi did not reply to requests for information.

d) Dr. Al-Ghamdi's Testimony

343. Finally, during the last week of the Hearing, Mr. Chak called Dr. Al-Ghamdi to testify in his defence and questioned him on a number of issues:

- Dr. Al-Ghamdi testified that in 2003 he spent several months negotiating his contract so that he would have 1.5 days per week of operating room time and adequate resources to do his job.

- He described the on-call system before 2010 as consisting of a week on-call at a time without a formal rotation. Each Monday the switchboard operator would call and find out who was available to take call that week.

- Dr. Al-Ghamdi estimated that he saw about 1000 patients per year. Although there is no fee (above the fee-for-service) for looking after your own patients in hospital, there is a payment of about $500 per 24 hours for being on-call for new patients. He made himself available for spine cases without receiving any on-call fee.

- Dr. Al-Ghamdi described the incident in 2010 when he was scheduled for two weeks of four in July. But the schedule was revised and he then was on for three weeks during the month. He complained to Dr. [redacted] but got no response. Eventually a locum was scheduled who did much of the time that Dr. Al-Ghamdi had been scheduled to cover. In the meantime, Dr. [redacted] made a complaint to the CPSA which was subsequently dismissed. Dr. Al-Ghamdi commented that he felt like he had been hit with a big hammer since he believed that the Bylaws would be used to deal with on-call disputes and not reporting to the CPSA.

- Dr. Al-Ghamdi testified that things got worse for him after he filed the Human Rights Complaint and also after he sued the Region for breach of contract. His orthopedic colleagues refused to cover his patients. Things also got worse after the Gilege case (the patient of Dr. [redacted] who bled to death) and Dr. Al-Ghamdi had to locate the body in the Funeral Home.

- Dr. Al-Ghamdi described the situation in 2006 when he applied to have his privileges become Active. His understanding was that Dr. [redacted] was coming to Grande Prairie with a Committee to review racism. According to Dr. Al-Ghamdi, and despite the involvement of his lawyer, the review became about Dr. Al-Ghamdi's privileges. Dr. Al-Ghamdi claimed that he did not hear anything about the results of the review and the recommendations. However, he then testified that he filed a judicial review application with respect to the Theman report and the QEII pledged not to act on the Theman report if Dr. Al-Ghamdi withdrew that application.

- Dr. Al-Ghamdi stated that there was a huge turnover of staff at the QEII and that those people leaving told him that they were leaving because of racism or poor management.

- Dr. Al-Ghamdi testified that there is an Occupational Health and Safety Code which clearly indicates that sharps should not be passed to another person and that needles should not be re-capped.

- Dr. Al-Ghamdi testified that, in his view, there were three complaints about him to the CPSA. The first was the letter from Dr. [redacted] regarding the on-call schedule, the second was the notification from Dr. [redacted] about not working with Dr. Al-Ghamdi anymore, and the third occurred in August of 2013 as a letter from Ms. Tracy Rice. The other document the CPSA received was a letter from Dr. [redacted] with notification of the Immediate Action taken at the QEII.

- Dr. Al-Ghamdi testified that he has now brought a complaint against the CPSA on the ground that he was fraudulently charged. He testified that he is not sure why he was suspended. The procedure at AHS was a mirror image of the CPSA procedure, except at AHS there was no charge. He complained that there was a lot of interchange of information between the two procedures.

- Dr. Al-Ghamdi testified that when he had patients in the QEII he would see them every day (sometimes twice a day) and that he did not expect or ask other surgeons to see his patients. If he was going away, he would plan for his patients to be well enough to be looked after by a family physician.

- Dr. Al-Ghamdi testified that things got particularly difficult late in 2012 when Dr. [redacted] was sanctioned by the CPSA, the Human Rights Claim was dismissed, and Dr. [redacted] patient bled to death. He described how Dr. [redacted] bumped his patient and how he learned about the death of Ms. [redacted] He also described how he had attempted to become the Medical Examiner on the case and how this had worsened his relationship with Dr [redacted]

- Dr. Al-Ghamdi described how the Septemher 2012 call schedule came out without his name on it as he had indicated that he would be away. But on September 5, the on-call schedule was modified to show Dr. Al-Ghamdi's name on each Wednesday. Because of this, he called Dr. [redacted] and also contacted Dr. [redacted]

- Dr. Al-Ghamdi testified as to why he refused to agree to cover the patients of the other orthopedic surgeons when he was on-call unless there was an official handover. His reasoning was that patients should be involved in determining who their physician was and their permission obtained before someone else was responsihle for their care. He testified that otherwise if he was called to see another surgeon's patient, he would be required to do a history and examination

and seek their permission to provide therapy, even if all that was needed was something for pain relief. The result was that the other surgeons refused to see Dr. Al-Ghamdi's patients and he did not see theirs.

- Dr. Al-Ghamdi described going to a conference in November of 2012 and finding out that someone had booked an outpatient clinic for him while he was away. He does not know how this happened but seemed prepared to accept that it was a mistake and not intentional. One patient made a complaint to the CPSA about this although it was dismissed.

- Dr. Al-Ghamdi testified that, in his view, the QEII changed its policy just to target him. By way of example, he described the change to the OR policy which stated that after hours, the official on-call surgeon for each specialty had first call on the operating room and that others had to negotiate with that surgeon in order to be able to do a case.

- Dr. Al-Ghamdi complained about the CPSA investigation process. The investigator, Mr. West, contacted Dr. Al-Ghamdi early and obtained his response to the complaint. Dr. Al-Ghamdi testified that around the same time or shortly thereafter, Mr. West wrote letters (sometimes several) to many people asking for anything that could be used against Dr. Al-Ghamdi. Mr. West later asked for; and obtained, a more detailed response from Dr. Al-Ghamdi.

- Mr. Chak introduced a letter from Dr. Al-Ghamdi's previous lawyer to Dr. [redacted] indicating that Dr. Al-Ghamdi wanted to be on-call. Dr. Al-Ghamdi maintained that the orthopedic colleagues had no authority to remove him from the call schedule. Indeed, Dr. Al-Ghamdi stated that, by doing so, they were actually resigning from Dr. Al-Ghamdi's call schedule.

- Dr. Al-Ghamdi testified that in early 2013 he sent a memo to Ms. MacDonell at the QEII asking her to circulate a memo to all staff indicating that Dr. Al-Ghamdi

would be on-call every day for new consultations. Dr. Pope then sent a letter advising Dr. Al-Ghamdi that if he wished this to be circulated, he should do it on his own stationary from his office as it was not proper QEII business.

- Dr. Al-Ghamdi testified that he called a number of the ER physicians and advised that he was available for consultations. One called him and asked him to see a patient with a hip fracture. It was this patient that Dr. Al-Ghamdi was trying to get into surgery when the conversation with Tracy Rice occurred in July 2013. Dr. Al-Ghamdi eventually called Dr. [redacted] who approved Dr. Al-Ghamdi doing this case, which was eventually done the following morning. Dr. Al-Ghamdi testified that he had had another patient needing surgery, but the next day someone else did the surgery without speaking to Dr. Al-Ghamdi.

- Dr. Al-Ghamdi testified that he had contacted Mr. West and provided him with the recording of his conversation with Nurse Rice and advised him to immediately dismiss this complaint since it was causing Dr. Al-Ghamdi a lot of trouble.

- Dr. Al-Ghamdi explained that his understanding of the Immediate Action was that he was suspended from the OR and that, according to the Bylaws, this would be for a maximum of two weeks. But the suspension was extended and then applied to the entire QEII. The five individuals selected to deal with the hearing into this issue have now rendered their recommendation that Dr. Al-Ghamdi's relationship with AHS should be terminated.

- Dr. Al-Ghamdi stated that the CPSA hearing has been an abuse of process. There was no complaint, and they have produced unsigned documents, created lies and made false statements. In his opinion, the whole process is fraudulent.

- Mr. Chak then proceeded through the charges. Dr. Al-Ghamdi denies being disruptive and says he is a patient advocate and others have told lies about him.

- In relation to the first Particular regarding the on-call schedule, Dr. Al-Ghamdi denied that he refused to take call. He testified that he was removed from the call schedule and pointed out that, as an independent physician, he was entitled to take holidays, retire, or move away.

- He testified that AHS suggested the parallel on-call system, not him. He finds Particular (a) and (b) to be contradictory: one states that he will not do call, whereas the second one states that he is available all the time.

- In relation to the remaining Particulars, Dr. Al-Ghamdi's evidence was described in the section of these Reasons dealing with each of the particulars.

- Dr. Al-Ghamdi believes he has been the subject of a workplace mobbing and that the mob included Mr. Boyer, Mr. West, Dr. [redacted], the orthopedic surgeons, Dr. [redacted] Nurse Rita Young, and certain nurses. He believes his medical and surgical career, as well as his reputation, have been destroyed by this. He described the CPSA and the Tribunal in very uncomplimentary terms and even implied criminal activity.

- Dr. Al-Ghamdi concluded that much of his problem was because of Islamophobia. He reminded the Tribunal of other Muslims who have left Grande Prairie but are now working well in other environments (including Dr. [redacted], Dr. [redacted] and Dr. [redacted])

- Dr. Al-Ghamdi's final comment was to denigrate the Tribunal (again) for not clarifying the charges against him. He stated that he wondered how the Tribunal can judge him when the charges are vague and non-specific.

344. Mr. Boyer then cross-examined Dr. Al-Ghamdi about a number of issues:

- On cross-examination, Dr. Al-Ghamdi clarified how he managed to attend law school and continue his practice. During the first semester, he attended classes all week. After that, he attempted to arrange his classes into one or two days per week – such as Monday and Tuesday or Monday and Friday. He had someone cover his patients and call him if there was a problem. He also did summer courses (research projects). He acknowledged that he did not join the Students' Association and managed not to be included in class pictures or publications.

- Dr. Al-Ghamdi articled in Dawson Creek, BC, over a two year period, two days per week. At this time, a family physician covered his patients because the orthopedic surgeons refused.

- Mr. Boyer asked Dr. Al-Ghamdi if he was demonstrating professional courtesy when he sent 5900 pages of material to Mr. Boyer in response to a ruling from the Tribunal that he must provide Mr. Boyer with a list of the witnesses he would call for the week of Hearing in January 2016 and the documents he would put to them. Dr. Al-Ghamdi expressed that he was doing what he had been instructed and did not believe Mr. Boyer's statement that there was 5900 pages.

- Mr. Boyer asked about the Theman review. Dr. Al-Ghamdi stated that the review was supposed to be about management of the QEII and about discrimination, harassment, and accountability. Even though his lawyer agreed to the makeup of the Committee, he denies that the review was to be about him, his behavior, and his privileges. He refused to have any kind of assessment, to have a mentor, or participate in a behavior agreement. He indicated that he fired his lawyer, obtained a new one and filed a judicial review which was withdrawn when the QEII agreed not to use the Theman Report.

- Dr. Al-Ghamdi acknowledged that he wrote a complaint about Dr. [redacted] to the CPSA, but when asked for additional information about that complaint he did not provide it. His view was that the CPSA had the complaint and they should act on it.

- Dr. Al-Ghamdi maintained that AHS's process about his hospital privileges and the CPSA process were mirror images and that information produced at one process quickly turned up at the other. He withdrew from the AHS hearing because, in his view, it was unfair as he was not permitted to adequately cross-examine the witnesses.

- Dr. Al-Ghamdi testified that when he was going to be away, he always completed a 'Doctor Away' form. He denied that he had any obligation to find a replacement for his on-call responsibility. In his view, this was the QEII's responsibility and if no one was available then arrangement for a locum would occur. This was the QEII's responsibility.

- Dr. Al-Ghamdi denied that he had instructed; or asked, Nurse Jordan to bring all eight trays of instruments into the OR and denied instructing her to open them for the patient with the infected prosthetic knee joint.

- Dr. Al-Ghamdi continued to deny that Mr. West had notified him that the scope of the Investigation had changed from the three letters of complaint to an assessment of his behavior, despite Mr. West's letter giving him such notification having been entered as an exhibit.

- Dr. Al-Ghamdi maintained that not wearing a mask in or near the OR was not only unprofessional but criminal as it was gross negligence.

- Dr. Al-Ghamdi denied that he told Nurse Rice that Dr. [redacted] had approved a parallel on-call system. (The transcript of the conversation confirms that Dr. Al-

Ghamdi stated that there is a two-surgeon system and 'check with Alberta Health Services' - Chris Eagle.)

- Dr. Al-Ghamdi claimed that CPSA Investigators must be licensed under the Alberta *Security and Investigators Act* when working under the *Health Professions Act*. He also argued that all hospitals, including the QEII, are required to provide Surgical Assistants for certain cases. Mr. Boyer pointed out that neither of these claims are correct.

E. Reasons for Finding Dr. Al-Ghamdi Guilty of Disruptive Conduct

345. Below, the Tribunal reviews the applicable expectations of behaviour of a regulated physician. Some of these were identified in the charge as Section 52 of the *Canadian Medical Association Code of Ethics*, and the *Standards of Practice, Collaboration in Patient Care; Standard 3)* and *Job Action; Standard 28*. In addition, as discussed above, conduct which harms the integrity of the profession, includes disruptive behaviour as identified in the CPSA publication "Managing Disruptive Behaviour in the Healthcare Workplace". These expectations of behaviour are considered in the context of the evidence reviewed above.

346. The *Canadian Medical Association Code of Ethics* (section 52) states that members must "collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services." Certainly, the Tribunal heard considerable evidence that Dr. Al-Ghamdi failed to collaborate with his colleagues in orthopedic surgery in the development and functioning of an effective system of on-call coverage. Dr. Al-Ghamdi refused to accept the decisions of the majority of the group and, indeed, failed to participate in meaningful discussions as, in his view, if he did not approve it then it was not official.

347. Section 52 goes on to state: 'treat your colleagues with dignity and as persons worthy of respect'. It is clear that Dr. Al-Ghamdi did not accept this responsibility of the ethical physician. He repeatedly reported his colleagues to the medical administration in the QEII, to more senior medical personnel at AHS, and to the CPSA for behaviors that he perceived to be unprofessional. During testimony, Dr. Al-Ghamdi repeatedly attacked the integrity of his surgical colleagues.

The Tribunal does not accept that his behavior towards his colleagues was respectful and it certainly was not collaborative. He did not seek to resolve issues in a collaborative manner.

348. The CPSA Standard *Collaboration in Care; Standard 3)* also deals with collaboration among physicians, regulated healthcare providers, and other members of the care team in the care of a patient or a group of patients. *Job Action; Standard 28*; this standard also refers to treating other health care providers with dignity and respect and communicating effectively with other members of the team. As noted in the paragraph above, Dr. Al-Ghamdi did not collaborate effectively with his colleagues in orthopedic surgery or in the OR setting to facilitate the care of patients. He maintained that he did not need to advise his colleagues that he was not available to meet his on-call responsibilities and instead sent a note to the Medical Staff office indicating that he was not available and expected someone else to resolve the issue. Although Dr. Al-Ghamdi maintained throughout the Hearing that he was excluded from the on-call schedule and from any decision-making role in relation to the OR, the Tribunal became convinced that these exclusions came after repeated attempts by his colleagues to develop the collaborative relationships that exist in most other organizational structures within healthcare.

349. The CPSA Standard *Job Action; Standard 28* states that a physician must not withdraw services with the direct or indirect purpose of supporting job action for personal economic gain if such actions could put the immediate health of patients at significant risk. Dr. Al-Ghamdi did refuse to provide on-call service on more than one occasion when he had seemingly agreed to do so, or at least had not previously provided notice that he would not provide the coverage. Although there was no direct testimony stating that Dr. Al-Ghamdi's action was for personal economic gain, he did refuse to see patients whom he deemed to have minor orthopedic issues, preferring to leave these cases for his colleagues so that his time was protected to do major cases. Finally, the Tribunal heard about at least one patient who Dr. Al-Ghamdi refused to see after that patient had been referred to Dr. Al-Ghamdi for assessment of a fracture through a joint. This case was described by Dr. [redacted]

350. The Tribunal was provided two documents created in Alberta which address disruptive conduct in the healthcare workplace:

a) The CPSA created a 'Guidance Document' in 2010 entitled 'Managing Disruptive Behavior in the Healthcare Workplace'. The definition of disruptive behavior in this document is: *"Disruptive behavior is an enduring pattern of conduct that disturbs the work environment"*. This document notes that disruptive behavior can include the use of objectionable language, episodes of uncontrolled anger, and verbal and physical threats that cause negative impacts on those involved. But disruptive behavior can also be passive; this might include: repeated refusals to comply with known and accepted practice standards, a chronic refusal to work collaboratively with colleagues, staff, and patients; a failure to respond to calls for assistance (such as when on-call), or persistent lateness.

b) In 2013 the Health Quality Council of Alberta created the second document titled 'Managing Disruptive Behavior in the Healthcare Workplace'. The Framework outlined in this document is based on the document noted above from the CPSA. These two organizations had worked together to make this second document appropriate for the broader audience in Alberta's health system and to create a toolkit to help identify disruptive behavior. The definition of disruptive behavior used in this document is: "Disruptive behavior is personal conduct (words, actions or interactions) beyond that normally accepted as respectful interpersonal behavior, which disturbs the work environment and/or potentially poses a risk to delivery of safe and quality healthcare". Disruptive behavior can consist of such behaviors as yelling, swearing, name-calling, uncontrolled anger, slamming doors, use of sarcasm etc. But disruptive behavior can also be inappropriate forms of communication such as "patronizing and insulting remarks, shaming others publicly, threatening others with retribution, litigation or violence, verbal insidious intimidation such as gossiping, spreading rumors, etc or be totally non-verbal such as the rolling of eyes, glaring etc". Disruptive behavior can also be in the form of harassment or discrimination which is prohibited in legislation.

351. Dr. Al-Ghamdi argued that the CPSA did not follow its own procedures as set out in its 2010 Guidance Document "Managing Disruptive Behaviour in the Healthcare Workplace", and that failure undercut the CPSA's ability to proceed with the charge against Dr. Al-Ghamdi. The Tribunal does not see the logic of this argument. The Guidance Document offers definitions, examples, and recommended strategies for dealing with disruptive behaviour at the local level. It recommends early intervention, and recommends CPSA involvement in only the most serious cases. This Tribunal finds the Guidance Document helpful as an articulation of the types of behaviour that would harm the integrity of the profession. However, whether a hospital or AHS has followed its recommendations is irrelevant to the task before the Tribunal: the Tribunal's task is to determine whether the allegation against Dr. Al-Ghamdi has been established on a balance of probabilities. Further, speculating about what might have happened if the strategies in the Guidance Document had been used in this case is not productive, and does not assist the Tribunal in its assigned task.

352. Although the term "disruptive conduct" is not referenced in the *Health Professions Act*, there are an increasing number of cases relating to physicians charged with disruptive behavior. (For instance: *Perron v. Guelph Hospital*, 2014 ONSC 1032; *Re Sogbein*, [2013] OCPSD no 17; *Alghaithy v. University of Ottawa*, 2012 ONSC 14; *Khan v. Scarborough General Hospital*, [2009] OJ no 5437; *Toronto East General Hospital v. Gopinath*, 2014 ONSC 2731.) In Alberta, the best known case is that of Dr. Cooper who had his hospital privileges permanently cancelled after being found guilty of disruptive conduct under the *Hospital's Act* (*Cooper v. Hospital Privileges Appeal Board*, 1999 ABQB 165). As noted above, in 2010 the CPSA created a Group to develop a document on dealing with disruptive behavior in the healthcare workplace. The term 'disruptive behavior' has not, however, been incorporated into the Canadian Medical Association Code of Ethics or the Standards of Practice for Alberta. Nonetheless, there is language in both the Code of Ethics (see section 52) and in the Standards of Practice (see *Collaboration in Patient Care; Standard 3*) which apply to behavior that is consistent with that described in the CPSA document on Disruptive Behavior. Although the term 'ungovernable' has also been used to refer to regulated professionals who refuse to adhere to the structures and policies of the profession, this has primarily been restricted to instances in which the regulated professional refused to abide by rulings of a professional college. (See: *Litchfield v. College of Physicians and Surgeons of*

Alberta, 2005 ABQB 962; *Law Society of British Columbia v. Hall*, 2007 LSBC 26; *Law Society of Upper Canada v. Horwood*, [2009] LSDD no 77; *Law Society of Alberta v. Broda* – 2010; *College of Physicians and Surgeons of Saskatchewan v. Ali*, [2016] SJ no 56.) Therefore, the Tribunal accepts that the allegation of disruptive conduct in the healthcare workplace is a valid charge by the CPSA.

353. Based on the evidence, the Tribunal concludes that Dr. Al-Ghamdi's conduct is consistent with the definition of disruptive conduct. Dr. Al-Ghamdi has engaged in this conduct over a period of ten years and this conduct has resulted in the breakdown of his professional relationships with his physician, nursing, and hospital medical administrative colleagues, and this has had a negative impact on the quality of care at the QEII in Grande Prairie, Alberta.

354. It is important to acknowledge that Dr. Al-Ghamdi has not been charged with a lack of knowledge or skills. He is a well-trained orthopedic surgeon with further fellowship training in spinal surgery. The Tribunal did not hear evidence from any witnesses that Dr. Al-Ghamdi lacked good clinical judgment or that his technical skills in the OR were lacking. However, this Hearing is about Dr. Al-Ghamdi's conduct in relation to his medical and nursing colleagues at the QEII and within AHS and its predecessor in the region, the Northern Lights Regional Health Authority.

355. As was set out above, the Tribunal finds that of 8 of the 13 particulars listed in the charge of disruptive conduct have been established on the balance of probabilities. None of these 'particulars' specifically mention the term 'disruptive conduct'. It is for this reason that the Tribunal elected to include another section in this Decision dealing specifically with behavior that falls within the definition of disruptive conduct. It is important to note that Dr. Al-Ghamdi's disruptive conduct has been 'passive', in that he has not been observed being verbally abusive, shouting, using profanity, or threatening physical harm. Rather, his behavior had been more that of refusing to collaborate with colleagues, and taking every opportunity to report his physician and nursing colleagues for what he perceived to be unprofessional behavior. Dr. Al-Ghamdi's perceptions of unprofessional conduct often reflected his belief that his colleagues lacked knowledge and skills. At times, Dr. Al-Ghamdi complained about his colleagues shouting at him

or using profanity toward him. While such behavior is not to be condoned, it is important to consider the degree to which Dr. Al-Ghamdi provoked his colleagues.

356. Dr. Al-Ghamdi claimed that his colleagues have misinterpreted his behaviour and he was actually just being a patient advocate. The Tribunal does not accept this explanation. For instance, there was no patient interest at stake when Dr. Al-Ghamdi refused to participate with his orthopedic surgery colleagues in an on-call schedule for the QEII. Dr. Al-Ghamdi is quick to point out that he did not refuse to participate, but that it was the other surgeons who excluded him. But the Tribunal heard evidence that Dr. Al-Ghamdi had previously refused to adhere to the on-call schedule that he had seemingly agreed to follow. Dr. Al-Ghamdi held the view that the Medical Staff Bylaws state that a group of physicians sharing a call schedule must all agree and was of the view that if agreement cannot be reached then AHS should be involved. Indeed, Dr. Al-Ghamdi did attempt to involve AHS executives and was successful in involving the Facility Medical Director in disputes over the call schedule. However, the central issue was that Dr. Al-Ghamdi did not agree, and would not agree with the wishes of the remainder of the group. Indeed, it was his view that a call schedule for orthopedic surgery could not be official until he accepted it. Moreover, Dr. Al-Ghamdi believed that if he was planning to be away, all he was obligated to do was notify the Medical Staff Office and it was then the QEII's responsibility to arrange for someone to do the call for the Wednesdays he was scheduled. The Tribunal heard from a number of physician witnesses who functioned as part of other on-call groups and all agreed that if an individual was unable to be available for their on-call schedule requirement, that individuals had the responsibility to arrange for coverage by trading days with a colleague. Dr. Al-Ghamdi did arrange to switch days with his colleagues from time to time and the Tribunal heard from the Department Head that, to his knowledge, no one had ever refused to switch on-call days with Dr. Al-Ghamdi. However, despite this, Dr. Al-Ghamdi chose to notify the Medical Staff Office that he would be away and expected others to deal with the problem.

357. The situation with the on-call disputes became more problematic from 2008-2011 when Dr. Al-Ghamdi enrolled in the study of Law at the University of Alberta. This required him to be absent from the QEII for days each week. Initially he depended on the good-will of his surgical colleagues to cover his patients. However, this soon became an issue and his colleagues refused

to do this. It is interesting to speculate whether, if Dr. Al-Ghamdi had been honest with his colleagues and advised them that he was studying law, things would have transpired differently. As it was, Dr. Al-Ghamdi did not tell anyone in the QEII community that he was studying law and stated emphatically during his testimony that it was none of their business. It is the Tribunal's opinion that when a colleague plans to be absent from the hospital and from the community frequently it is the other orthopedic surgeons' business because it affects their personal lives and their ability to care for the patients requiring orthopedic surgical services. Moreover, after graduation and during 2011-2012, Dr. Al-Ghamdi pursued his articling studies in Dawson Creek in British Columbia. This necessitated him being away for more time but he still did not inform his colleagues what he was doing. Indeed, he repeatedly told his colleagues that he was taking vacation. Such behavior cannot be interpreted as being for the purpose of advocating for his patients; Dr. Al-Ghamdi was advocating for himself.

358. Because Dr. Al-Ghamdi was away from the QEII for so much time during his Law studies and during articling, he signed over care of his patients to a family physician. Admittedly, Dr. Al-Ghamdi was available by phone to help this physician if acute problems arose. However, he sometimes was leaving patients who he had operated on the day before. This arrangement was not in keeping with the provisions of Article 4.2.7 (d) of the Medical Staff Bylaws and it is unlikely the Hospital Administration would have approved it had they been informed.

359. It was this sense of entitlement that in late 2012 drove Dr. Al-Ghamdi's colleagues to a breaking point and they officially informed Dr. Al-Ghamdi that they would no longer share on-call with him. Around the same time, Dr. Al-Ghamdi was refusing to 'cover' the patients of the other surgeons when he was on call at night unless there was a formal 'handover' of each patient. The other surgeons did not think this was necessary and the Tribunal heard that other groups did not employ such an arrangement. Therefore, the other orthopedic surgeons refused to cover Dr. Al-Ghamdi's patients when they were on call. Dr. Al-Ghamdi's response to being excluded from the orthopedic surgery on-call schedule was to make himself available at any time to see referrals from the Emergency Department. This was despite having been informed by Dr. [redacted] of AHS that if he wanted to have a 'parallel' on-call schedule, it would require the co-operation of his colleagues and the Hospital Administration. Moreover, he was advised that it was not

acceptable for any individual to be on-call 24 hours per day every day. Despite this, Dr. Al-Ghamdi informed certain physicians in the Emergency Department that he was available for referrals and accepted some patients who required surgery. However, the OR policy was that the surgeon who was officially on-call for each specialty had first-call on the OR facilities. This meant that Dr. Al-Ghamdi needed to negotiate with the on-call orthopedic surgeon about when he could do his surgical case; this, he was not prepared to do. It was this impasse that occurred on the evening in late July 2013 when the alleged threat to Ms. Tracy Rice occurred and Dr. Al-Ghamdi was subsequently suspended from the QEII. Dr. Al-Ghamdi clearly knew about the policy concerning access to OR time after hours since he was present at the meeting of surgeons when it was presented and he was the only one who voted against it.

360. According to the CMA Code of Ethics, physicians are obligated to report incidences of professional misconduct they have observed; if they do not, then they might be guilty of professional misconduct. However, Dr. Al-Ghamdi made no distinction between relatively minor deviations and much more serious matters; he reported to the CPSA or CARNA most everything he observed that was not, in his opinion, proper. This certainly has been a major issue in the relationship between Dr. Al-Ghamdi and his medical and nursing colleagues. In general, he did not speak to the colleague in question before reporting them and in some instances, the subject of the report had no indication that Dr. Al-Ghamdi was at all unhappy with their conduct. This particularly applied to his nursing colleagues. In some instances, Dr. Al-Ghamdi reported colleagues for unprofessional conduct when he had not personally witnessed the subject conduct. An example of this was Dr. Al-Ghamdi's reporting of Dr. [redacted] to the CPSA for speaking harshly to Dr. [redacted] because Dr. [redacted] had told a prospective recruit that the QEII in Grande Prairie had a racist environment. He also reported the anesthetists at the QEII to the Minister of Health for false billing practices when at best he could only have had a suspicion, and not proof, that this had occurred.

361. Dr. Al-Ghamdi seemed to believe that if he could 'prove' that other people at the QEII had committed acts of professional misconduct then it somehow resolved the charges against him. Therefore, much of his defence in this case focused on demonstrating Nurse Young's poor management skills, Dr. [redacted] poor clinical judgment, Dr. [redacted] use of improper

language, Dr. [redacted] possible drug abuse, and Dr. [redacted] failure to complete medical records. In pursuit of this goal, Dr. Al-Ghamdi spent numerous hours of hearing time attempting to have witnesses confirm evidence of these 'wrongdoings' by others, rather than focusing his defence on the specific charges against him. Almost all witnesses he called or cross-examined were questioned on the same menu of items dealing with the conduct of others. Throughout all of this, he repeatedly asked witnesses to comment on his personal behavior, particularly noting that he was always polite and never shouted or used profane language.

362. Dr. Al-Ghamdi also claimed that he was the target of workplace mobbing at the QEII and called Dr. [redacted] as an expert witness to testify. Dr. [redacted] presented his view that, indeed, Dr. Al-Ghamdi had been the target of workplace mobbing. Dr. [redacted] based his testimony on an interview with Dr. Al-Ghamdi and a documentary review of material sent to him by Dr. Al-Ghamdi: the West Investigation Report, thousands of pages of transcript and 241 exhibits. However, Dr. [redacted] admitted that there are people in organizations that nobody gets along with who deserve to be expelled and he acknowledged that it was not clear whether Dr. Al-Ghamdi was such a person. He described name calling as an important part of mobbing and noted that Dr. Al-Ghamdi had been called some terrible names. Whereas the testimony the Tribunal heard affirms this, the name calling mostly involved the personnel in the ORs who worked closely with Dr. Al-Ghamdi and it was not clear to the Tribunal whether name-calling was a prominent feature of Dr. Al-Ghamdi's experience at the QEII. Dr. [redacted]s pointed out that the term 'disruptive physician' is a discrediting term and it is elastic in the sense that it can refer to a broad spectrum of behavior. He also assessed the workplace (as poisonous) in Grande Prairie, but in the Tribunal's view, this assessment was likely based on Dr. Al-Ghamdi's description. Dr. [redacted] also described the Hospital Administration as ineffective and invisible, however the evidence for either of these statements was not clear. Dr. [redacted] also reasoned that since this was clearly a case of workplace mobbing, the CPSA was not justified in initiating a hearing. Finally, Dr. [redacted] stated that he saw no evidence of professional misconduct by Dr. Al-Ghamdi and therefore could see no reason for the hearing.

363. Although the Tribunal accepted Dr. [redacted]' expertise in the phenomenon of workplace mobbing, Dr. [redacted] based his conclusions on a biased sample of the evidence the Tribunal

heard. The Tribunal does not believe that Dr. [redacted], or anyone, is capable of evaluating such a complex situation, existing for 10 years and involving many individuals, merely by a documentary review and the interview of only the respondent. In order to evaluate such a complex dynamic, Dr. [redacted] would certainly need to personally assess the environment and interview more of the affected individuals before reaching such a 'simple' conclusion about this very complex situation. The Tribunal, therefore, while appreciating Dr. [redacted] testimony, believes that he vastly underestimated Dr. Al-Ghamdi's contribution to the environment at the QEII and Dr. Al-Ghamdi's capacity to disrupt the institution's function and the lives of many people working there.

364. Dr. Al-Ghamdi also ascribed much of his problem in Grande Prairie to racism both in the community and at the QEII. The Tribunal did hear of remarks made, particularly in the OR environment, that were racist and particularly targeted those of Arab/Middle Eastern heritage and the Muslim faith. While such comments are inappropriate and have no place in the healthcare or any other workplace, the Tribunal concludes that Dr. Al-Ghamdi's fellow workers directed such remarks at one individual who was persistently making their daily life very difficult. Furthermore, Dr. Al-Ghamdi did launch a Human Rights Complaint on this same basis and it did not find evidence of racism in this environment. That decision was upheld on appeal. This Tribunal acknowledges remarks with ethnic and religious connotations are hurtful and damaging to the workplace environment and all effort should be made to curtail them. However, the Tribunal does not accept that racism and Islamophobia was a major contributor to the genesis or the maintenance of Dr. Al-Ghamdi's conduct.

365. Finally, the Tribunal found that, as the hearing proceeded, Dr. Al-Ghamdi's credibility increasingly became an issue. It was clear that Dr. Al-Ghamdi misled the Tribunal on a number of occasions and the evidence heard convinced the Tribunal that he had also lied to a number of his colleagues. Certainly, Dr. Al-Ghamdi lied to Ms. Tracy Rice when he informed her that there was a 'two surgeon system' and implied that Dr. [redacted], CEO of AHS, had approved it. Clearly, Dr. Al-Ghamdi lied when he denied to several colleagues that he was attending law school. He was also untruthful when he told the Tribunal that he did not know that Mr. [redacted] (the patient of Dr. [redacted] was so sick. Indeed, Dr. [redacted], the Anesthetist, testified that he had

told Dr. Al-Ghamdi that he had assessed Mr. [redacted] and found him critically ill. Dr. [redacted] also testified that he 'begged' Dr. Al-Ghamdi to allow Mr. [redacted] to proceed to surgery first. The Tribunal is of the view that Dr. Al-Ghamdi lied when he denied instructing the nurses to open the additional trays of instruments when dealing with the patient with the infected knee prosthesis. Later, during his testimony, Dr. Al-Ghamdi told the Tribunal that his habit was to bring in all the instruments that he thought he might need and have them opened to be sure that nothing was missing. This behavior, at best, is disrespectful of the potential need for such instruments by others and of the time workers must spend to clean and sterilize unused instruments. Dr. Al-Ghamdi also misled the Tribunal when he denied threatening Dr. [redacted] that he would report him to the CPSA for unprofessional conduct. Dr. [redacted] was able to provide the Tribunal with the email he had received from Dr. Al-Ghamdi containing this threat. There was also evidence that Dr. Al-Ghamdi changed the urgency rating on at least one of his patients – independent of a change in clinical status - so that he could have his surgical case proceed first.

366. There were a number of other inconsistencies in Dr. Al-Ghamdi's presentations to the Tribunal. He maintained that the number of visible minority physicians in Grande Prairie had decreased and that he had 'interviewed' these individuals as to why they were leaving and had been told that it was because of discrimination and racism. However, as Dr. [redacted] testified; and also illustrated with documents from the CPSA, the fact is that the number of visible minority physicians has increased significantly in Grande Prairie. Dr. Al-Ghamdi also informed one of his witnesses that he had thirteen Degrees when in fact he has four degrees and a number of certificates and diplomas. He also presented Ms. Janet Loseth as a highly experienced OR nurse, when she was, in fact, one of the least experienced of the nurses at the facility. The Tribunal also heard that Dr. Al-Ghamdi's credibility with his medical colleagues had progressively decreased; Dr. [redacted] testified that by 2012 the other orthopedic surgeons had reached the conclusion that they did not trust Dr. Al-Ghamdi's professional integrity or anything that he said. Overall, Dr. Al-Ghamdi's credibility decreased progressively as the hearing proceeded and the Tribunal found him less credible than most of the other witnesses.

F. Dr. Al-Ghamdi Guilty of Unprofessional Conduct

367. For the reasons noted above, the Tribunal finds Dr. Al-Ghamdi guilty of demonstrating a pattern of disruptive behavior with a number of his medical and nursing colleagues at the QEII. Moreover, the Tribunal finds that this behaviour is contrary to the behaviour expected of physicians as referred to in the Canadian Medical Association Code of Ethics and the CPSA Standards of Practice, and the HPA, and that this amounts to unprofessional conduct. The unprofessional conduct certainly resulted in a breakdown of Dr. Al-Ghamdi's professional relationships with hoth his medical colleagues and the staff at the QEII as well as with many of the administrative staff at the QEII and in AHS. The Tribunal also finds that this unprofessional conduct had a negative impact on the delivery of health services at the QEII. For instance:

a) The opening of more instruments than necessary without regard to the impact on the other surgeries, the limited number of instruments and the need to re-sterilize them before using them;

b) The occurrence of inappropriate delays for some patients receiving surgical care because Dr. Al-Ghamdi insisted on having his patient(s) proceed first, based on his contention that his patient(s) had been booked first or that he had not heen properly consulted about delaying his case(s);

c) The complete breakdown of trust and collegiality between colleagues caused problems with the functionality of the hospital (such as the on-call schedule);

d) The atmosphere of fear and mistrust, specifically in the operating rooms at the QEII, created by Dr. Al-Ghamdi's behaviour;

e) As indicated in Dr. [redacted] letter of December 2012, the attention and resources of colleagues working with Dr. Al-Ghamdi became focused on dealing with Dr. Al-Ghamdi, distracting from patient care.

368. The Tribunal has also concluded that the actions of Dr. Al-Ghamdi cannot be justified by his right to free speech. While acknowledging some inappropriate comments and actions by others at the QEII, the Tribunal does not believe that this reflects a racially charged environment that would justify Dr. Al-Ghamdi's behaviour. Finally, the Tribunal believes that the CPSA has acted appropriately to protect the public by conducting the Investigation and this hearing.

VIII. Conclusion

369. As noted at the outset, this has been a long and challenging hearing. The Tribunal is very aware of the potential impact its decision will have on Dr. Al-Ghamdi, and it is only after a careful review of the evidence and legal principles; and much deliberation, that it has come to this conclusion.

370. The Tribunal will receive submissions from the parties on the appropriate sanction. It is prepared to do so in writing, or in person at an oral hearing. The Tribunal would ask the parties to advise the Tribunal (by advising the Hearings Director) within 14 days of this decision, how they would like to proceed with the next stage.

Signed on behalf of the Hearing Tribunal by the Chair

Dated: April 11, 2017

Dr. Eldon R. Smith

APPENDIX A

LIST OF WITNESSES IN ATTENDANCE AT CPSA HEARING RE: DR. M. AL-GHAMDI – OCTOBER 17, 2014 – SEPTEMBER 23, 2016

1.	James West	October 17, 2014
2.	[redacted]	April 20 - 21, 2015
3.	[redacted]	April 22, 2015
4.	[redacted]	April 23, 2015
5.	[redacted]	April 24, 2015
[redacted]		May 11, 2015
7.	[redacted]	May 12, 2015
8.	Kristy Ivans	May 13, 2015
9.	[redacted]	May 13, 2015
10.	Rita Young	May 14, 2015
11.	Gail Coristine	May 15, 2015
12.	[redacted]	October 13, 2015
13.	[redacted]	October 14, 2015
14.	James West	October 15, 2015
15.	Kerianne Dunlap	October 16, 2015
16.	[redacted]	November 9, 2015
17	[redacted]	November 10, 2015
18.	[redacted]	November 12, 2015
19.	[redacted]	November 13, 2015
20.	[redacted]	December 17, 2015
21.	[redacted]	December 18, 2015
22.	Bonny Nelson	January 11, 2016
23.	[redacted]	January 11, 2016
24.	Janet Loseth	January 12 - 13, 2016
25.	[redacted]	January 13 - 14, 2016
26.	[redacted]	February 16, 2016
27.	Yvonne Vos	February 17, 2016
28.	Denise Beaudin	February 18, 2016
29.	Bev Peters	February 19, 2016
30.	[redacted]	March 7, 2016
31.	[redacted]	March 7, 2016
32.	[redacted]	March 8, 2016
33.	Jonathan Carlzon	March 8, 2016
34.	Janet Sasaki	March 9, 2016
35.	[redacted]	March 10, 2016
36.	Hazel Ross	March 10, 2016
37.	[redacted]	March 11, 2016

38. Sharon Barron	March 11, 2016
39. Peter (Jonathan) Faulds	April 18, 2016
40. [redacted]	April 18, 2016
41. Wendy Dumais	April 18, 2016
42. Shane Ray	April 18, 2016
43. Denise Giebelhaus-Graw	April 19, 2016
44. Hazel (Josephine) Badger	April 19, 2016
45. Theresa Jordan	April 19, 2016
46. [redacted]	April 19, 2016
47. [redacted]	April 19, 2016
48. Deborah Magusin	April 20, 2016
49. [redacted]	April 20, 2016
50. Ginger Krause	April 20, 2016
51. [redacted]	April 20, 2016
52. [redacted]	April 20, 2016
53. Sheila Dorscheid	April 20, 2016
54. Heather Halwa	April 20, 2016
55. Holly Ljuden	April 20, 2016
56. Alan Hansen	April 21, 2016
57. [redacted]	April 21, 2016
58. Jennifer Power	April 21, 2016
59. Wanda Hobbs	April 21, 2016
60. Belinda Parsons	April 21, 2016
61. [redacted]	April 21, 2016
62. [redacted]	April 21, 2016
63. Stephanie Malekoff	April 21, 2016
64. Kevin (Douglas) Parsons	April 21, 2016
65. [redacted]	September 19, 2016
66. Dean Pangracs	September 19, 2016
67. Dr. Mohammed Al-Ghamdi	September 20, 2016

APPENDIX B

LIST OF EXHIBITS
ENTERED AT CPSA HEARING RE: DR. M. AL-GHAMDI
OCTOBER 17, 2014 – SEPTEMBER 23, 2016

31	ALBERTA HEALTH SERVICES MEDICAL STAFF RULES, APPROVED AND EFFECTIVE 28 FEBRUARY 2011	584
32	ORIGINATING NOTICE FOR JUDICIAL REVIEW - COURT FILE NUMBER 1404 00720, FILED DECEMBER 23, 2014	685
33	VOLUME OF DOCUMENTS - DR. [redacted], TABS 1 - 11, PAGES RN1 TO RN60	730
34	E-MAIL FROM DR. AL-GHAMDI TO DR. [redacted] AND DR. [redacted] RE PROBLEM AND HOSTILITY, DATED JULY 27, 2013	812
35	MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE ON-CALL SCHEDULE, DATED JULY 26, 2013	851
37	VOLUME OF DOCUMENTS - DR. [redacted], TABS 1 - 8, PAGES WW1 TO WW27	929
36A	(FOR IDENTIFICATION) LETTER FROM AHS TO BISHOP & MCKENZIE, DATED JUNE 18, 2013 (SUBSEQUENTLY IDENTIFIED AS DOCUMENT VY16 OF EXHIBIT 52)	933
38	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE INAPPROPRIATE DOCUMENTATION, DATED MAY 23, 2012	994
B	(FOR IDENTIFICATION) PATIENT RECORD	1003
C	(FOR IDENTIFICATION) OPERATIVE REPORT	1004
D	(FOR IDENTIFICATION) ELECTRONIC MEDICAL RECORD	1006
39	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE COMMENT IN DICTATION, DATED JUNE 16, 2012	1006
40	OHLHAUSER AND ASSOCIATES REPORT, DATED OCTOBER 2006	1013
41	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE RECRUITMENT, DATED DECEMBER 30, 2010	1017
42	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE ON CALL, DATED OCTOBER 28, 2010	1018

43	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE MEETING, DATED OCTOBER 15, 2012	1024
44	E-MAIL FROM DR. [redacted] TO REBEKAH WILLIAMS RE DECEMBER SCHEDULE - ORTHOPEDIC, DATED DECEMBER 9, 2011	1027
45	E-MAIL FROM DR. [redacted] TO REBEKAH WILLIAMS RE DECEMBER SCHEDULE - ORTHOPEDIC, DATED DECEMBER 9, 2012	1028
46	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE FEBRUARY SCHEDULE, DATED JANUARY 9, 2012	1028
47	E-MAIL FROM REBEKAH WILLIAMS RE DR. AWAY NOTICE, DATED FEBRUARY 27, 2012	1030
48	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE ORTHO MEETING, DATED OCTOBER 7, 2012	1039
49	E-MAIL FROM DR. AL-GHAMDI RE CHRISTMAS CALL, DATED OCTOBER 22, 2012	1040
50	E-MAIL FROM DR. [redacted] OFFICE RE HAND OVER OF PATIENTS, DATED JANUARY 21, 2011	1080
51	E-MAIL FROM DR. AL-GHAMDI TO DR. [redacted] RE PATIENT AFTER-HOUR COVERAGE, DATED NOVEMBER 17, 2012	1083
52	VOLUME OF DOCUMENTS - DR. [redacted] TABS 1 - 12, PAGES VY1 - VY61, VY66 - VY69	1149
53	AGREEMENT DATED JUNE 12, 2013, BETWEEN HEALTH REGION 8 AND DR. AL-GHAMDI	1163
54	E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI RE INFECTION PREVENTION AND CONTROL SURGICAL PATIENTS, DATED SEPTEMBER 29, 2012	1214
55	E-MAIL FROM DR. AL-GHAMDI TO DR. [redacted] RE ZMD RESPONSE TO OR SCHEDULE E-MAIL CONCERN, DATED JULY 9, 2013	1285
36B	(FOR IDENTIFICATION) LETTER DATED MAY 16, 2013, FROM WALTER S. MCKALL TO DR. [redacted]	1338

56	DISMISSAL NOTICE OF COMPLAINTS DIRECTOR, COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA, DATED AUGUST 26, 2013, RE MARY NASEDKIN, AND LETTER FROM CARNA TO MARY NASEDKIN, DATED SEPTEMBER 25, 2013	1367
57	VOLUME OF DOCUMENTS - DR. [redacted], TABS 1 - 6, PAGES RD1 - RD13	1646
58	OR ELECTIVE SURGICAL SCHEDULES FOR MAY 2007, MARCH 2007, OCTOBER 2007, JANUARY 2010 AND NOVEMBER 2011	1681
59	BUNDLE OF DOCUMENTS, CONSISTING OF RED LIST, UNSCHEDULED PROCEDURES, DATED NOVEMBER 04, 2011, AND\ VARIOUS PATIENT CARE RECORDS	1702
60	DOCUMENT ENTITLED RED LIST - UNSCHEDULED PROCEDURES, DATED NOVEMBER 15, 2012	1728
61	E-MAIL CHAIN COMMENCING WITH E-MAIL FROM DR. [redacted] TO DR. [redacted], DR. A[redacted] DR. AL-GHAMDI, RE CHRISTMAS CALL, DATED OCTOBER 19, 2012	1752
62	E-MAIL CHAIN COMMENCING WITH E-MAIL FROM DR. [redacted] TO DR. AL-GHAMDI, RE FEBRUARY ON-CALL, DATED JANUARY 18, 2012	1758
63	ORTHOPEDICS ON CALL ROSTER DISTRIBUTED AUGUST 29 2012	1767
64	DOCUMENT RELATING TO MEDICAL DEVICE MIZUHO OSI MODULAR TABLE SYSTEMS.	1773
65	E-MAIL CHAIN COMMENCING WITH E-MAIL FROM DR. [redacted] TO DR. [redacted] RE IMPAX AND NORTHERN REPOSITORY, DATED NOVEMBER 17, 2012	1783
66	CMPA RISK FACT SHEET ENTITLED 'PATIENT HANDOVERS'	1783
67	DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA, RE DR. [redacted]	1806

94	E-MAIL FROM DR. MOHAMMED AL-GHAMDI TO DR. [redacted], DATED JULY 3, 2012	2834
95	OR ELECTIVE SURGICAL SCHEDULE - FINAL, APRIL 2012	2847
96	LETTER FROM DR. [redacted] TO DR. MOHAMMED AL-GHAMDI, DATED JUNE 6, 2012	2859
97	PORTION OF CHART RELATING TO PATIENT JH	2860
98	DOCUMENT ENTITLED 'DRESS CODE - WEARING OF MASKS	2895
99	E-MAIL CHAIN FROM DR. MOHAMMED AL-GHAMDI TO DR. [redacted], DATED DECEMBER 7, 2012	2908
100	MINUTES OF MEETING OF ZONE CLINICAL DEPARTMENT - SURGICAL SERVICES, DATED DECEMBER 10, 2012	2908
101	ORTHOPEDICS ON CALL ROSTER DISTRIBUTED NOVEMBER 24TH - DECEMBER 2009	2918
102	E-MAIL CHAIN FROM DR. MOHAMMED AL-GHAMDI TO DR. [redacted], DATED MAY 12, 2013	2923
103	MEMO FROM DR. [redacted] TO VARIOUS RECIPIENTS, DATED DECEMBER 6, 2006	2924
104	LETTER FROM DR. [redacted] TO MR. CHILTON, DATED SEPTEMBER 17, 2006	2925
105	DRAFT POLICY OF PEACE COUNTRY HEALTH, CARE OF SURGICAL PATIENTS, DATED DECEMBER 2008	2929
106	DRAFT POLICY OF PEACE COUNTRY HEALTH, CORRECT SITE SURGERY AND PREOPERATIVE PAUSE, DATED FEBRUARY 21, 2006	2929
107	MEMO TO ALL QE11 SURGEONS, FROM DR. [redacted], DATED APRIL 19, 2008	2931
108	MEMO FROM DR. [redacted] TO SURGICAL COLLEAGUES, DATED OCTOBER 4, 2006	2931
109	LETTER FROM DR. [redacted] TO SURGEONS/ ANAESTHETISTS, DATED DECEMBER 3, 2007	2931

110	COMPUTER USB MEMORY STICK CONTAINING RECORDING OF CONVERSATION BETWEEN DR. AL-GHAMDI AND TRACEY RICE	2961
111	BUNDLE OF DOCUMENTS RE JAMES WEST - TABS 1 – 7	2991
112	UNOFFICIAL TRANSCRIPT RE TELEPHONE DISCUSSION BETWEEN DR. AL-GHAMDI AND NURSE TRACEY RICE	3008
113	UNOFFICIAL TRANSCRIPT RE CONVERSATION BETWEEN DR. AL-GHAMDI AND DR. [redacted]	3008
114	BUNDLE OF DOCUMENTS RELATING TO COLLEGE INVESTIGATION	3129
115	COMPLETE CPSA INVESTIGATION RECORDS RELATING TO FILE NO. 100441.1.1	3165
116	OPERATIVE - DETAIL RELATING TO PATIENT AD	3220
117	ALBERTA HEALTH SERVICES POLICY 'WORKPLACE VIOLENCE: PREVENTION AND RESPONSE'	3335
118	ALBERTA HEALTH SERVICES CODE OF CONDUCT	3384
119	ORTHOPEDICS ON CALL ROSTER FOR AUGUST 2012 - DISTRIBUTED JUNE 18, 2012	3385
120	POSTING FROM FACEBOOK PAGE OF TRACEY L. RICE, MARCH 28, 11:36 A.M.	3450
121	(1) OPERATIVE REPORT RE PATIENT TLH (2 PAGES), HISTORY AND PHYSICAL RE PATIENT CCM (1 PAGE) AND OPERATIVE REPORT RE PATIENT CCM (2 PAGES) (2) LETTER FROM ALBERTA HEALTH SERVICES TO COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA, DATED MAY 25, 2015 RE PATIENT CCM (3) LETTER FROM ALBERTA HEALTH SERVICES TO COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA, DATED MAY 25, 2015 RE PATIENT TH	3496
122	BUNDLE OF DOCUMENTS RE DR. [redacted]	3512
123	CHAIN OF E-MAILS COMMENCING WITH E-MAIL FROM SEAN CHILTON TO DR. [redacted], DATED MAY 29, 2003	3528

136	MEMO FROM DR. [redacted] TO DR. [redacted], DATED FEBRUARY 25, 2004	3640
137	MEMO FROM DR. [redacted] TO DISTRIBUTION LIST, DATED FEBRUARY 10, 2005	3669
138	DOCUMENT ENTITLED 'MANAGING DISRUPTIVE BEHAVIOR IN THE HEALTHCARE WORKPLACE GUIDANCE DOCUMENT', FALL 2010	3697
139	BUNDLE OF DOCUMENTS RE DR. [redacted] - TABS 1 – 2	3719
140	MEMO FROM GAIL DEAGLE TO VARIOUS RECIPIENTS, DATED MAY 17, 2007	3739
141	MEMO FROM GAIL DEAGLE TO VARIOUS RECIPIENTS, DATED MARCH 7, 2008	3739
142	DOCUMENT ENTITLED GROUP CALL SCHEDULE, WITH FAX DATE OF MAY 19, 2005	3742
143	MEMO FROM JEN TREGER TO DISTRIBUTION LIST, DATED JULY 29, 2009	3752
144	MEMO FROM DR. [redacted] TO MEDICAL STAFF OF QEII HOSPITAL, DATED NOVEMBER 29, 2004	3757
145	MEMO FROM SEAN CHILTON TO ALL PHYSICIANS, DATED NOVEMBER 14, 2006	3758
146	MEMO FROM DR. [redacted] TO ALL PHYSICIANS WORKING IN EMERGENCY, DATED NOVEMBER 14, 2006	3760
147	MEMO FROM DR. [redacted] TO DR. MOHAMMED AL-GHAMDI, DATED JANUARY 15, 2010	3769
148	BUNDLE OF DOCUMENTS STARTING WITH LETTER FROM COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA TO DR. [redacted], DATED OCTOBER 25, 2011	3801
149	LETTER FROM DR. M. AL-GHAMDI TO DR. [redacted], DATED JULY 23, 2008	3848
150	LETTER FROM DR. MOHAMMED AL-GHAMDI TO DR. [redacted] DATED DECEMBER 14, 2007	3849

165	DOCUMENT ENTITLED 'MANAGING DISRUPTIVE BEHAVIOUR IN THE HEALTHCARE WORKPLACE', MARCH 2013, PROVINCIAL FRAMEWORK	4345
166	DOCUMENT ENTITLED 'MANAGING DISRUPTIVE BEHAVIOUR IN THE HEALTHCARE WORKPLACE', MARCH 2013, RESOURCE TOOLKIT	4346
167	MINUTES OF THE CREDENTIAL COMMITTEE MEETING HELD MAY 21, 2009	4368
168	LETTER TO DR. POPE FROM DR[redacted] AND DR. [redacted], DATED OCTOBER 30, 2009 (SEE ALSO EXHIBIT 89 - PM29 TO 30)	4434
169	CPSA DOCUMENT ENTITLED 'PROCESSES USED TO RESOLVE COMPLAINTS UNDER THE HPA'	4845
170	TWO (2) NOTICES TO ATTEND/PRODUCE	4855
171	LETTER FROM DR. [redacted] AND DR. [redacted] TO DR[redacted] AND DR. [redacted], DATED MARCH 7, 2004	4887
172	EXCERPT FROM CPSA FILE 130052.1.1 (10 PAGES)	4948
173	DOCUMENT TITLED 'REPORT OF THE COMMITTEE TO REVIEW DR. MOHAMMED AL-GHAMDI'S PRIVILEGE REQUEST', UNDATED (12 PAGES)	4967
174	AUTOMATIC E-MAIL REPLY FROM DR. [redacted] TO DR. M. AL-GHAMDI, DATED JANUARY 1, 2014	5121
L	(FOR IDENTIFICATION) BUNDLE OF DOCUMENTS COMMENCING WITH E-MAIL FROM DR. MOHAMMED AL-GHAMDI TO DR. [redacted], DATED SEPTEMBER 30, 2013 (13 PAGES)	5136
175	(PREVIOUSLY MARKED AS EXHIBIT 121) (1) OPERATIVE REPORT RE PATIENT TLH (2 PAGES), HISTORY AND PHYSICAL RE PATIENT CCM (1 PAGE) AND OPERATIVE REPORT RE PATIENT CCM (2 PAGES) (2) LETTER FROM ALBERTA HEALTH SERVICES TO COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA, DATED MAY 25, 2015 RE PATIENT CCM (3) LETTER FROM ALBERTA HEALTH SERVICES TO COLLEGE	5202

203	MEMO DATED JULY 3, 2008, FROM DR. [redacted] TO ALL PHYSICIANS AND EMAIL FROM DR. [redacted] TO SEVERAL PHYSICIANS DATED JULY 7, 2008	6504
204	LETTER DATED MARCH 6, 2013, FROM DR. [redacted] TO NORTH ZONE PHYSICIANS	6505
200B	ALBERTA HEALTH SERVICES CONFLICT OF INTEREST BYLAW DATED MAY 14, 2013	6511
205	AFFIDAVIT OF BEV PETERS SWORN FEBRUARY 17, 2015	6585
206	AFFIDAVIT OF DENISE BEAUDIN, SWORN FEBRUARY 26, 2015 (PREVIOUSLY EXHIBIT H FOR IDENTIFICATION)	6777
207	PRINTOUT FROM COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA WEBSITE FROM MARCH 6, 2016, CONSISTING OF THREE DOCUMENTS: INFORMATION ABOUT FILING A COMPLAINT, COMPLAINT REPORTING FORM, AUTHORIZATION FOR RELEASE OF INFORMATION	6813
208	DOCUMENT ENTITLED *A PHYSICIAN'S GUIDE TO OCCUPATIONAL HEALTH AND SAFETY RESPONSIBILITIES*, FROM COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA WEBSITE, DATED SEPTEMBER 2008	6821
209	VOLUME OF DOCUMENTS - DR. [redacted] [redacted], PAGES KM1 TO KM34	6871
210	LETTER FROM DR. [redacted] TO KASIA KOPER, DATED FEBRUARY 9, 2011	6889
211	BUNDLE OF DOCUMENTS COMMENCING WITH E-MAIL FROM DR. [redacted] TO DR. [redacted], DATED SEPTEMBER 27, 2011, CONSISTING OF 8 PAGES	6890
212	LETTER FROM COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA TO DR. [redacted], DATED JULY 29, 2011	6890
213	INVESTIGATION REPORT OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA, DATED MARCH 26, 2013, RELATING TO A COMPLAINT FROM MR. [redacted] REGARDING CARE PROVIDED BY DR. AL-GHAMDI	6890

APPENDIX C

INTERIM DECISIONS

Interim Decision No. 1 (Preliminary Decision) dated December 1, 2014, dealing with preliminary objections to proceeding raised by Dr. Al-Ghamdi.

Interim Decision No. 2 dated January 25, 2015, dealing with procedural issues arising in advance of the hearing on the merits of the complaint.

Interim Decision No. 3 dated August 17, 2015, dealing with Dr. Al-Ghamdi's request for an adjournment, change of venue, disclosure of witnesses and their anticipated testimony, and the College's request for guidance regarding disclosure of documents.

Interim Decision No. 4 dated December 10, 2015, dealing with Dr. Al-Ghamdi's application to cover the costs of the witnesses and for advanced costs.

Interim Decisions No. 5 dated December 17, 2015, application of the College to quash some of the notices to attend and notices to produce issued by Dr. Al-Ghamdi.

Interim Decision No. 6 dated December 24, 2015, dealing with Dr. Al-Ghamdi's non-suit application.

Interim Decision No. 7 dated February 4, 2016, dealing with application of the College to quash notices to attend; applications from Dr. Al-Ghamdi: to produce court reporter's audio recordings, to reverse prior order relating to disclosure; relating to witness availability; to exclude the public from the hearing; and to reconsider the non-suit application.

Interim Decision No. 8 dated February 29, 2016, deciding the applications of Dr. Al-Ghamdi to: disqualify Mr. Boyer as counsel for the College; obtain advance ruling on his right to cross examine any of his witnesses; and to exclude illegally obtained evidence.

Interim Decision No. 9 dated March 24, 2016, relating to emails between the Hearing Tribunal and the Hearings Director in relation to a request from Dr. Al-Ghamdi for 78 Notices to Attend; and regarding the location of the hearing in April of 2016.

Interim Decision No. 10 dated April 7, 2016, dealing with without prejudice communications being entered as part of an exhibit.

Interim Decision No. 11 dated May 3, 2016, relating to Dr. Al-Ghamdi providing the names of witnesses to the Hearing Tribunal and Mr. Boyer as directed.

Interim Decision No. 12 dated May 4, 2016, dealing with Dr. Al-Ghamdi's applications to: have the hearing closed to the public; have the text of a telephone recording expunged from the record; and have College's counsel ordered to take a number of steps.

Interim Decision No. 13 dated June 10, 2016 related to having expert witnesses attend to testify, and Dr. Al-Ghamdi retaining Counsel and seeking an adjournment of the hearing.

COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
RSA 2000, c H-7

AND IN THE MATTER OF A SANCTION HEARING REGARDING
THE FINDINGS AGAINST DR. MOHAMMED AL-GHAMDI

FINAL DECISION
OF
THE HEARING TRIBUNAL INTO SANCTION
BY
THE COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

Hearing Tribunal	**Dr. Eldon Smith**
	Mr. Wayne McKendrick
Independent Counsel to the Hearing Tribunal	**Mr. John Carpenter**
Counsel for the Complaints Director	**Mr. Craig Boyer**
Counsel for Dr. Al-Ghamdi	**Mr. Arman Chak**

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I. INTRODUCTION

1. On October 17, 2014, the College of Physicians & Surgeons of Alberta (the "CPSA") initiated a hearing into allegations of unprofessional conduct by Dr. Mohammed Al-Ghamdi (the "Conduct Hearing"). The Hearing Tribunal consisted of Dr. Eldon Smith, Chair, and Mr. Wayne McKendrick, Public Member (the "Tribunal").

2. The Tribunal reconvened for a hearing on sanction on September 5, 2017 (the "Sanction Hearing") with preliminary meetings and exchanges of written submissions prior to that date. This is the decision on the sanction (the "Sanction Decision").

II. BRIEF SUMMARY OF THE CONDUCT HEARING FINDINGS

3. The charge against Dr. Al-Ghamdi was that since 2003 (for over 10 years) he had demonstrated a pattern of disruptive conduct in his dealings with a number of medical colleagues and nursing staff at the Queen Elizabeth II Hospital in Grand Prairie, Alberta (the "QEII"), which had resulted in a breakdown of his professional relationships with those colleagues and staff to the detriment of health services at that hospital (the "Charge"). The Charge listed 13 related particular acts:

a. failing to participate in and follow the on-call schedule and procedures for orthopedic surgery at the hospital;

b. purporting to have a parallel on-call schedule of his own to try to avoid having to deal with the on-call orthopedic surgeon at the hospital when booking a patient for surgery;

c. failing to cooperate with medical colleagues and nursing staff to ensure surgical cases were performed on the basis of medical need for urgent care;

d. failing to finish a surgical case in a timely manner while another surgeon was in need of the same operating room to deal with an urgent case;

e. failing to replace the safety cap on used needles/sharps and leaving the item for other staff to deal with and putting that staff person at risk of being poked by the uncapped needle/sharp;

f. cultivating a culture of fear and distrust through making complaints to the Alberta Human Rights Commission, the College and Association of Registered Nurses of Alberta or the College of Physicians & Surgeons of Alberta;

g. cultivating a culture of fear and distrust through threatening to start or starting legal action;

h. cultivating a culture of fear and distrust through recording of a conversation without the knowledge of the person in the conversation;

i. cultivating a culture of fear and distrust through making numerous complaints to administration at the hospital and the health authority;

j. failing to follow the issue/dispute resolution processes set out in the bylaws and policies applicable to hospital medical staff;

k. not obtaining consent for the surgery from his patient until immediately before the procedure rather than when booking the patient for surgery creating unnecessary stress and delay;

l. advising patients and other doctors that he was able to book patients at the hospital when he did not have active privileges at the time; and

m. having nursing staff open sterilized packs of surgical instruments which were not reasonably required for the procedure at hand and thereby making these instruments unavailable for other surgeons until the nursing staff had re-sterilized those instrument packs.

All of which was contrary to his obligations under the Canadian Medical Association Code of Ethics, including in particular section 52, and Standards of Practice No. 3 and No. 28 established under the *Health Professions Act* ("HPA"), and as such constitutes unprofessional conduct.

4. At the Conduct Hearing, evidence was heard from 67 witnesses (17 called by the CPSA Complaints Director (the "Complaints Director") and 50 by Dr. Al-Ghamdi) over the course of 47 days. A total of 276 exhibits were entered.

5. A decision from the Conduct Hearing was issued on April 11, 2017 (the "Conduct Decision"). In it, it was found that 8 particulars (a, b, c, f, g, i, j, and m) of the 13 in the Charge against Dr. Al-Ghamdi had been proven and that he had engaged in disruptive conduct amounting to unprofessional conduct.

6. With respect to the Sanction Hearing, these reasons begin by summarizing the process, the evidence, and the parties' arguments. Finally, the sanction is addressed.

III. SANCTION HEARING PROCESS

7. For the Sanction Hearing, the Tribunal heard witnesses and submissions on September 5, 2017 at the CPSA office in Edmonton, Alberta.

8. Present were:

- Dr. Eldon Smith, Chair;
- Mr. Wayne McKendrick, public member;

- Mr. John Carpenter, independent legal counsel to the Tribunal;
- Mr. Craig Boyer, legal counsel to the Complaints Director;
- Dr. Mohammed Al-Ghamdi; and
- Mr. Arman Chak, legal counsel to Dr. Al-Ghamdi (as of on or around May, 2016).

9. Prior to the Sanction Hearing, there were a number of preliminary exchanges. These have been included, with counsels' agreement, as an Exhibit (280).

10. Firstly, the Tribunal asked the parties for their positions as to whether an oral hearing was required or the matter could proceed solely with written submissions.

11. Dr. Al-Ghamdi objected to an oral hearing with the calling of witnesses. He also raised a concern respecting the bifurcation of the hearing process (i.e. the Conduct Hearing versus the Sanction Hearing). Further, he argued that the Tribunal was inappropriately expanding its jurisdiction to deal with the Complaints Director's new submission that Dr. Al-Ghamdi is ungovernable, and thus his license ought to be revoked as a sanction. (The bifurcation and the ungovernability issues will be discussed in more detail below).

12. The Complaints Director advocated for an oral hearing as he intended to call several witnesses. The Complaints Director also submitted that he had previously advised Dr. Al-Ghamdi of the sanction being sought, and thus there should be no issue in that regard.

13. After this exchange of correspondence between the parties, it was determined that an oral hearing on sanction was appropriate, so as to hear from relevant witnesses. The Sanction Hearing was scheduled to proceed on September 5 and 6 (if necessary), 2017. Written submissions on sanction were exchanged in advance (with the Complaints Director having until August 15, 2017 to provide submissions and Dr. Al-Ghamdi having until August 25, 2017 to provide his submissions).

14. Prior to the Sanction Hearing in September, a conference call was held on July 28, 2017 to deal with several issues Dr. Al-Ghamdi raised, including:

a. Whether evidence could be called in respect of sanction;

b. If so, whether the proposed evidence should be heard in light of the description the Complaints Director provided as to the witnesses' identities and the nature of their proposed testimony; and

c. Whether sufficient particulars had been provided to Dr. Al-Ghamdi in respect to that evidence in order that he may prepare and respond.

15. The Tribunal reviewed the evidence that the Complaints Director proposed to call in light of Dr. Al-Ghamdi's concerns and issued a ruling (Interim Decision #14).

16. It was decided that the following witnesses of the Complaints Director would be heard:

- Dr. [redacted], former Hearings Director for the CPSA, regarding her decision to retain personal legal counsel – which related to the issue of those legal costs being included in the costs of the hearing;

- Dr. [redacted] who would describe remedial treatment programs available to address the type of conduct involved in this case; and

- Mr. James West, former CPSA Investigator, to provide records obtained from Alberta Health summarizing Dr. Al-Ghamdi's health care billings from 2010 until 2017 for the purposes of evidencing Dr. Al-Ghamdi's impacted financial situation, which would be relevant to assessing his ability to pay costs.

17. The Tribunal did not allow the Complaints Director to call Dr. Laurie Hiemstra to provide evidence concerning Dr. Al-Ghamdi's conduct during his training period in orthopedic surgery in Winnipeg.

18. Further, the Tribunal was satisfied that the Complaints Director had provided sufficient particulars to Dr. Al-Ghamdi about the evidence to be called, but would revisit this issue if new concerns were raised.

19. Both parties provided their written submissions on or before the respective deadlines and the Sanction Hearing proceeded in CPSA chambers on September 5, 2017.

IV. SANCTION HEARING EVIDENCE

A. Evidence of Witnesses

20. The witnesses' evidence is summarized below.

(1) [redacted]

21. The Complaints Director called Dr. [redacted] former Hearings Director for the CPSA. The Complaints Director sought to include, in the costs of the Hearing, the costs for Dr. [redacted] legal counsel.

22. Dr. [redacted] described the Hearing Director's role and provided evidence regarding her role with Dr. Al-Ghamdi and the Conduct Hearing, particularly in dealing with issuing notices for witnesses to attend and/or produce (the "Notices").

23. She testified that Dr. Al-Ghamdi required an extensive number of Notices and she was required to sign a voluminous amount (i.e. around 100 of them). Dr. Al-Ghamdi forwarded numerous Notices to her office, often just a few days before the Tribunal's next scheduled meeting, and the Notices had set the same day and time for the witnesses' appearances before the

Tribunal. Further, Dr. Al-Ghamdi also called her to testify regarding the conduct of hearings (on March 8, 2016) and she required her legal counsel's assistance to do so.

24. Further, Dr. Al-Ghamdi frequently challenged her interpretation of aspects of the HPA, necessitating her to seek out legal assistance. She also believed that she needed legal assistance to ensure the Notices were properly formatted.

25. Dr. [redacted] described her experience with this Conduct Hearing as unique.

26. On cross-examination, Dr. [redacted] acknowledged that there was no official CPSA format for the Notices. Further, although her legal counsel helped her formulate responses to Dr. Al-Ghamdi's questions and, on occasion, communicated with Dr. Al-Ghamdi concerning these issues, she was not aware of her counsel having ever responded directly to Dr. Al-Ghamdi without consulting her first.

(2) [redacted]

27. The Complaints Director called Dr. [redacted]t to provide evidence on remedial treatment programs.

28. With respect to her credentials, she advised that, after acquiring her degree in medicine, she trained in psychiatry and assumed a staff position in Calgary. In 2005, she accepted a position with the CPSA as Assistant Registrar. She was responsible for monitoring physicians with health problems, reviewing physician prescribing practices, and dealing with research ethics committees. In 2015, she returned to practice and, with colleagues, has developed and operates an independent comprehensive occupational assessment program ("COAP") for physicians who have experienced professional difficulties.

29. She testified that a COAP was lacking in western Canada but that there was a perceived need. Many physicians or psychologists who encounter difficulty with their health authority or

with their licensing body are found to have underlying health issues, which contribute to their difficulties.

30. The COAP that she developed consists of a team of people who are qualified to assess different aspects of a physician's problems. The team includes another psychiatrist, a psychologist, and a neuropsychologist. A letter from Dr. [redacted] describing the COAP was entered as an exhibit (277).

31. On cross-examination, she elaborated that during her work at the CPSA, she was responsible for the development of the document entitled "Management of Disruptive Behaviour in the Workplace" in 2010.

32. She explained that a significant portion of people identified as disruptive are suffering from other stress in their lives – this could be family difficulties or it might be a major psychiatric illness, such as bipolar disease. In these situations, the disruptive behavior might be a symptom of the psychiatric illness. With respect to her understanding of passive disruptive behavior, she explained that behavior, such as not attending meetings, might also be the result of psychiatric illness, such as depression.

33. Dr. [redacted]t acknowledged that she had no experience in dealing with discrimination and health law, specifically with the difficulties that independent specialist physicians might have working in a hospital environment, or with systemic bias within an institution. She also knew the term "workplace mobbing", but had no experience relating to it. Further, with respect to her experience with culturally sensitive diagnoses, she explained that she had encountered this in her inner-city work recently, particularly in relation to indigenous patients and the residential school situation.

34. With respect to treatment options, Dr. [redacted] agreed that, for persons with disruptive behaviour, one option was mentorship. For subjects with no mental illness diagnosis, the mentor could help the subject understand the impact of certain actions on others and suggest alternative responses and perhaps more self-reflection. She also indicated that there were skilled therapists

in Alberta who could help individuals with passive disruptive behavior reflect on their conduct and how it impacts others. In relation to situations involving people of different cultures and languages, Dr. [redacted] indicated that it is important that people in the work group feel comfortable in asking others to repeat their comments so that understanding is optimal. Individuals from different cultures must feel comfortable in describing how things are done in their culture and enquiring if such responses would be appropriate in their current environment.

35. On re-direct, Dr. [redacted] was questioned as to whether personality disorders were a consideration during the COAP assessment. Dr. [redacted] indicated that this did occur and, generally, noted that such disorders are difficult to treat. In large part, the outcome depends on the patient's ability to understand the impact of their behavior on others and their potential to modify that behavior. Some are more successful than others and this influences treatment outcomes.

36. The Tribunal questioned Dr. [redacted] about several issues, including relating to comparisons between the Alberta COAP and other well-known programs in the USA. Dr. [redacted] indicated that there are several excellent programs in the USA which Canadian Colleges have used. The difficulty has been that the treatment options are sometimes not available in Canada and the recommendations are sometimes not consistent with the Canadian health system. The Alberta COAP reflects the Canadian context.

37. Dr. [redacted] indicated that there were no other Canadian COAP-like programs, other than one in Toronto.

38. Dr. [redacted] was asked to comment on the issue of the un-cooperative physician. She acknowledged that this does happen but, in her experience, usually the physician recognizes that the process is attempting to help him/her and he/she cooperates. She acknowledged that physicians in these programs may be very anxious and perhaps defensive out of fear that he/she might not be allowed to practice again.

39. Dr. [redacted] indicated that perhaps the major success factor in cases referred to the COAP is the physician's ability to successfully address his/her difficulties and become re-integrated into his/her work environment.

40. Finally, it was acknowledged that the COAP has had limited experience with re-evaluation. In two instances she remembered, the physicians had done very well and understood how they had gotten into difficulty in the first place.

(3) Mr. James West

41. The Complaints Director called Mr. James West who had appeared twice at the Conduct Hearing as a CPSA Investigator. The reason for his appearance at this time was that the Complaints Director had asked Mr. West to obtain health services billing information from Alberta Health pertaining to Dr. Al-Ghamdi from January of 2010 until present. He received this from Alberta Health in a summary format. Despite an objection from Dr. Al-Ghamdi, the Tribunal ruled that this information was relevant and accepted it as an exhibit (278). This showed a decline in Dr. Al-Ghamdi's billings from mid-2013 onwards (coinciding with the time when his hospital privileges were suspended).

42. Under cross-examination, Mr. West acknowledged that he is no longer an investigator at the CPSA but did request this information from Alberta Health in his capacity as investigator on the case involving Dr. Al-Ghamdi.

(4) Dr. Mohammed Al-Ghamdi

43. Dr. Al-Ghamdi testified and gave evidence in a number of areas.

44. With respect to Dr. [redacted], Dr. Al-Ghamdi testified that he had contacted her and asked her for a template for the Notices but was told there was none. He also asked how she selected the Tribunal panel members and indicated that he had concerns about bias with those selected.

45. In relation to the numerous Notices to Attend (approximately 70) issued for the same day and time, Dr. Al-Ghamdi indicated that he had received legal advice on this matter and the rationale was to send Notices to this large group and then to contact them and arrange a mutually convenient date and time for each individual to testify. If an individual failed to appear, Dr. Al-Ghamdi was of the belief that he could compel them because they had received proper notice.

46. Dr. Al-Ghamdi also expressed his concern about the confidentiality of the process. He was surprised that counsel for the Complaints Director had asked the Tribunal to quash a number of his Notices to Attend. Counsel for Alberta Health Services had also requested a number of these Notices be quashed because they named members of the QEII workforce, and having so many individuals absent from work on the same day could impact the quality of care at the QEII. Dr. Al-Ghamdi believed that both of these requests reflected a breach of confidentiality.

47. With respect to the COAP Dr. [redacted] outlined, Dr. Al-Ghamdi indicated that this program was of no use to him because he was not suffering from a mental illness. The Tribunal had found that he is guilty of some improper conduct for which he takes responsibility.

48. Dr. Al-Ghamdi had reviewed the Tribunal's findings and, while he disagrees with the conclusion, he accepts that he may be wrong. He believes that he was lacking mentorship and that he tried to compensate for this by pursuing more education. He believes that he would benefit from mentorship as Dr. [redacted] had suggested. In addition, he noted the need to work within a functional team. He stated that an important component of a functional team would be a senior surgeon in his field who could act as a mentor. He described Dr. Sunohara as such a person who worked with Dr. Al-Ghamdi when he first arrived in Grande Prairie.

49. In regards to the testimony of Mr. West, Dr. Al-Ghamdi does not understand the relevance of the information collected concerning his billings and implied that this was an improper access to his personal information.

50. He went on to describe his activities since his hospital privileges were suspended. These have included running an office clinic on occasion as a general physician. He also attends

conferences to maintain his general knowledge about medicine. An exhibit was tendered and accepted (as 279), summarizing Dr. Al-Ghamdi's education and training. Dr. Al-Ghamdi described his extensive training and his degrees and diplomas received. Recently, he has become an examiner for the Medical Council of Canada. As to leadership positions, he is the Vice-President of Public Relationships for the Toastmasters Club of Grande Prairie and previously was the Vice-President of the Medical Examiners' Association of Alberta and briefly was acting head of surgery at the QEII. He also held leadership positions in the past as an intern and as a resident in orthopedic surgery.

51. In response to the suggestion that he is ungovernable, Dr. Al-Ghamdi claimed that he respects authority. However, if he perceives something as incorrect, then he believes it is his ethical responsibility to report the incident so it can be dealt with and resolved.

52. Dr. Al-Ghamdi then advised what he thought would be a fair and reasonable sanction relating to each of the 8 particulars to the Charge for which he had been found guilty:

i. Particular a (re: the on-call schedule): If he obtained privileges at another hospital, Dr. Al-Ghamdi would want to better-understand the issues around the on-call schedule and the expectations of the group. He believes that it would be very important for him to have a mentor to advise him how to deal with the on-call issues.

ii. Particular b (re: independent parallel on-call system): Dr. Al-Ghamdi pointed out that he only tried this system once and it did not work. If he returns to working in a hospital then he will just follow the regular on-call schedule.

iii. Particular c (re: failing to cooperate with colleagues to assure that surgical cases are scheduled based on priority): Dr. Al-Ghamdi believes that he may have advocated too much for his patients. If he went back to work in a hospital he would leave the decision-making to the person with the appropriate authority.

iv. Particular f (re: cultivating a culture of fear by making human rights and professional regulatory body complaints): Dr. Al-Ghamdi believes that this all arose from him making complaints about his colleagues. Dr. Al-Ghamdi pointed out that it was not his intention to create a culture of fear. When he made a complaint about a colleague, he believed it was a confidential process – when that confidentiality was lost, then there was fear. For this issue, he needs to have a mentor to advise him about the best way to handle his concerns. He believes this mentor would need to be a senior orthopedic surgeon working in the hospital where Dr. Al-Ghamdi obtained privileges. He confirmed that he was aware that before he received privileges in a new hospital, he would need to provide full disclosure of his previous difficulties. He recognizes that this will be difficult. He has already applied to various hospitals in the province and elsewhere; however, no hospital will grant privileges while there is an ongoing CPSA matter.

v. Particular g (re: cultivating a culture of fear by legal action): Not specifically addressed by Dr. Al-Ghamdi.

vi. Particular i (re: cultivating a culture of fear by making complaints to hospital administration and the health authority): Dr. Al-Ghamdi indicated that he filed his complaints in an earnest attempt to make things better. It did not work. If he should be fortunate enough to work in another hospital, he hoped that it would be more functional than the QEII. Once again, the most important factor would be for him to have a senior mentor to advise him how best to advocate for needed change.

vii. Particular j (re: failing to follow hospital processes and policies): Dr. Al-Ghamdi thinks that if he had the chance in a new hospital, he would seek to exchange concerns in an informal way. This means he would raise a concern with administration and expect them to deal with it – and give them sufficient time to do so. Again, he believes that having a mentor would be important to help him deal with issues in a better way.

viii. Particular m (re: having nurses open sterilized packs of surgical instruments not used): Dr. Al-Ghamdi believes that his response to this would be for him to have a proper surgical preference card, which would be assessed by the mentor to assure that it was reasonable. If concerns existed, he would change the preference card to meet the expectations of others. He would also assure that his preference card was comparable to those of other surgeons.

53. In addressing what would be a fair and reasonable sanction, given the Conduct Hearing findings, Dr. Al-Ghamdi began by noting that no patients had been harmed by his actions. On that basis, he does not think that being removed from the register is fair or appropriate. He reminded the Tribunal that the Conduct Hearing focused on only a few of the 10,000 patients he had managed. He also pointed out that the CPSA had not previously found him guilty of the Charge of disruptive conduct, and so he did not have the opportunity to deal with it in the past.

54. On the basis of these above considerations, Dr. Al-Ghamdi put forth that a letter of reprimand would be the appropriate sanction. He also suggested that he have a mentor and that no costs be ordered since the lengthy nature of the hearing was more the CPSA's responsibility than his.

55. On cross-examination by the Complaints Director, Dr. Al-Ghamdi described another orthopedic surgeon, Dr. [redacted] as having been a mentor to him for clinical care and stated that he had consulted him a number of times concerning specific patients. However, Dr. Al-Ghamdi believes that the mentor he now needs should have senior administrative awareness. Dr. Al-Ghamdi disagreed that Dr. [redacted] had a practice similar to that of Dr. Al-Ghamdi because of the difference between practicing at a University Hospital and in Grand Prairie.

56. When asked how the proposed mentor would be compensated, Dr. Al-Ghamdi had no answer. He understands that some mentors do not expect compensation, although others might.

57. Dr. Al-Ghamdi described the QEII as dysfunctional with a toxic environment. However, he was not able to name a hospital in Alberta that would meet his description of one that was more functional and less toxic.

58. The Tribunal then questioned Dr. Al-Ghamdi and it was put to him that the evidence presented during the Conduct Hearing pertaining to the call schedule was not that he did not understand it, but that he did not agree with it. Dr. Al-Ghamdi indicated that he could work within a group call schedule if there was a clear procedure and he understood it. Previously, he had followed the medical staff bylaws but the other members of the group had other procedures and did not follow the bylaws.

59. Dr. Al-Ghamdi was also asked to comment on his appreciation for the authority of heads in his division and department. He responded that he respected authority but that often the people in these positions did not address the issue that Dr. Al-Ghamdi had raised so he moved to the next level of authority following the medical staff bylaws. He acknowledged that he may have tried to go too fast.

V. SANCTIONS SUBMISSIONS

60. The parties put forth their arguments via written and oral submissions. These arguments are summarized below.

A. Complaints Director's Submissions

1. Bifurcation

61. The Complaints Director addressed Dr. Al-Ghamdi's preliminary issue pertaining to the bifurcation of the hearing. This issue was raised at the Conduct Hearing and discussed then. However, in light of the re-emergence of this issue since the Conduct Decision, the Complaints Director presented a recent case, *Ontario (Securities Commission) v MRS Sciences Inc.*, 2017 ONCA 279, leave to appeal refused [2017] SCCA No 188 [*MRS*], where bifurcated hearings (merit versus sanction) were discussed and the process was held not to be a breach of procedural

fairness. In that case, bifurcation was permitted, despite the panels at the different stages of the hearing being differently constituted.

2. Ungovernability

62. During closing argument at the Conduct Hearing, the Complaints Director argued that Dr. Al-Ghamdi was ungovernable and his license and practice permit should be cancelled.

63. The Complaints Director cited a number of cases in support.

64. A main argument was that physicians practice in environments dependent on teamwork and collegiality, and if a physician cannot work in such an environment, the unfortunate reality is that such a physician cannot continue to practice.

65. Portions of Dr. Al-Ghamdi's testimony were highlighted for the Tribunal with associated conclusions, including:

a. Dr. Al-Ghamdi is trained as a surgeon and yet he cannot practice surgery from an office;

b. He is not qualified to practice family medicine;

c. The nurses in the operating rooms at the QEII have refused to work with him;

d. Dr. Al-Ghamdi has proclaimed that he does not have a condition that might contribute to a lack of insight into the findings against him. Indeed, he does not see himself as having played a role in those difficulties and continues to point to the system and to others as being at fault. Dr. Al-Ghamdi claims that he would do much better if he had a mentor – however, there have been many senior administrators and colleagues at the hospital who have offered him advice (which

he refused to accept), and who have made decisions (which he rejected). Dr. Al-Ghamdi has been incapable of accepting alternative perspectives.

e. Dr. Al-Ghamdi has vigorously attacked many of his colleagues and, in some instances, this resulted in less than optimal care for patients. He has repeatedly displayed his disdain for colleagues at the QEII (such as Dr. [redacted] among others) in the surgical and anesthesia group – all persons with whom he would need to work collaboratively if he was to succeed as a surgeon.

66. The Tribunal asked for comment on whether Dr. Al-Ghamdi is ungovernable specifically with respect to how he has conducted himself with the CPSA or if he is ungovernable in the health system. In response, the Complaints Director pointed to the following:

a. Section 52 of the Code of Ethics of Alberta Health Services states that physicians are expected to work with their colleagues. Since Dr. Al-Ghamdi is a regulated member who works in the healthcare system, this includes the CPSA.

b. During this process, Dr. Al-Ghamdi has significantly focused his attacks on the CPSA, and there is no evidence he accepts regulation by them. Rather, he accuses the CPSA of bias, discrimination, and even corruption.

c. The CPSA would not be acting in the public interest if it allowed a member who openly disparages the CPSA's authority to regulate him, to continue to practice as a surgeon.

67. It was submitted that if the Tribunal did not find Dr. Al-Ghamdi ungovernable, these arguments would still be relevant to the type of sanction ordered. However, it was emphasized that if Dr. Al-Ghamdi had shown any evidence of improvement in his conduct, or even a willingness to change, then the issue of governability would not have been raised. It is because Dr. Al-Ghamdi continues to demonstrate a lack of insight and no interest in changing that the ungovernable label is appropriate.

68. In addition to the written submissions on the matter, when the Tribunal questioned the Complaints Director, a number of further observations were cited in support of the assertion that Dr. Al-Ghamdi is ungovernable:

a. There was evidence from Dr. Al-Ghamdi's colleagues, and from administrators in the QEII, the health region and in Alberta Health Services, that Dr. Al-Ghamdi had a view of how things should be done and did not accept the views of others.

b. Dr. Al-Ghamdi just does not accept the input or decisions of others in general, as is evident through his complaint to the Human Rights Commission. When his application was denied he appealed the decision to the Court of Queen's Bench, then to the Court of Appeal, and finally, he tried to appeal to the Supreme Court of Canada; it has been dismissed at each level.

c. Moreover, Dr. Al-Ghamdi's approach persisted despite attempts to help him understand his difficulties. The case, *Litchfield v College of Physicians and Surgeons of Alberta*, 2008 ABCA 164 [*Litchfield*], was cited as an example of a physician who refused to take advice about how he should practice; he was subsequently found ungovernable.

d. Dr. Al-Ghamdi has attempted to characterize his actions as being a patient advocate. However, many times it appeared he was merely advocating for himself.

e. Dr. Al-Ghamdi developed a profound sense of entitlement, which was only increased when he went to law school (but lied to his colleagues about why he was away).

f. Dr. Al-Ghamdi lied or misled his colleagues in his attempts to have his own way.

g. When he was on-call, Dr. Al-Ghamdi refused to care for his colleagues' patients unless they transferred care to him – something that none of the other practice groups did and the orthopedic surgeons did not want to do.

h. Repeatedly, Dr. Al-Ghamdi did not take responsibility; he complained and expected others to deal with his issues. As in *Ahluwalia v College of Physicians and Surgeons of Manitoba,* 2017 NBCA 15, 409 DLR (4th) 651 [*Ahluwalia*], Dr. Al-Ghamdi did not offend a patient, but his continued behavior, along with no indication of rehabilitative potential, mitigates against allowing him to continue to practice. Allowing him to continue to practice would not provide an adequate assurance of patient safety nor enhance the public's faith in the medical profession's ability to regulate itself.

i. Dr. Al-Ghamdi's actions did result in harm or potential harm to patients, and particularly to Mr. [redacted], another doctor's patient who was seriously ill with recurrent gastric bleeding; Dr. Al-Ghamdi did not allow Mr. [redacted] surgery to precede his less urgent case (as discussed in the Conduct Hearing).

j. It is not possible for Dr. Al-Ghamdi to work alone – no physician can be available 24-hours per day every day. There has to be collaboration between physicians or the whole system fails.

k. Dr. Al-Ghamdi also claimed that things would be better if he worked in a larger, more functional hospital, however if he could not be successful in a small hospital, how could he possibly function in a large and more complex institution where so much depends on teamwork?

69. In response to the argument that the issue of ungovernability is only being argued now at the Sanction Hearing, it was submitted that it was necessary for the Complaints Director to first have the findings from the Conduct Hearing before determining if the findings made were sufficiently severe to warrant a finding of ungovernability. In defence of this position, the

Complaints Director referenced paragraph 23 of *Ahluwalia*, which demonstrates that ungovernability is considered at the penalty stage. Ungovernability is a sanction issue, whereas the disruptive conduct itself was the subject of the merits issue.

3. Sanction Determination Irrespective of Ungovernability

70. The Complaints Director's verbal arguments largely mirrored his written submissions. The case *Jaswal v Newfoundland (Medical Board)*, [1996] NJ no 50 (Nfld TD) [*Jaswal*] at para 36 was cited for its list of relevant factors when determining the appropriate sanction. It was submitted that the Alberta Court of Appeal and other Canadian adjudicators have referenced this case as the authority.

71. The relevant *Jaswal* factors were highlighted:

a. Nature and gravity of proven allegations: The Tribunal had found Dr. Al-Ghamdi guilty of a pattern of disruptive conduct that was serious, and which had escalated over a number of years, culminating in the suspension of his hospital privileges in mid-2013.

b. Age and experience of the offending physician: Although Dr. Al-Ghamdi arrived in Grande Prairie as a young and inexperienced surgeon, one would have expected him to develop maturity as he gained experience. By the time of the events in 2013, Dr. Al-Ghamdi had been practicing in Grande Prairie for 9-10 years.

c. Previous character of the physician: Although the CPSA had not previously made discipline findings against Dr. Al-Ghamdi, the Investigation Report indicates that Drs. [redacted] and [redacted] had stated that Dr. Al-Ghamdi had 'similar' troubles during his residency training in Winnipeg. This conflicts with Dr. Al-Ghamdi's statement in his written submission that "it is impossible that a similar situation will occur again". As well, the QEII had previously used an external

committee, which included the CPSA Registrar, to review Dr. Al-Ghamdi's privileges. The committee recommended against Dr. Al-Ghamdi receiving active privileges; Dr. Al-Ghamdi did not accept this conclusion and threatened court action (and has pursued an appeal of a dismissed human rights complaint against the health authority and leave to appeal to the SCC was sought and denied). Dr. Al-Ghamdi now suggests that his difficulties would have been avoided if there had been better communication and he had had the benefit of a mentor. It was put forth that this was part of Dr. Al-Ghamdi's inability to accept the decisions of people in positions of authority, mostly because he did not agree with them (i.e. their interpretation of hospital bylaws). Dr. Al-Ghamdi suggested that he have a senior orthopedic surgeon as a mentor, but had no suggestions as to who this would be or how that person would be compensated.

d. Number of Times the Offence was Proven to Have Occurred: With Dr. Al-Ghamdi, the pattern of behaviour has occurred for approximately 10 years.

e. Role of the Physician in Acknowledging What Had Occurred: Dr. Al-Ghamdi maintains that he treats people with respect. However, witnesses at the Conduct Hearing relayed that at times Dr. Al-Ghamdi's treatment of others was unacceptable. Certainly, there is a difference between the way Dr. Al-Ghamdi views himself and how others perceive him.

Dr. Al-Ghamdi also maintains that he made his complaints about others confidentially, and it was when that confidentiality was breached that the fear and distrust developed. This ignores the fundamental principle of administrative law that the individuals Dr. Al-Ghamdi named had the right to hear and respond to his complaints against them.

Dr. Al-Ghamdi's view does not support his claim that what happened will never happen again and demonstrates his lack of insight into the effects of his behavior. Dr. Al-Ghamdi also continues to blame his problems on the disorganization and

toxic environment at the QEII and suggests that he would not have these problems if he worked in a better hospital. However, he was unable to name such a hospital in Alberta. Moreover, in continuing to blame the hospital, Dr. Al-Ghamdi ignores his personal role in the situation.

f. Whether the Offending Physician Has Already Had Financial or Other Penalties as a Result of the Allegations: There is no question that Dr. Al-Ghamdi has suffered financially since his hospital privileges at the QEII were suspended and subsequently terminated (see Exhibit 278). Although the financial information in Exhibit 278 was produced to demonstrate this as a mitigating point, Dr. Al-Ghamdi fought to keep this information from the Tribunal – referring to the process as a breach of his confidentiality.

g. The Factors on the Need to Promote Specific and General Deterrence to Protect the Public, the Need to Maintain the Public's Confidence and the Degree to which the Offensive Conduct Falls Outside the Range of Permitted Behavior were dealt with Together: *Ahluwalia* was cited in support of the importance of these factors.

h. Range of Sentence in Other Similar Cases: The Complaints Director pointed out that the HPA (section 82) outlines the range of sanctions available to the Tribunal and provided a number of cases as useful comparators for this purpose.

72. Further, although Dr. Al-Ghamdi has already faced consequences for his conduct at the hospital, it does not mean that there should be no disciplinary sanction. In *Québec (Directeur des poursuites criminelles et pénales) v Jodoin*, 2017 SCC 2, [2017] 1 SCR 478 [*Jodoin*] the Supreme Court ruled it is possible to have a regulator's consequence on top of the court imposed consequences for the same conduct. In addition, in *Groia v Law Society of Upper Canada*, 2016 ONCA 471, 131 OR (3d) 1 (leave to appeal to the SCC granted: [2016] SCCA no 310) [*Groia*] the Ontario Court of Appeal ruled that it is possible for the same conduct by a lawyer during a trial to be punished both by the court and the regulator. By analogy, this should extend to the

situation here with the hospital and the CPSA. As a regulator, the CPSA can also impose consequences because it is responsible for the profession's ethical and professional standards.

73. To summarize his position on sanction, the Complaints Director submitted that Dr. Al-Ghamdi should have his license and practice permit revoked. The alternative would be a suspension with conditions, including a multi-disciplinary assessment. However, the Complaints Director submitted that since Dr. Al-Ghamdi's testimony was such that an assessment would be of no value (and that he would be better served with better communications and a senior mentor), the appropriate sanction would be a revocation of his license. Section 82 of the HPA includes this as one of the sanctions the Tribunal can impose.

4. Costs

74. With respect to the issue of costs, the Complaints Director pointed out that this has been the most expensive hearing ever for the CPSA, with total costs exceeding $1 million. The Complaints Director submitted that it was because of Dr. Al-Ghamdi that the costs were excessive. For instance, it was because of Dr. Al-Ghamdi's conduct that Dr. [redacted] felt it was necessary to obtain legal assistance in her role as Hearing Director; she felt intimidated and threatened by Dr. Al-Ghamdi's demands. Dr. Al-Ghamdi also repeatedly complained to the Tribunal about Dr. [redacted], who did not issue Notices in accordance with his instructions (although when Dr. Al-Ghamdi was asked to forward copies of the email exchanges with Dr. [redacted] they were not presented). Further, Dr. Al-Ghamdi requested Notices to individuals who should not have been given notice and was even upset when the Tribunal quashed some of the more inappropriate ones.

75. The Complaints Director submitted that, on average, hearings cost around $25,000.00 per day (referencing *Alberta College of Physical Therapists v Fitzpatrick*, 2015 ABCA 95 and *Osif v College of Physicians & Surgeons (Nova Scotia)*, 2009 NSCA 28). This is roughly what the costs were for this 47 day hearing (with 67 witnesses).

76. The Complaints Director also pointed out that Dr. Al-Ghamdi was responsible for the prolonged duration of the hearing, as he called 50 of these witnesses and yet many merely confirmed testimony provided by the Complaints Director's witnesses. Further, Dr. Al-Ghamdi spent extended periods of time cross-examining the Complaints Director's witnesses and even in examination-in-chief of his own witnesses.

77. The Complaints Director argued that even though Dr. Al-Ghamdi had a right to a full defence, it was not appropriate for him to take the approach that he did and then suggest that he is not responsible for a large portion of the costs. Further, it is not appropriate to expect the profession as a whole to subsidize such a defence. The cases, *Chen v The College of Denturists of Ontario*, 2017 ONSC 530 [*Chen*], and *Hoff v Pharmaceutical Assn. (Alberta)* (1994), 151 AR 146 (QB), were cited in support of the member appropriately bearing costs.

78. The Complaints Director also submitted that the determination of costs is not a mathematical calculation, but the Tribunal should consider the amount of time spent on unsuccessful allegations versus successful ones and whether witnesses were called unnecessarily.

B. Dr. Al-Ghamdi's Submissions

79. Preliminarily, Dr. Al-Ghamdi pointed out that this whole matter commenced with three complaints the CPSA received regarding him and none of those complaints were the focus of the 47 days of the Conduct Hearing and that the matter involved a newly created Charge and particulars. Dr. Al-Ghamdi held some negative views of the CPSA, the Tribunal, and the hearing processes used.

80. Dr. Al-Ghamdi also pointed out that in May of 2016, he had enquired with the CPSA as to the penalty they were seeking but received no answer. Further, the Complaints Director had no interest in finding a resolution through any of the available processes.

81. Dr. Al-Ghamdi advised in his written submissions that he will appeal the Conduct Decision. However, this has not impacted the Tribunal's decision on sanction which is based on the Charge that was proven.

82. Despite his arguments, Dr. Al-Ghamdi recognized that the Tribunal has made a decision on the Charge and now must make decisions on sanction and cost.

1. Bifurcation

83. Dr. Al-Ghamdi took issue with the bifurcation of the hearing and the Tribunal's jurisdiction to do so. He argued there can be no bifurcation of a complaint without proper process being adhered to respecting a complaint. Proper process was not followed and, he submitted, the original complaints evolved into a new Charge of disruptive conduct, and the remedy being sought was not clearly set out in the beginning.

84. Dr. Al-Ghamdi also distinguished *MRS* as, in that case, bifurcation was legislated, unlike under the HPA.

85. Without a legislated hearing process or an outlined process from the commencement allowing for bifurcation, Dr. Al-Ghamdi submitted that bifurcation of the hearing is a breach of procedural fairness.

2. Ungovernability

86. Dr. Al-Ghamdi strongly contests that he can be declared ungovernable. He argues that if he has acted in an ungovernable way it should be a matter for deliberation under the *Hospitals Act*, not for the CPSA.

87. Dr. Al-Ghamdi submitted it was not clearly set out from the beginning that this characterization was a possibility and it has only been introduced at the sanction stage. Also, the

terms "ungovernable" and "disruptive" cannot be used interchangeably; moreover, the concept of disruptive conduct is not mentioned in the HPA.

88. The Tribunal asked Dr. Al-Ghamdi to respond to the Complaints Director's argument that the sanction phase was the appropriate time to consider governability. He responded that the Complaints Director was obliged to present his case on ungovernability during the Conduct Hearing and not just at the time of sanction, and since ungovernability was not part of the original Charge it cannot be entertained now.

89. Further, Dr. Al-Ghamdi argued that the CPSA could only prove that he is ungovernable if he had demonstrated that he will not abide by CPSA rulings, and this has not been shown. He has aggressively defended, but that does not mean he is ungovernable. Dr. Al-Ghamdi refers back to paragraph 352 of the Conduct Decision, where the term ungovernability was associated with a refusal to adhere to structures and policies of the profession, or more commonly, a refusal to abide by rulings of a professional college.

90. Dr. Al-Ghamdi submitted that there is no suggestion he will not follow whatever decision is made to address his "passive disruptive conduct".

91. There is also the corresponding issue of the sanction sought as the result of an ungovernability characterization. If the Complaints Director was going to seek revocation of his license, then this should have been raised with the Charge. It is necessary for the member to know, at the outset, what the CPSA will present and the sanction sought so that the defendant can properly mount a defence.

3. <u>Sanction Outside of Ungovernability Finding</u>

92. With respect to the recommended sanction, Dr. Al-Ghamdi submitted the following:

a. Proportionality must be an overarching concern. The case, *Swart v College of Physicians and Surgeons (P.E.I.)*, 2014 PECA 20 [*Swart*] was cited in his written

materials without elaboration. Upon review of that case by the Tribunal, although the appeal was allowed on procedural fairness grounds, the Court noted that proportionality is a consideration when selecting penalty.

b. Dr. Al-Ghamdi has already been punished and continues to be punished. Because of the action under the *Hospitals Act* in 2013, he has been unable to practice surgery.

c. He may not be able to work in any other hospital - possibly in the world as a result of these proceedings. Dr. Al-Ghamdi has attempted to find a practice position in Alberta and in other provinces without success. He does continue to practice as a consultant in an office setting, which provides some value to patients.

d. He does have communication problems and he is disadvantaged by the fact that English is not his first language.

e. Dr. Al-Ghamdi does not believe that a program, such as the one Dr. [redacted] described, would benefit him since he does not have a 'diagnosis'; he needs mentorship.

f. Prior to this matter he had practiced for 13 years without an incident involving a patient.

g. The CPSA knew about the issue with the call schedule for years and took no issue with it, but now, by combining a number of issues, they consider it disruptive behavior. The CPSA has wrongly created an 'omnibus' case against him where, interestingly, the three original written complaints against him, responsible for commencing the investigation, have been ignored. When the Tribunal pointed out that it is the particulars taken together that provide sufficient evidence to support the Charge, Dr. Al-Ghamdi recognized that the Tribunal concluded his conduct

did affect health services at the QEII, but said he was already punished for that under the *Hospitals Act*.

h. There should be a specific sanction for each issue/particular proven. The remedy should ensure that the specific particular proven does not happen again.

i. He pointed out that the Tribunal only found 8 of the 13 particulars were proven. The Tribunal found that this behavior amounted to unprofessional conduct but this does not indicate what should be done about it. He does not believe that cases the Complaints Director cited (i.e. *Jaswal, Cooper, Ahluwalia* and *Litchfield*) lie at the same point on the spectrum of severity or are analogous to his situation.

j. Even if Dr. Al-Ghamdi is guilty of disruptive conduct, it is at the less severe end of the scale. His behavior was passive; there was no yelling or swearing involved.

k. It was mused that if Dr. Al-Ghamdi was such a bad individual over such a long period of time, why did the CPSA not take earlier action (i.e. suspend his license at some earlier date)? Dr. Al-Ghamdi believes it was because there was no harm to the public and it was on the lower end of severity.

l. Dr. Al-Ghamdi's current situation should be assessed as context for the sanction; he practices without a problem in an office setting, not in an orthopedic operating room.

m. It was reiterated that revocation of Dr. Al-Ghamdi's license is not fair or reasonable; it would be very serious and must not be done lightly.

n. There is no jurisprudence justifying the cancellation of his license.

o. The Complaints Director cited *Jaswal* and *Ahluwalia*, which are completely distinguishable. He also points out that there is no well-known standard of conduct that has been breached, which is a factor.

p. There was no harm to the public and the CPSA's advocacy for a severe sanction is unjustified and punitive.

93. Although Dr. Al-Ghamdi gave evidence that he would benefit from a mentor and referenced a reprimand as possibly being appropriate, he did not specifically provide the Tribunal with a suggestion as to sanction in his written submissions.

4. Costs

94. With respect to costs, Dr. Al-Ghamdi argued that this was a unique case and the expansiveness of the Conduct Hearing was not his fault. Dr. Al-Ghamdi has a familiarity with administrative law and he responded appropriately.

95. Further, the Charge based on disruptive conduct was newly created (and not related to the original three complaints that commenced the investigation). Dr. Al-Ghamdi should not be held responsible for the newly created Charge.

96. In addition, the Complaints Director chose to make the case about a 10 year period, making it a very difficult process, and they should accept responsibility for that. This did not revolve around a finite issue that could be dealt with as a single event.

97. There must also be consideration for the fact that 5 of the 13 particulars were ultimately not proven and the Tribunal did not even consider the original complaints.

98. Finally, in relation to Dr. [redacted] it was maintained that she has a public role and her decision to seek legal assistance should not impact the costs of the hearing.

5. Other

99. Dr. Al-Ghamdi takes issue with the prosecution. He submits the Complaints Director waited 10 years to present its case, there was no harm to the public, and the case concerned interpersonal issues. He was a long-standing member with no previous convictions under the HPA and he deserves the opportunity to rebuild.

VI. SANCTION DECISION

100. During the 47 days of the Conduct Hearing, the Tribunal heard 67 witnesses who described Dr. Al-Ghamdi's conduct and their perceptions of the impact of that conduct on them, their fellow workers, and the functionality of the hospital in its mission to provide patient care. The Tribunal previously ruled that Dr. Al-Ghamdi's conduct met the definition of a pattern of disruptive conduct (the actual deliberated Charge). Moreover, the Tribunal found that the disruptive conduct was severe and negatively impacted health services at the QEII. The Tribunal concluded that this pattern of conduct amounted to unprofessional conduct.

101. The Tribunal members have deliberated long on the appropriate sanction, recognizing that the Complaints Director has asked for a finding that Dr. Al-Ghamdi is ungovernable and for the revocation of his license and practice permit. For reasons referenced below, the Tribunal does not find Dr. Al-Ghamdi ungovernable, but does believe that he is deserving of suspension of his license with significant conditions. If Dr. Al-Ghamdi can satisfy these terms and conditions, he will be able to resume the practice of medicine.

1. Bifurcation

102. Preliminarily, the Tribunal will address the bifurcation of the hearing into the component that dealt with the Charge (the Conduct Hearing) and this one dealing with sanction (the Sanction Hearing). It is recognized that the bifurcation process was already discussed in the Conduct Decision (at paras 41-43); however it will be addressed again at this stage in light of it being re-raised.

103. In the Tribunal's view, a bifurcated hearing is permitted, is not outside of the ambit of procedural fairness and, in some ways, can be more efficient.

104. The Tribunal disagrees with Dr. Al-Ghamdi that the Tribunal is operating outside its jurisdiction unless bifurcation is explicitly provided for either in the HPA or hearing rules. The Tribunal's powers to control a hearing are wide and to require legislation to address every possible development in the hearing process is unreasonable. The HPA does not prescribe or mandate a specific hearing process, and *allows* the CPSA latitude to oversee the hearing process. Other rules in the HPA support this (such as s. 79(5) of the *HPA,* which allows evidence to be given in any manner that the hearing tribunal considers appropriate).

105. Further, the parties were notified of the bifurcation in advance, even if not at the outset, prior to the Conduct Hearing. Additionally, the parties had an opportunity to discuss the bifurcation process and, when it was elected to proceed in this fashion, written submissions on this particular sanction issue were exchanged prior to the Sanction Hearing. This conforms with the principals of *audi alteram partem* and the concepts of procedural fairness.

106. In *MRS*, in which bifurcation was at issue, the second panel was differently constituted with new members (despite that not being specifically authorized by statute), and yet this was not held to be a breach of procedural fairness.

107. The preferential aspects of bifurcated hearings were alluded to in the earlier stages of the *MRS* case (2015 ONSC 6317 and (2011), 34 OSCB 12288): optimizing efficiency and determining sanctions based on the allegations proven. Separate issues are involved at each stage (whether an allegation has been proven versus what sanctions should be imposed based on the allegation(s) proven) and, to ensure procedural fairness, each party has the opportunity to present evidence and make submissions on those issues.

108. Finally, Dr. Al-Ghamdi objected to a license revocation sanction on the grounds that it was not set out at the commencement. However, the breadth of sanctions that may be ordered

(including a license revocation) is explicitly outlined under the HPA and license revocation was always a possibility. It did not need to be set out at the outset as, again, the type of sanction appropriate would depend on the allegations proven.

2. Ungovernability

109. Dr. Al-Ghamdi takes issue with the Tribunal addressing ungovernability at the Sanction Hearing, as opposed to as an allegation in the Conduct Hearing. Relatedly, Dr. Al-Ghamdi takes issue with the pursuit of license revocation as a sanction that flows from an ungovernability finding.

110. However, the ungovernability concept was raised at the Conduct Hearing (and even touched on in the Conduct Decision at paras 30, 75, 352 in dealing with the disruptive conduct charge), and Dr. Al-Ghamdi was given an opportunity to fully address this argument at this juncture. Ungovernability is also a concept that is routinely addressed at the sanction/penalty stage (such as in *Litchfield*), presumably based on the allegations proven.

111. As for the sanction of license revocation being sought by the Complaints Director, it is explicitly outlined as a possible order under s. 82(h) of the HPA.

112. In light of principles of procedural fairness, a member should have the opportunity to address the sanctions specifically, and this was done here, first with an exchange of written submissions and next at an oral hearing with the opportunity to call and cross-examine witnesses.

113. Even though the Tribunal does not take issue with the concept of ungovernability being raised and deliberated here, the Tribunal declines to find that Dr. Al-Ghamdi is ungovernable.

114. From the Tribunal's review of the cases presented, the question of ungovernability generally arises where a member of a professional regulatory body does not respect or abide by that governing regulatory body (i.e. *Law Society of Upper Canada v. Crozier*, [2005] OJ no 4520 [*Crozier*]; *Law Society of Alberta Re Grosh* – Hearing Committee Report October 19, 2009

[*Grosh*]). Although ungovernability may be raised amongst other conduct issues, it is the member's relationship with the professional governing body that is the source of an ungovernability characterization (i.e. *Law Society of British Columbia v Hall*, 2007 LSBC 26 [*Hall*], *Law Society of Upper Canada v Horwood*, [2009] LSDD No 77 [*Horwood*], *Law Society of Alberta v Broda* – Hearing Committee Report April 15, 2010 [*Broda*], and *Grosh*).

115. In the Complaints Director's written submissions, he pointed to *Ahluwalia* as a recent pronouncement against a physician who was deemed ungovernable, with a resulting cancellation of his medical license, despite there being no evidence of an "offended patient". The Complaints Director then cited a passage from the Manitoba Court of Appeal as to why Dr. Ahluwalia was ungovernable (at para 45):

> The Panel held that at least three factors strongly suggested that Dr. Ahluwalia was ungovernable. They included:
>
> i) that he engaged in several different types of serious misconduct involving multiple written and oral misrepresentations to the College;
>
> ii) that the misrepresentations indicated that he was prepared to lie to his governing body to avoid its exercise of its regulatory jurisdiction and that his failure to comply with the appropriate regulations for medical charting, computer software and maintenance showed that he was prepared to break the rules – this led the Panel to conclude that he would not respond truthfully or practice medicine in accordance with the required standards in the future; and
>
> iii) that he had committed similar transgressions in the 1990s, which indicated to the Panel that he had a lack of insight into the seriousness of his misconduct and the importance of adhering to professional standards.

116. This excerpt supports the conclusion that an important criteria is that the member does not have respect for, or acquiescence to, the governing body's authority.

117. The Complaints Director also referred to a number of cases where disruptive conduct was at issue, but they were not directly on point as they either did not involve a regulatory governing body as a party, such as the CPSA (i.e. *Perron v Guelph General Hospital*, 2014 ONSC 1032 [*Perron*]; *Alghaithy v University of Ottawa*, 2012 ONSC 142 [*Alghaithy*]; *Regina Qu'appelle Regional Health Authority v Dewar*, 2011 SKQB 392 [*Dewar*]; *Khan v Scarborough General Hospital*, [2009] OJ No. 5437 [*Khan*]; *Cooper v Hospital Privileges Appeal Board*, 1999 ABQB 165 [*Cooper*]; *Toronto East General Hospital v Gopinath*, 2014 ONSC 2731 [*Gopinath*]) or, while there was disruptive behavior in a professional regulatory context, ungovernability was not at issue (i.e. *Coffey v College of Licensed Practical Nurses of Manitoba*, 2008 MBCA 33; *Re Sogbein*, [2013] OCPSD 17 [*Sogbein*]; *Re Amer*, [2011] OSTSD 28 [*Amer*]; *Bermel v Registered Psychiatric Nurses Assoc. of Man.*, 2001 MBQB 223 [*Bermel*]; *Carr v Nova Scotia (Board of Dispensing Opticians)*, 2006 NSSC 13 [*Carr*]; and *Przysuski v College of Opticians of Ontario*, [1996] OJ no 611 [*Przysuski*]).

118. It is recognized that when ungovernability is established, a revocation of a license or practice permit is typically ordered (i.e. *Ali v College of Physicians and Surgeons of Saskatchewan*, [2016] SJ No 56 (QB), *Horwood*, *Ahluwalia*, *Crozier*, *Grosh*, *Broda*, and *Hall*), as public confidence in the self-government of the professional necessitates a severe consequence where such governing authority is flouted.

119. Dr. Al-Ghamdi engaged in disruptive conduct in a professional context, which is certainly serious, particularly in light of the impact on the delivery of health services. The evidence surrounding that disruptive conduct (i.e. relating to a lack of insight or improvement) will factor into the sanction ultimately ordered; however, a finding of ungovernability is not warranted.

3. Sanction Determination Irrespective of Ungovernability

120. As alluded to above, the cases the Complaints Director cited support that a serious disciplinary response is warranted for the disruptive conduct.

121. To determine an appropriate sanction based on the disruptive conduct, the *Jaswal* factors have been looked at.

122. The *Jaswal* factors are often examined for the purpose of determining appropriate sanctioning in a professional regulatory context, as was done in other cases such as *Litchfield* in the CPSA context. As such, the factors are examined below, while keeping in mind the overarching concern of proportionality, as Dr. Al-Ghamdi argued.

123. Dr. Al-Ghamdi attempted to distinguish *Jaswal* on the basis that in that case the doctor breached a clear public standard, and that in this case there is no clear public standard that had been breached. However, the standard for conduct was already deliberated at the Conduct Hearing and reflected in the Tribunal's finding of misconduct. The issue now is the appropriate sanction.

124. The non-exhaustive list of factors that ought to be considered, as set out in *Jaswal* (at para 35), are addressed below:

1. The Nature and Gravity of the Proven Allegations: Dr. Al-Ghamdi was found guilty of a pattern of disruptive conduct that was serious and extended over a long period of time. For the purpose of sanction, the particulars should not be examined in complete isolation, but must be taken together in light of the global, proven charge of disruptive conduct. Dr. Al-Ghamdi takes issue with combining a number of issues over a number of years, but this reflects the proven Charge.

2. The Age and Experience of the Offending Physician: Dr. Al-Ghamdi did not have advanced experience at the onset of his working at the QEII but, over the years, he would have been expected to have the maturity and professionalism not to engage in this continued sort of conduct.

3. The Previous Character of the Physician and In Particular the Presence or Absence of any Prior Complaints or Convictions: The Tribunal did not accept as relevant the evidence relating to Dr. Al-Ghamdi's residency training in Winnipeg and it did not impact the assessment of this factor. Although the Charge itself involves conduct spanning over 10 years of practice, it is recognized that the CPSA has not previously disciplined Dr. Al-Ghamdi.

4. The Age and Mental Condition of the Offended Patient: As Dr. Al-Ghamdi has highlighted, there was no offended patient in this case.

5. The Number of Times the Offence was Proven to have Occurred: Although this is the first time the CPSA has found against Dr. Al-Ghamdi, the disruptive conduct occurred over a 10 year period.

6. The Role of the Physician in Acknowledging what had Occurred: Dr. Al-Ghamdi continues to lack insight into his own culpability in this matter and blames other parties/situations. This includes pointing to: the toxic environment at the QEII; having the confidentiality of his complaints about others violated; his limitations in the English language; the absence of a mentor; the prosecution in this matter being overzealous; and this proceeding being a "witch hunt" (his term) etc. He also minimizes his conduct by saying his conduct did not actually harm a patient. Otherwise, no real evidence was proffered as to Dr. Al-Ghamdi's rehabilitative potential, other than his own self-serving evidence that things will improve with a reprimand and a mentor and that he accepts responsibility for his actions.

7. Whether the Offending Physician Had Already Suffered Other Serious Financial or Other Penalties as a Result of the Allegations Having Been Made: Exhibit 278, detailing Dr. Al-Ghamdi's billings, demonstrates the negative financial repercussions these proceedings have had. Further, Dr. Al-Ghamdi gave evidence that these proceedings will hamper his ability to secure work in any other hospital.

8. The Impact of the Incident on the Offended Patient: It is recognized that Dr. Al-Ghamdi did not directly offend or harm a patient per se, but there was the generalized impact of Dr. Al-Ghamdi's conduct and the risk his disruptive conduct would endanger patients.

9. The Presence or Absence of Any Mitigating Circumstances: By Dr. Al-Ghamdi's own evidence, he does not suffer from a mental condition that could have impacted his conduct. Other possible considerations under this category have already been discussed under other factors (i.e. his not taking responsibility for actions) and will not be re-addressed here. However, the Tribunal will comment on Dr. Al-Ghamdi's limitations with the English language as allegedly being a contributor to his present predicament. The Tribunal points to the fact that he has trained and practiced in orthopedic surgery in the English language and has obtained a law degree and MBA in the English language, evidencing functioning ability in the language; this detracts from language being a significant mitigating factor.

10. The Need to Promote Specific and General Deterrence and, Thereby, to Protect the Public and Ensure the Safe and Proper Practice of Medicine: There is a need for both specific and general deterrence of disruptive conduct in order to facilitate the collegial and effective delivery of health services, which in turn benefits the public.

11. The Need to Maintain the Public's Confidence in the Integrity of the Medical Profession: To allow disruptive conduct to continue without recourse would undermine the public's confidence in the medical profession. As was alluded to in *Ahluwalia,* the purpose of a substantial penalty can be to send a message for the purpose of public confidence.

12. The Degree to which the Offensive Conduct that was Found to have Occurred was Clearly Regarded, by Consensus, as being the Type of Conduct that would

Fall Outside the Range of Permitted Conduct: Dr. Al-Ghamdi's disruptive conduct clearly falls below the range of accepted conduct, as was determined at the Conduct Hearing; there was no compelling evidence to refute this conclusion.

13. The Range of Sentences in Other Similar Cases: The Complaints Director provided a number of cases imposing license revocation for egregious conduct (i.e. sexual misconduct) or where there was a finding of ungovernability. In other cases dealing with disruptive conduct (where ungovernability was not found or at issue), sanctions ranged from reprimands to suspensions.

The cases the Complaint Director provided, even if not directly on point, are helpful. A number of them address disruptive conduct by a physician, but not in the context of a regulatory body proceeding with sentencing. However, from these cases it can be seen that disruptive conduct is regarded as serious and can elicit significant consequence.

For instance, in *Perron* the physician's disruptive behavior had led to a revocation of hospital privileges by the hospital board. Similarly, in *Khan* the disruptive conduct (involving sending an email to hospital staff, including references to staff salaries), resulted in the hospital board suspending privileges. Likewise, in *Alghaithy*, the physician's disruptive conduct led to dismissal from residency training by the program committee. In *Dewar*, past disruptive conduct precipitated the physician being required to enter into a resolution agreement, which provided for rehabilitative and corrective measures, and created a resignation trigger for future occurrences (although the more recent occurrence was not found to have triggered the resignation). Then, in *Cooper*, the disruptive conduct over a number of years (involving a lot of interpersonal conflict) resulted in hospital privileges not being reinstated, thus permanently cancelled. This outcome in *Cooper* was not only based on the conduct itself, but also on there being no viable alternative solution for the future (this was unlike *Gopinath* where, despite the disruptive

behavior, an appointment was allowed to be renewed as there were signs of improvement).

In other cases involving regulatory issues, such as *Bermel*, *Carr* and *Przysuski*, where the focus was the professional's treatment of patients or customers, the sanctions ranged from license revocation, suspension and reprimand, respectively.

The cases in which a regulatory body addressed a physician's disruptive conduct were limited. *Amer* involved a confrontation between a physician and hospital security staff, which led to a reprimand, publication/notification, and costs. However, in that case, the unprofessional conduct was not widespread and did not span over 10 years.

Then there is *Sogbein*, where the physician had threatened a police officer who pulled him over, and the physician had been disrespectful and unprofessional in the past. The physician was sentenced to a four month suspension, and a number of terms and conditions were put on his practice permit (such as requirements to attend counselling and enter into a support program, work under a workplace monitoring agreement, and practice in a group setting). He was also ordered to pay costs (for the one day hearing, which was truncated as the doctor had agreed to the facts and admitted the misconduct). This case suggests a suspension, terms and conditions for reinstatement, and costs are appropriate. However, the level of misconduct in *Sogbein* was not of the same magnitude (in extent and impact on health service delivery) as that found to have been committed by Dr. Al-Ghamdi. Moreover, mitigating factors were Dr. Sogbein's co-operation with the process and acknowledgment of responsibility.

The relevant cases discussed above that address disruptive conduct (i.e. *Amer* and *Sogbein*) are not analogous to the one at hand, as Dr. Al-Ghamdi's disruptive conduct was more serious and of long-standing nature.

125. Dr. Al-Ghamdi seemed to suggest that his conduct should elicit less severe consequences (in that it falls at the lower end of the scale of severity and was more passive). He then suggested an appropriate sanction was a reprimand or the assignment of a mentor.

126. Proportionality must be taken into account, including the fact that this was the first time this type of charge has been proven against Dr. Al-Ghamdi. However, at the same time, the sanction order must reflect the seriousness of the misconduct and its impact.

127. Here, a reprimand, without a more significant disciplinary measure, would be insufficient to address the unprofessional behavior. Significant sanctions must be ordered to address the misconduct and provide corrective measures for the future.

128. However, the Tribunal also finds that a license revocation, with no opportunity to practice in the future, would be inappropriate.

129. While the Tribunal has rejected the Complaints Director's request that it find Dr. Al-Ghamdi ungovernable, it finds the Complaints Director's alternative submission on sanction reasonable. The Tribunal sanctions Dr. Al-Ghamdi with a three (3) year suspension. As is detailed in the Order section of this decision, it also orders a comprehensive assessment program, with successful compliance with recommended treatment(s), course(s) and re-assessment(s), and the payment of costs to the CPSA related to the investigation and hearing.

130. The Tribunal agrees with Dr. Al-Ghamdi that a mentor may be of great benefit to him in future interactions with the healthcare system. However, the Tribunal hesitates to mandate this for several reasons:

i. It may be extremely difficult to identify an appropriate mentor, particularly initially. Dr. Al-Ghamdi indicated that for him to work in a hospital environment as a surgeon, he would need a senior orthopedic surgeon with senior administration experience as a mentor. However, this individual would not be appropriate if Dr. Al-Ghamdi returns to a general practice environment.

ii. The Tribunal does not believe that the failure to develop a mentor relationship should be the factor that prevents Dr. Al-Ghamdi from returning to practice.

iii. The Tribunal does believe that, should the assessment (or re-assessment) program recommend that a mentor be part of the therapy, then this should be mandated by the CPSA with the candidate for mentor being approved by the Registrar.

131. The level of disruption Dr. Al-Ghamdi caused was extremely deleterious and damaging to the delivery of health services at the QEII Hospital. A three year suspension is warranted to reflect the severity of that conduct both as a specific and as a general deterrent.

132. Finally, the Tribunal also agrees with the Complaints Director that the fact that Dr. Al-Ghamdi has faced consequences at the hospital does not preclude a regulatory body from investigating and taking action based on its mandate. *Jodoin* and *Groia* support this. Further, in *Sogbein* (at para 14), it is noted that the fact that the physician was sanctioned by the hospital "does not detract from this Committee's duty to express the abhorrence of the profession toward his conduct, and to send a message that the profession will not tolerate behavior of this kind".

4. Costs

133. The hearing regarding Dr. Al-Ghamdi's disruptive conduct has been an enormously expensive undertaking. The estimated cost for the entire hearing is greater than $1 million, which is consistent with the daily cost being around $25,000.00 over 47 days of hearing. As the Complaints Director submitted, this daily cost is roughly in line with typical hearing costs.

134. The Tribunal finds Dr. Al-Ghamdi is significantly responsible for making this hearing complex and long. He chose to represent himself up until the final days of the Conduct Hearing, which in and of itself is not inherently problematic, but he engaged in long and repetitive examination-in-chief of his witnesses, and even more detailed and repetitive cross-examination of the Complaint Director's witnesses. An excessive number of Notices were also issued at his behest. Dr. Al-Ghamdi re-called one of the witnesses for the Complaints Director on two further

occasions and many of Dr. Al-Ghamdi's witnesses did not further his case and, frequently, they merely confirmed the evidence provided by the Complaints Director's witnesses.

135. Further, although Dr[redacted] has a public role, it was because of Dr. Al-Ghamdi's repeated demands and complaints to the Tribunal about Dr. [redacted] that she decided that she needed to obtain legal support.

136. The conduct relating to the Charge did span over 10 years, but complexity in these types of professional misconduct cases is not novel. Dr. Al-Ghamdi's approach contributed significantly to making resolution of this matter complex and difficult. The Tribunal finds that Dr. Al-Ghamdi bears a significant portion of the blame for the very high costs.

137. The Tribunal points to *Chen* (at para 6) for the proposition that, "while the Member has the right to a thorough investigation and the right to a hearing, he also bears some responsibility for the overall costs. The costs of the investigative and discipline process cannot solely be the onus of the rest of the College's membership".

138. The Tribunal does recognize that, as was reflected in Exhibit 278, Dr. Al-Ghamdi has already suffered a major impact on his income. He has been unable to practice surgery since mid-2013, when his hospital privileges were suspended and subsequently cancelled.

139. There are several ways that the Tribunal could determine the allocation of costs. Recognizing that not all of the particulars of the Charge were proven (with 8 out of the 13 particulars having been proven), the Tribunal has decided that Dr. Al-Ghamdi should be responsible for 8/13 of the total costs (which includes the costs of counsel for the Hearings Director). In light of his financial situation, the costs are ordered payable within three (3) years of the date of this Order.

VII. ORDER

140. For the reasons above, the Tribunal rules that:

a. Dr. Al-Ghamdi's license and practice permit are suspended for three (3) years, commencing from the date of this Order. He may apply to have his license and practice permit reinstated after he has met conditions (i) and (ii) below to the satisfaction of the CPSA Registrar. Should Dr. Al-Ghamdi meet the conditions listed in (i) and (ii) below to the satisfaction of the CPSA Registrar, he can apply to have his license and practice permit reinstated after two years.

i. Dr. Al-Ghamdi must enroll in, and successfully complete, a comprehensive assessment program (COAP), such as that described by Dr. [redacted] Dr. Al-Ghamdi may choose another comparable assessment program but the CPSA Registrar must approve it before he participates. The assessment must involve a component assessing fitness to practice; this assessment must conclude that he is fit to practice medicine before his license will be re-instated. Dr. Al-Ghamdi shall exclusively bear the cost of this program.

ii. Dr. Al-Ghamdi must enroll and successfully complete any course of therapy recommended by the above assessment, which may include: ongoing therapy by a psychologist, courses in improving interpersonal relationships; a re-assessment after a period of therapy; and endorsement of a mentorship. The latter should be a senior physician and regulated active member of the CPSA in good standing, to act as a mentor and as a discussant on issues of conduct within the health system and appropriate responses as specific issues arise including the interpretation of health system bylaws. The CPSA Registrar must be consulted and approve any mentor selection and arrangement. Dr. Al-Ghamdi shall exclusively bear the cost of these programs.

b. Dr. Al-Ghamdi must pay costs of the Investigation and Hearing within three (3) years of the date of this Order. Should Dr. Al-Ghamdi have his license and practice permit re-instated after two years of suspension, but the costs noted above have not been completely paid by the end of the third year, the CPSA may again suspend his license and practice permit.

Dated: December 21, 2017 Signed by the Chair on behalf of the Hearing Tribunal

Dr. Eldon R. Smith

APPENDIX A

LIST OF WITNESSES IN ATTENDANCE AT CPSA SANCTION HEARING

SEPTEMBER 5, 2017

1. Dr. [redacted]
2. Dr. [redacted]
3. Mr. James West
4. Dr. Mohammed Al-Ghamdi

APPENDIX B

LIST OF EXHIBITS ENTERED AT CPSA SANCTION HEARING

SEPTEMBER 5, 2017

No.	Description
277	A Letter authored by Dr. [redacted] describing the COAP.
278	Summary of Alberta Health Billing from January of 2010 until the Present.
279	Summary of Dr. Al-Ghamdi's education and training.
280	Record of Preliminary Matters raised with respect to sanction.

APPENDIX C
INTERIM DECISIONS

Interim Decision No. 14 (Preliminary Decision) dated August 1, 2017, dealing with procedural issues on witnesses to be heard.