

COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF  
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,  
R.S.A. 2000, c. C-7

AND IN THE MATTER OF A HEARING REGARDING  
THE CONDUCT OF DR. BRYAN DICKEN

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

## **I. INTRODUCTION**

Pursuant to the *Health Professions Act*, the Hearing Tribunal held a hearing into the conduct of Dr. Bryan Dicken at the offices of the College of Physicians and Surgeons of Alberta ("the College") between May 19 and May 22, 2015. The members of the Hearing Tribunal were:

- Dr. Randy Naiker as Chair,
- Dr. Douglas Perry, and
- Mr. William Fayers (public member).

Mr. Sean Ward acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing were:

- Mr. Craig Boyer, legal counsel for the College,
- Dr. Michael Caffaro, Assistant Registrar of the College.
- Dr. Bryan Dicken appeared with his legal counsel, Ms. Barbara Stratton, Q.C. and Mr. Daniel Morrow.

## **II. ALLEGATION**

The allegations to be considered by the Hearing Tribunal were set out in the Notice of Hearing, dated March 4, 2015:

1. That between November 1, 2013 and April 1, 2014 you did fail to maintain an appropriate professional relationship with [REDACTED] [REDACTED] the 18 year old mother of your infant patient, [REDACTED] [REDACTED] particulars of which include one or more of the following:
  - a. Exchanging text messages of a personal nature with [REDACTED] [REDACTED]
  - b. Attending at [REDACTED] [REDACTED] apartment at [REDACTED] for no medical purpose,
  - c. Lying naked or semi-naked with [REDACTED] [REDACTED] and
  - d. Having sexually intercourse with [REDACTED] [REDACTED] on one or more occasions.

## **III. PRELIMINARY MATTERS**

The parties confirmed they had no objections to the composition or jurisdiction of the Hearing Tribunal, and no other preliminary matters were raised by the parties.



#### IV. EVIDENCE

The following Exhibits were tendered and entered by the parties, and were accepted as evidence by the Hearing Tribunal:

1. Agreed Exhibits:

- Notice of Hearing dated March 4, 2015;
- Complaint form from [REDACTED] dated February 28, 2014;
- Dr. Dicken letter in response dated March 20, 2014 with enclosures;
- Dr. Dicken letter dated March 28, 2014;
- Dr. McGonigle letter dated May 21, 2014;
- Dr. Chatur letter dated May 22, 2014;
- Medical records for [REDACTED] an infant;
- Alberta Health Care billing records for services provided by Dr. Dicken to [REDACTED] from September 1, 2012 to February 28, 2014;
- Alberta Health Care billing records for services provided to [REDACTED] for March 1 to April 30, 2014;
- Extracts of Dr. Dicken cell phone records from October 9, 2013 through April 6, 2014;
- Dr. Dicken's Pediatric surgery call group schedule for November and December 2013 and January 2014;
- Letter to Dr. R. Eccles dated January 22, 2015;
- Letter from Dr. R. Eccles dated January 30, 2015;
- Curriculum Vitae for Dr. R. Eccles;
- Letter from Dr. T. Masterson dated March 23, 2015;
- Curriculum Vitae for Dr. T. Masterson.

2. Supplemental Exhibits:

- Colour copy of Facebook pages from [REDACTED]
- Black and White copy of Facebook pages from [REDACTED]
- Text messages between [REDACTED] and [REDACTED] Telus mobility cellular telephone calls and text messages from November 16, 2013 to March 31, 2014;
- Photoshoot by [REDACTED] on October 8, 2012;
- Photoshoot by [REDACTED] on or about November 7, 2012;
- Photoshoot by [REDACTED] on or about June 17, 2013;
- Photoshoot by [REDACTED] on or about October 4, 2013;
- Photoshoot by [REDACTED] on or about October 29, 2013;
- Photoshoot by [REDACTED] on or about December 2, 2013;
- Transcript of conversation between Dr. Dicken and [REDACTED] on February 6, 2014.

3. Audio recording of telephone call between [REDACTED] and Dr. Dicken;
4. Text messages between [REDACTED] and [REDACTED]
5. Transcript of Interview with [REDACTED]
6. Audio recording of interview with [REDACTED]
7. Facsimile from Telus dated August 18, 2014 to Kristy Evans, enclosing calls between 780-206-7338 and 780-243-6550;

8. Shaw invoice for monthly services 21-February-14 to 20-March-14;
9. Alberta Health Services Anaesthesia Record;
10. Letter from Katherine Jarvis, Complaints Inquiry Coordinator for the College, to Dr. Dicken dated March 18, 2014;
11. Letter from Lana Bistriz MD to Barbara Stratton dated August 19, 2014.

Mr. Boyer called 4 witnesses to give evidence on behalf of the College:

- Dr. Robin Eccles
- [REDACTED]
- [REDACTED]
- Kristy Ivans

Ms Stratton called 4 witnesses to give evidence on behalf of the Investigated Member:

- Dr. Bryan Dicken
- Dr. Tami Masterson
- Dr. Lyle McGonigle
- Dr. Rehana Chatur

## WITNESSES

### Dr. Robin Eccles

Dr. Eccles identified herself as a pediatric general surgeon working at the Alberta Children's Hospital in Calgary. In addition to her clinical obligations, she was involved with several committees and affiliated with the University of Calgary. This included responsibility for teaching professional ethics to various learners that rotate through the surgical service at the Calgary Children's Hospital. She was accepted as an expert to provide opinion evidence in pediatric surgery, including professional ethics.

The College asked Dr. Eccles to provide her opinion on a scenario of a surgeon who was in a relationship with the mother of an infant that was in his care. She was asked as to whether this relationship would be appropriate as well as the opinion of the surgical community.

Mr. Morrow objected to this, citing that Dr. Eccles was asked specifically to answer in her experience whether she was aware of any pediatric surgeons who had sexual relationships with the mother of their patients. The follow up question was "if so, what is the consensus of the surgical community about such a relationship." Dr. Eccles denied knowing any surgeons that had engaged in sexual activity with the mother of their patients. Consequently, Mr. Morrow's point was that if Dr. Eccles was not aware of any such action, she could not then be asked to canvass the surgical community. He felt that the opinion provided by those surgeons would be compromised in that the scenario presented to them would be unknown and that they were not there to testify or to be cross-examined.

The Tribunal was prepared to hear evidence from Dr. Eccles regarding her opinion and she was specifically asked by the College to provide not only her personal beliefs, but also what she believed to be the general consensus of the surgical community. The Tribunal advised that they would consider appropriate weight as the context determined when considering any opinions from Dr. Eccles' regarding the views of any opinions from the surgical community.

Dr. Eccles testified that the important point is that there should not be a personal; and particularly not a sexual, relationship between a surgeon and the mother of an infant patient. In this particular scenario, there is a child that would require ongoing surgical care, in terms of managing issues with function and surgical complications versus a one-time surgical event. Having a personal relationship with the parent of the infant would interfere with the ability to provide care.

She testified that if the surgeon were to have a relationship with the mother, they would have to transfer care to another surgeon. She testified transferring care to another surgeon may compromise the care of the infant as the new surgeon may not have the same knowledge of the child's anatomy. Although one can read an operative report, it is not quite the same as having the knowledge of being there.

She further stated having a personal social relationship with that mother interferes with a physician's ability to provide care. She cited an imbalance in the physician-patient relationship.

Dr. Eccles further testified that it would not matter who initiated the relationship as the Code of Ethics dictates simply that this is not allowed, and within all boundaries that are taught, this is not something that should happen.

Dr. Eccles acknowledged that she was not an expert on social media such as Facebook or Twitter. She did comment that she has heard that other physicians have had to refuse Facebook friend request from patients. They simply refuse them. She acknowledged that she has never been in that position. She did testify that she did not believe Facebook should be used for patients unless it could be set up separately from a personal Facebook the way businesses do it.

With respect to emails, in some situations they are helpful particularly for families that live at a distance from a hospital. She stated if using a hospital email system, there are privacy and confidentiality filters that are in place. Using email has allowed patients families to send pictures as well as provide clinical decisions that do not necessarily require families to be in the clinic. Additionally, Dr. Eccles testified that on several occasions, she has given out her cell phone number to families who have texted her seeking advice. This often saves families long drives to her hospital. She states that the only photo she has ever received by text was a photo of an incision.

Dr. Eccles further testified that any electronic communication should always relate to the care of the patient.

Dr. Eccles stated in her practice, the text and emails do not become part of the clinical record. She states she deletes emails when it is no longer appropriate. She outlined that she will frequently write comments on lab reports which then become part of the patient's medical record.

Dr. Eccles further testified that if a relationship between a surgeon and the parent of an infant patient existed, it would demonstrate a power imbalance that is quite extreme. The imbalance would be an older more experienced surgeon who has helped a woman's child, such that the woman may be confusing medical care with sexual attraction. She may be confusing gratitude with the sense that she needs to express her gratitude in an inappropriate way.

Under cross-examination by Mr. Morrow, Dr. Eccles identified that coincidental contact between a surgeon and the parent of a patient would be fine, and that the parent would be expected to be treated with respect and given the best care possible for their child. She further stated that small gifts of gratitude such as a bottle of wine are frequent and appreciated. She added that a hug from

a parent was also acceptable. Finally, she identified that surgeons frequently get photos of their patients from families and a collage of pictures of the child's medical journey was also appropriate as a gift.

Dr. Eccles went on to explain that in the case of the infant patient born with anal atresia, a colostomy, a revised colostomy and a reconstruction procedure would be required. These procedures would span over approximately 18 months and would require extensive involvement and follow-up from the pediatric team. During the course of treatment for this patient anal dilation would also be required and would typically be performed by the patient's parent. These are often a source of significant anxiety, and would require close follow-up by the pediatric surgeon.

She acknowledged that during the course of her career she has seen a variety of communication methods including word processing computers, fax machines, email and now text messaging. The medical community has embraced these forms of communication as they are convenient and timely and allow good communication between physicians and patients. She acknowledged these mediums offer an opportunity to communicate with parents in a timely fashion and prevent a great deal of time spent playing telephone tag.

Furthermore, a picture sent by a parent can tell a surgeon a lot, particularly if that parent has a specific concern and is something that can be addressed immediately.

In the case of a complex pediatric patient living at home with a first-time mother, the need for timely communication is heightened.

She also went on to explain that communication with parents often occurs outside of a surgeon's regular office hours. While preferring to do this from her office, she did acknowledge that a conversation made from an office phone is ethical and in the same conversation made from a phone elsewhere is also ethical. It is the content and the purpose of the phone call that is important. This also applies to other media such as email or text messages.

In regards to Facebook, Dr. Eccles acknowledged that she had limited knowledge of the functionality and the usability of Facebook. She did acknowledge that "friending" a patient on Facebook must be approached with extreme caution and stated that she would not do this because she would not know how to set necessary privacy filters. She was not formally aware that two Facebook users could directly communicate with each other.

Dr. Eccles also stated that when providing her personal cell phone number to patients she advises them of the privacy issues surrounding the use of text messages between the parents and herself. If parents accept this, she proceeds to provide her number to them.

■■■■ ■■■■  
Ms ■■■■ identified herself as a photographer who was hired by Ms ■■■■ to do maternity and newborn pictures. She was originally from Nova Scotia, and has lived in Edmonton with her sister for the past five years. She stated she graduated from high school in 2007 and attended Bethany Bible College in 2009, where she studied youth ministry as a major and Christian counselling as a minor, though she did not complete her study.

Ms ■■■■ testified that she met Ms ■■■■ through email from an online advertisement. She stated that they initially began texting each other shortly after ■■■■ was born and a friendship

developed. Ms [REDACTED] offered to take pictures of [REDACTED] free of charge while in the NICU. Ms [REDACTED] stated that she began keeping Ms [REDACTED] company at the hospital in October 2013 while [REDACTED] was having surgical procedures done.

She further stated she lived with her sister and that Ms [REDACTED] and [REDACTED] stayed with them for some time shortly after [REDACTED] G-tube was inserted. This was because Ms [REDACTED] was living in Westlock and [REDACTED] residence was much closer to the Stollery Hospital if any complications occurred.

It was shortly thereafter that Ms [REDACTED] and Ms [REDACTED] decided that they would move in together in a two-bedroom apartment close to the Stollery Hospital. This occurred on December 27, 2013.

Ms [REDACTED] described interactions that she observed between Ms. [REDACTED] and Dr. Dicken. In October 2013 she testified that Ms [REDACTED] asked her to take a picture of Dr. Dicken. She believed that this was not unreasonable given the medical journey that they had gone through. She further describes that Ms [REDACTED] was initially wearing a blue pullover sweater that she had removed to reveal a see-through shirt right before Dr. Dicken came in. She testified, she initially thought it was "weird" but did not think too much of it.

She further describes that Ms [REDACTED] received a text message from her mother stating that she had seen Dr. Dicken in the elevator. She testified that the content was to the effect of Dr. Dicken being as lucky that they were not alone or she would have jumped him. Ms [REDACTED] stated that this would not be something she would expect from a mother, but again did not think much of it.

Later, Ms [REDACTED] told Ms [REDACTED] that Dr. Dicken had given her his personal phone number and that they had been texting back and forth. Mr. [REDACTED] stated that her mother could not find out because she would be really jealous. Ms [REDACTED] stated that she never really thought much about this as she was not aware that this type of interaction was not permitted between a physician and the patient's mother.

In the November 2013 hospitalization, Ms [REDACTED] was accompanying Ms [REDACTED] as [REDACTED] was about to go in for surgery. She stated that Ms [REDACTED] started giggling uncontrollably when Dr. Dicken entered. Ms [REDACTED] says she then stated, "okay, seriously, like, get over it. Like you've already told me what's happening, I don't care." She further explained that she knew Ms [REDACTED] and Dr. Dicken liked each other.

Ms [REDACTED] then stated that Dr. Dicken replied that they would have to wait a year after [REDACTED] is out of his care before they could do anything.

Later that night Dr. Dicken returned to check on [REDACTED] Ms [REDACTED] asked him jokingly if he had a doctor friend for her.

Ms [REDACTED] continued that Ms [REDACTED] and Dr. Dicken were texting each other. One to two days later she received a text from Ms [REDACTED] stating that Dr. Dicken had tapped her on the shoulder.

Ms [REDACTED] then went on to describe colour copies of her Facebook page which were included in Exhibit #2, Supplemental Exhibits. She described posting a picture of Dr. Dicken, Ms [REDACTED] and [REDACTED] to Ms [REDACTED] Facebook page. Ms [REDACTED] commented she had a dirty smirk on her face.



Ms [REDACTED] then testified how she was able to find Dr. Dicken in Ms [REDACTED] list of Facebook friends. From there, she sent him a direct Facebook message on November 26, 2013 advising him to be cautious of Ms [REDACTED] mother because she was "crazy" and would make a mess of things. Dr. Dicken thanked Ms [REDACTED] and on November 29, 2013 sent a Facebook message back stating his reluctance, acknowledging the risk he faced.

Ms [REDACTED] also described the Facebook exchange between her and Ms [REDACTED] in which Ms [REDACTED] states that because her cell phone died she no longer had Dr. Dicken's private number. Ms [REDACTED] then describes that Ms [REDACTED] messaged Dr. Dicken and he complied in giving her his number again.

She then described a series of text messages between herself and Ms [REDACTED]

In the first exchange, Ms [REDACTED] questions if it is "weird" that she is interested in a 42-year-old. Ms [REDACTED] jokingly responded not really. Ms [REDACTED] then tells her that Dr. Dicken has no choice but to date her. Ms [REDACTED] then advises that if a doctor dates a patient they can get into trouble. Ms [REDACTED] advised Ms [REDACTED] that she should probably not invite a nurse named [REDACTED] who also works at the Stollery Hospital, to their New Year's party in case Dr. Dicken showed up. She states she once again advised Ms [REDACTED] that if anyone found out about her and Dr. Dicken, they'd report him to the College.

Ms [REDACTED] described an additional exchange in which Ms [REDACTED] states that Dr. Dicken asked her if she was okay with him having kids, or if it would change the way she looked at him. Additionally, the exchange also suggests that Dr. Dicken asked Ms [REDACTED] out to his house. Ms [REDACTED] jokingly commented that she would take care of [REDACTED] and charge only \$30 an hour.

She continued with texts describing physical contact between Dr. Dicken and Ms [REDACTED] in which Ms [REDACTED] reports feeling scared after describing Dr. Dicken tapping her arm as she walked by. Furthermore, the exchange outlines Ms [REDACTED] account of Dr. Dicken coming into [REDACTED] room and putting his hand on her arm and hips. Ms [REDACTED] comments in the text that she liked it.

Ms [REDACTED] further described Ms [REDACTED] texting that she wouldn't mind if Dr. Dicken helped her in the patient room shower. She then texts that Dr. Dicken wanted to show her his private office.

Ms [REDACTED] then described the text exchange in which Dr. Dicken informed Ms [REDACTED] that he was married and had been divorced and had kids. Ms [REDACTED] later advises Ms [REDACTED] that she has something to tell her but she has to keep it quiet and promise that she won't say anything even to her sister. Ms [REDACTED] replied by asking Ms [REDACTED] if she had had sex with Dr. Dicken. Ms [REDACTED] initially denies this but then changes her answer to yes.

Ms [REDACTED] then testified about a series of erotic photos she took of Ms [REDACTED] in her basement studio. She stated that Ms [REDACTED] was trying to figure out something that she could give to Dr. Dicken for Christmas. She had also texted him and asked him what his favourite food was and he said chocolate. Ms [REDACTED] explained that is why chocolate is seen in several of the photographs. She states that she had Facebook messaged three of the photos to Ms [REDACTED] and she had sent them to Dr. Dicken. Ms [REDACTED] testified that he had made a comment along the lines of saying the photos were nice and asking for more.

Ms [REDACTED] then went on to testify about three separate occasions in which Dr. Dicken visited their apartment.

On the first occasion, when he arrived, she took [REDACTED] to the apartment building gymnasium. She returned approximately 45 minutes to an hour later and Dr. Dicken and Ms [REDACTED] were sitting at the kitchen table in the same place as when she left. At this point, Dr. Dicken left and Ms [REDACTED] advised Ms [REDACTED] that she had had sex with him. She provided Ms [REDACTED] with specifics.

On the second occasion, Ms [REDACTED] describes having [REDACTED] in her bedroom with her. She had come out of the bedroom to get formula for [REDACTED] when she saw both Dr. Dicken and Ms [REDACTED] lying on a mattress in the living room naked. She stated she got the formula from the kitchen and returned to her room to feed [REDACTED]. She once again exited her room to return unused formula and as she walked by, they pulled the sheets up to cover themselves. Ms [REDACTED] then stated that Ms [REDACTED] texted her apologizing and stated she would wash the sheets.

The third occasion occurred at night after Ms [REDACTED] had texted Dr. Dicken that she thought [REDACTED] G-tube site was infected and sent him a picture. Dr. Dicken responded he would come to the apartment to look at it. Ms [REDACTED] stated that Dr. Dicken did come to the apartment, looked at the site and advised Ms [REDACTED] to bring [REDACTED] to the clinic in the morning. After Ms [REDACTED] took [REDACTED] to the living room, Dr. Dicken remained with Ms [REDACTED] in her bedroom for approximately 30 minutes. Upon leaving the bedroom, he encountered Ms [REDACTED] sitting on a mattress in the living room and she joked with him about getting them a new couch as a housewarming gift.

Ms [REDACTED] also testified that previously she had asked Ms [REDACTED] whether she and Dr. Dicken were using protection. Ms [REDACTED] advised her that Dr. Dicken had a vasectomy. Ms [REDACTED] told Dr. Dicken on this occasion at their apartment that she had had a friend who got pregnant after her husband had a vasectomy and to make sure he was checked. He advised her he already did and not to worry about it.

Dr. Dicken also advised Ms [REDACTED] that he was familiar with the area as he had had a friend who lived in their building in College.

Ms [REDACTED] also testified that she had discussed with Dr. Dicken a previous encounter she had experienced at a walk-in clinic. At that time she had been suffering from bronchitis and was examined by a physician. During the examination she stated that the physician touched one of her breasts. In her discussions with Dr. Dicken, he advised her that it could have been a mistake and that physicians are trained to be careful. She testified that she spoke to him about it because she was seeking his opinion as a physician who does physical examinations. She also discussed this encounter with her own family physician who said it could have been an accident.

She also testified that she reported her observations between Ms [REDACTED] and Dr. Dicken to her family physician. She was told that she was not sure what her responsibility was as far as reporting it as a physician and that she was going to contact the College lawyers to see exactly what was going to happen and what she had to do. Because of this, Ms [REDACTED] thought that the relationship was being reported. Later her family physician advised her that because Ms [REDACTED] herself had not told her it was recorded, but not an official complaint. Ms [REDACTED] would have to go through that process.

Ms [REDACTED] stated that on January 13, 2014, her relationship with Ms [REDACTED] fell apart and she subsequently moved out of the apartment. She explained that Ms [REDACTED] had accessed her iPad and read several text messages in which Ms [REDACTED] called her a slut. Ms [REDACTED] advised Ms [REDACTED]

██████████ via text message to return to the apartment alone. Ms ██████████ returned with her sister ██████████ and Ms ██████████ would not open the door for her. The police were contacted and Ms ██████████ was able to retrieve some of her belongings and leave.

Ms ██████████ then stated that she had minimal contact with Ms ██████████ since this event. On one occasion Ms ██████████ asked if she could continue to use her photo session images for a project that she had started. On a separate occasion, she had requested her portion of the damage deposit which Ms ██████████ refused to give back. She advised Ms ██████████ that her family physician, Dr. Kasumovic, was aware of the situation.

Ms ██████████ then testified that she had contact with Dr. Dicken on one occasion since moving out of the apartment. This occurred on February 6, 2014 which was her sister's birthday. Dr. Dicken initially called her during the day, but Ms ██████████ was unable to talk as she was caring for her niece and nephew. She indicated she was unclear on whether or not she should talk to him and advised him to call her back. She contacted the College for advice on this but did not hear back. She subsequently decided she would record the phone call when Dr. Dicken called back later that evening.

Ms ██████████ then testified she officially filed the complaint with the College on February 28, 2014.

Under cross-examination, Ms ██████████ clarified ██████████ also goes by the last name ██████████ Ms Stratton would be referring to her as Ms. ██████████ and it was clear they would be talking about the same person.

Ms ██████████ was questioned about the photo she took of Ms ██████████ Dr. Dicken and ██████████ on page 112 of exhibit 2. She testified that she was more of a natural poser photographer, in that she does not like posed pictures. In this particular photo she told Dr. Dicken to sit down and he and Ms ██████████ did everything else. She denied the suggestion that she had asked them to lean in towards one another.

In relation to a second picture on page 113 of Exhibit 2, she testified that she did ask Dr. Dicken and Ms ██████████ to look at ██████████. She further stated that Ms ██████████ was sitting on Dr. Dicken's lap. She denied the suggestion that M. ██████████ was sitting on the arm of the chair.

Ms ██████████ also testified that her expertise was as a photographer taking maternity, newborn, child and family pictures. The series of erotic pictures contained in Exhibit 2 was a new style of photography for her and Ms ██████████ asked her to do them. She denied the suggestions that she actually asked Ms ██████████ to pose for these photographs. She further denied the suggestion that Ms ██████████ never did tell her that she sent the pictures to Dr. Dicken, as she testified she was there when Ms ██████████ sent them to him.

Ms ██████████ outlined that she frequently was at the hospital when Dr. Dicken made his rounds to check on ██████████. She was there in a supportive role to Ms ██████████. She denied asking Dr. Dicken if he was married. She also denied asking him what type of car he drove. She did acknowledge that she showed Dr. Dicken a picture of a medical resident that she had on her phone. She asked if he knew the resident and he said he did not. She also acknowledged that she did ask Dr. Dicken if he would like to party with her and Ms ██████████ on New Year's Eve. She also acknowledged jokingly asking if he had a doctor friend for her.

She denied asking Dr. Dicken why he liked Ms ██████████ more than her. She also denied the suggestion that Dr. Dicken ignored some of her comments. Additionally, she denied that Ms ██████████ told her that her behavior was inappropriate. She denied any frustration arising from



Dr. Dicken not responding to her joking comments. Furthermore, she denied questioning his heterosexuality.

Ms. [REDACTED] acknowledged hearing about Dr. McGonigle as one of the pediatricians involved in [REDACTED] care during her various hospital admissions. She did not remember another male caregiver coming in to look at [REDACTED] and denied telling any such person that he was good-looking.

Ms. [REDACTED] also denied ever flirting with Dr. Dicken and denied becoming frustrated when he was not interested in her.

Ms. [REDACTED] testified that sexual relations between Ms. [REDACTED] and Dr. Dicken happened between November 29, 2013 at around 4 PM and November 30, 2013 at around 11:30 AM. She was unaware of Dr. Dicken's operating room schedule for that day. Her recollection was that [REDACTED] was in the hospital on November 29, 2013. She agreed that [REDACTED] was discharged according to the presented discharge summary on November 29, 2013. It was her understanding that [REDACTED] was discharged and went to her grandmother's house along with Ms. [REDACTED]. At some point, Ms. [REDACTED] returned to the hospital where she met Dr. Dicken in a hallway. She testified Ms. [REDACTED] told her they had met in the hallway and were talking and he took her back to what she thought was his office. Ms. [REDACTED] could not tell if it was his office or someone else's office, commenting to Ms. [REDACTED] that there were no pictures, though she thought it was really weird that there were no photos in his office. She added that she did not believe Ms. [REDACTED] went there to have sex with Dr. Dicken, but ultimately that is what happened.

Ms. [REDACTED] stated that she and Ms. [REDACTED] had met with Dr. Dicken just prior to the G-tube insertion procedure of November 27, 2013. She describes Ms. [REDACTED] as not being overly worried about the procedure and more interested in Dr. Dicken at the time. She testified that Ms. [REDACTED] was giggling uncontrollably and that Dr. Dicken although laughing, was more professional about it. She acknowledges the two were flirting. She further stated that Dr. Dicken told her he was attracted to Ms. [REDACTED] and he would have to wait a year to be able to become involved with the mother.

When questioned about Facebook, Ms. [REDACTED] stated that she was not one of Dr. Dicken's Facebook friends. She was questioned in regards to her comment in the Facebook exchange between her and Dr. Dicken where she said she "could say 100% there was nothing and [she] would if it came down to it." However, she testified that she knew something was happening which is why she wrote to him. On further questioning she acknowledges that she was prepared to lie and told him that she was prepared to lie. Dr. Dicken replied back stating he has tried to keep things very professional and Ms. [REDACTED] testified she left it at that.

Regarding the second sexual contact, Ms. [REDACTED] maintained this happened on December 30, 2013 at about 12:30 PM. Ms. [REDACTED] told her that they had sexual relations that afternoon.

The next incident of alleged sexual relations between Dr. Dicken and Ms. [REDACTED] occurred on January 4, 2014 at noon. Ms. [REDACTED] acknowledged that she saw Ms. [REDACTED] and Dr. Dicken lying together naked on the mattress at this time. She stated that Dr. Dicken knew that she and [REDACTED] were in the apartment. She testified that she walked by not once, but twice when getting [REDACTED] formula and that Ms. [REDACTED] and Dr. Dicken did not even bother to cover up.

She denied the suggestions that none of this happened.

[REDACTED] confirmed the last sexual contact occurred on January 8, 2014 at approximately 9 pm. [REDACTED] had concerns about [REDACTED] G-tube at that time and had sent Dr. Dicken a text

message containing a photo of the G-tube site. She testified Dr. Dicken came to the apartment to look at the site but also saw [REDACTED] in the clinic on January 9, 2014. She stated that he was going to take out the tubing and change something which is why it had to be in the clinic. She further testified that both Dr. Dicken and Ms [REDACTED] were in Ms [REDACTED] bedroom while she was in the living room with [REDACTED]. She did not talk with Ms [REDACTED] about sexual relations on this occasion. She acknowledged that she cannot say with 100% certainty that they had sexual activity.

She maintained that Dr. Dicken had come to the apartment on January 8, 2014.

Ms [REDACTED] agreed that discussing a vasectomy is an intimate topic to discuss with someone who is not a sexual partner. She stated that she had mentioned a friend who got pregnant after her husband had a vasectomy and so made a joke to the effect that Dr. Dicken better get it checked. She states that was the extent of the conversation it was not a direct detailed conversation about the vasectomy.

When questioned about the phone call of February 6, 2014, Ms [REDACTED] testified that she intended to record the phone call and did not advise Dr. Dickens that it was being recorded. When asked why she had recorded the call, she indicated she wanted to protect a situation in case anything ever came between her and Ms [REDACTED] and also in case the College had asked for something. She acknowledges that she made a number of accusations during that call, but testified that she simply played out exactly what had happened. She stated that she had the same conversation she would have had if the call had not been recorded.

Ms [REDACTED] also outlined an incident where an employee from Direct Energy came to her apartment. This was on January 8, the same night Dr. Dicken was there the last time. The employee of Direct Energy was there on a service call and began a personal conversation with Ms [REDACTED]. He asked if she and Ms [REDACTED] wanted to go out with him that evening. The employee told her he was interested in Ms [REDACTED] but also had a friend who would be interested in Ms [REDACTED]. Ms [REDACTED] denies going out with these individuals that night however they did end up coming to her apartment. One of the individuals ended up in the bedroom that Ms [REDACTED] and [REDACTED] were in and, according to Ms [REDACTED] he told her he was instructed to do so by Ms [REDACTED] via text message.

Ms [REDACTED] denied the suggestion that she shoved him into Ms [REDACTED] room. She acknowledged that Ms [REDACTED] was quite upset when the individual came out holding [REDACTED]. Ms [REDACTED] said she received a text from Ms [REDACTED] stating [REDACTED] needed to come back to bed because they had an appointment in the morning. [REDACTED] stated that Ms [REDACTED] did not physically come out of the room.

Ms [REDACTED] denied the suggestion that Ms [REDACTED] told her she needed to get these two men to leave the apartment, and that if she didn't get them to leave, than she herself better leave. Ms [REDACTED] acknowledged she moved out of the apartment within days of this incident.

Ms [REDACTED] acknowledged Ms [REDACTED] did read the messages on her iPad that were critical of her. Ms [REDACTED] told her, Ms [REDACTED] that she was angry but Ms [REDACTED] never told her about what. Ms [REDACTED] denied taking Ms [REDACTED] phone and sending text messages to herself to create a series of text messages back and forth between the two of them, and denied that Ms [REDACTED] had confronted her about having done so.

She further stated that Ms [REDACTED] never told her that she needed to move out of the apartment. When the police were involved Ms [REDACTED] gathered her belongings and left. The

police stated that Ms [REDACTED] and M. [REDACTED] appear to have a good relationship and should anything be missing they could talk to each other and get anything through them. Ms [REDACTED] denied telling M. [REDACTED] that she would get back at her, or Dr. Dicken. She also denied telling her that she was going to complain about Dr. Dicken at that time.

Ms [REDACTED] stated at a later time, she did advise Ms [REDACTED] that she would file a complaint against Dr. Dicken, after she had spoken to her own physician about it. Ms [REDACTED] denied she was going to get back at her by complaining about Dr. Dicken. She denied that Ms [REDACTED] told her that this was stupid and that she should take it out on somebody else.

Ms [REDACTED] acknowledged that she had sent text messages and Facebook messages to Ms [REDACTED] after moving out, but stated they were solely regarding her missing items.

She denied ever having a conversation with [REDACTED] [REDACTED]. The extent of their contact was a voicemail he left stating that she was not to contact his daughter or his granddaughter.

Ms [REDACTED] also denied ever receiving a cease and desist letter from Ms [REDACTED] and Mr. [REDACTED] lawyer.

Ms [REDACTED] then testified that she did not send any text messages to Ms [REDACTED] declaring her intention to report Dr. Dicken, but simply stated that Dr. [REDACTED] knew about the situation and was reporting Dr. Dicken to the College as set out in Exhibit 4.

Ms [REDACTED] further testified that she's over how her relationship ended with Ms [REDACTED]. She also testified that she is not frustrated and angry at Dr. Dicken and how he acted towards her. She testified that she is not seeking revenge against them by making this complaint to the College. She testified she was not aware that after making the complaint, Dr. Dicken would have to quit caring for [REDACTED]. She acknowledged that Ms [REDACTED] would be upset by the complaint, but maintained this is not why she filed it.

Under re-examination by Mr. Boyer, Ms [REDACTED] testified that she is not involved in any litigation with either Ms [REDACTED] or Dr. Dicken. She further clarified that she has not received any type of cease and desist letter from a lawyer.

[REDACTED] [REDACTED]  
Ms [REDACTED] identified herself as the sister of [REDACTED] [REDACTED]. She knew [REDACTED] [REDACTED] as one of [REDACTED] friends and acknowledged that [REDACTED] had stayed at her home for approximately 10 days in December 2013. She further testified that [REDACTED] and [REDACTED] had lived together for approximately 2 ½ weeks.

She stated that when the relationship dissolved, [REDACTED] was not happy with her sister. When she drove Ms [REDACTED] back to the apartment there were approximately four people inside the apartment that refused to let her in. Consequently, the police were called in order to gather Ms [REDACTED] personal effects. Ms [REDACTED] stated that not all those items were picked up and that she had maintained contact with Ms [REDACTED] in order to obtain and return their respective personal effects.

She testified that she had never been to the hospital with Ms [REDACTED]. She did not charge Ms [REDACTED] rent during the time she stayed at her house.

Ms [REDACTED] testified that M. [REDACTED] had lived with her for approximately five years with the exception of couple of days and the two week period when she lived with Ms [REDACTED]. She said Ms [REDACTED] is like a second mother to her children and is involved with their daily care. She testified that she is comfortable leaving her children in the care of Ms [REDACTED] when she and her husband are away.

Under cross-examination by Mr. Morrow, Ms [REDACTED] acknowledged that she had a phone conversation with Rebecca Gaetz from the College, but no formal interview.

She further testified that she had received a text message from Ms [REDACTED] saying that she was upset, and she advised her sister of this. She also stated that she was not going to let Ms [REDACTED] go to the apartment by herself. Upon arrival she had called the police to assist her and [REDACTED] in getting [REDACTED] belongings.

### **Kristy Ivans**

Ms Ivans identified herself as an investigator and resolution advisor for the College. She was the investigator assigned into the conduct of Dr. Dicken by the Complaints Director. She conducted an interview with Ms [REDACTED] on April 9, 2014.

The full audio recording of this interview was played during the hearing. The entire transcript of this interview was submitted as exhibit 5.

Ms Ivans testified that Ms [REDACTED] was not under oath while the interview was conducted.

Ms Ivans testified that she had contacted TELUS for text message records between the respective telephone numbers of Ms [REDACTED] and Dr. Dicken. She was seeking records for the time period of November 16, 2013 to March 31, 2014. The response from TELUS was submitted as Exhibit 7.

Mr. Boyer confirmed that there were no other witnesses called by the College.

### **Dr. Bryan Dicken**

Dr. Dicken identified himself as a pediatric surgeon working at the Stollery Children's Hospital. He is an Associate Professor of Surgery as well as the divisional chief of surgery. He is currently married and has two children.

He describes patients being referred to him in three primary ways. Firstly, via family physician or pediatrician in an outpatient setting. Secondly, would be through the emergency department. The third category would be those that would require immediate emergency surgeries such as congenital anomalies which would be referred through either the pediatric intensive care unit or the NICU.

The postsurgical follow-up care would be allocated between himself and the pediatrician was described as variable. Some cases would be simple requiring only one follow-up visit and the patient would subsequently be discharged. Conversely, some medical problems can be complex and lifelong and often involves the co-management of patients because of the complexity of their problems.



Dr. Dicken testified that he will always see every single family before surgery as well as after surgery. He feels that that is imperative. He also described that he will frequently pop up in between surgeries in case he did not get a chance to see the families.

Dr. Dicken identified that he does not have a private clinic and that the clinic he uses is attached to the clinical sciences building. He also has a small administrative office in a very high traffic area of the Department of Surgery. He estimates that there are 35 surgeons crammed into the small area. The office contains his desk and a bookshelf and has a door that can be closed. Outside of this office are two administrative assistants and the chief's office. He states he does not use the chief's office and does not even have keys to that office. He also stated that he has an administrative secretary across the hall from him and an additional secretary for his divisional chief position further down the hallway.

Dr. Dicken viewed himself as being very approachable prior to this complaint. He certainly enjoyed speaking with families and often sat whenever possible. He stated that there is good evidence that shows if you sit, people will believe or feel like you spent more time with them. He also tried to relieve tension. He frequently drew diagrams and gave families ample opportunity to ask questions.

He stated that he would initiate contact only if it relieved anxiety and had a purpose. He also outlined that it was not uncommon for parents to jump up and embrace him after surgery. He understood the meaning of this and certainly prior to this allegation, was okay with it.

He testified that he has been invited to birthday parties of a child that he has operated on, but has never attended. He indicated he is not comfortable with that and is not looking for gratitude.

He acknowledged dealing with conflict in the past and found that additional confrontation resulted in an escalation of the situation which made him terribly uncomfortable. He described a strategy for dealing with conflict by often excusing himself and returning at a later time.

Dr. Dicken testified that he knew that any relationship between the patient, the patient's family and himself was to be conducted in a professional manner and that there should be no intimate relations at all with the caregiver, parents or otherwise. He felt that he always tries to be objective but understands that people are people and that circumstances surrounding any surgery can be very stressful. He testified he is not adverse to chatting about things with families that will ease their mind and relax them. He frequently acknowledges to families that he also has children and he finds this takes the weight off their shoulders knowing that as a parent, he understands what is at stake.

He further testified that he would not socialize with families outside of the hospital. He stated it just made him feel uncomfortable. He also stated he would never offer care to relatives or people that are close to him because he feels strongly that this would compromise the provision of objective care.

Dr. Dicken testified he understood that initiating any type of relationship between the doctor and the patient's decision-maker or caregiver would be unethical in Alberta.

He outlined [REDACTED] medical situation when he first met her in September 2012. She had a high imperforate anus and weighed roughly 800 g. He had conducted the creation of a colostomy and a mucous fistula which, if not performed, would have been fatal. Dr. Dicken testified that he continued to provide care to [REDACTED] when she was transferred from the Stollery Children's Hospital to the Royal Alexandra Hospital.

He testified that his initial contact with the family was with the grandfather of the patient. Ms [REDACTED] and the biological father [REDACTED] were not engaged to the point that he felt they should be. He scolded them for this and told them they needed to take more responsibility for the child. He further stated that for the mother in particular, she took this to heart. He also testified that Ms [REDACTED] behaved more aggressively and was more confrontational when she was around [REDACTED].

By December 2012, [REDACTED] had experienced a complication at the colostomy site and required a revision. He testified that Ms [REDACTED] and [REDACTED] were very keen on having the colostomy reversed. Dr. Dicken preferred to see the child to gain weight to 4 kg before this was done. This was because the procedure is very involved and would require the reconstruction of the anus.

Dr. Dicken testified that the biological father was most concerned about moving forward and getting the reconstruction done. He stated that he had been to several appointments through the spring of 2013. Ultimately the procedure was performed on June 19, 2013.

Shortly thereafter, Dr. Dicken testified that he received a phone call from Ms [REDACTED] while he was out for dinner with his family. He stated she was concerned that there was a complication with the procedure. Dr. Dicken testified he was surprised that she had his number and admits that he was caught off guard and a little bit harsh with her. He stated that he did not have the private number setting on his cell phone set as many home numbers will not accept private callers.

He directed Ms [REDACTED] to bring [REDACTED] to the Stollery emergency room as she felt that her local hospital in Westlock would not be prepared to deal with [REDACTED] complications. He facilitated that process by phoning the emergency department to let them know she would be arriving, but advised her that he was not on call and would not be seeing her.

On July 9, 2013 Dr. Dicken had a clinical visit with [REDACTED] [REDACTED] and Ms [REDACTED]. At this visit he was going to teach both parents the process of anal dilation. He testified that [REDACTED] was uncomfortable with the procedure, however Ms [REDACTED] with a little bit of encouragement, was able to perform it. Dr. Dicken testified that the outcomes are much better when parents are able to perform this procedure as they can do it more frequently and conveniently.

He then saw [REDACTED] on September 4, 2013 and confirmed that the dilation procedures had been carried out appropriately.

On October 3, 2013 Dr. Dicken testified that he had closed the colostomy and was not anticipating any planned surgery at that point. He did state that he would continue to see the child intermittently to check the perineum and to ensure that the child's stooling behavior was appropriate. He planned to transfer general pediatric care to either Dr. McGonigle or Dr. Chatur while making himself available for any surgical concerns.

By November 2013 [REDACTED] had developed respiratory issues and failure to thrive. At this point she had had a nasogastric tube in for some time and it was his recommendation that a G-tube be placed. Dr. Dicken testified that this procedure involved a laparotomy or an open procedure and felt that it was not a relatively minor operation. He agreed that there is certainly a risk of death with a G-tube. The procedure was performed on November 27, 2013 and there were no complications.

Dr. Dicken then testified about his initial meeting with Ms [REDACTED] in October 2013. He stated that she was introduced as the photographer but this quickly changed. He describes her as being

overly familiar or comfortable. She didn't seem to have difficulties being too friendly. She was a complete stranger to him yet her behavior was very "jokey".

In reference to the photographs of Exhibit 2 at pages 112 and 113, Dr. Dicken testified that these photos were taken on unit 4E3 of a double room in the hospital. He describes a curtain being between two patient beds oriented at a six and 12 o'clock position with a nurse present in the room. He stated these pictures occurred while on his afternoon rounds when he came in the room to see the child. Dr. Dicken was unable to state when these photos were taken. He noted that in the photo the child still has the nasogastric tube so the photo was obviously taken before the G-tube surgery.

At the mother's request, she had asked if some photos could be taken which was not uncommon. In the first picture, he testified that Ms [REDACTED] instructed them on where to sit and that Ms [REDACTED] sat on the arm of the chair. Ms [REDACTED] instructed them to lean in. Dr. Dicken further testified that it was not possible for Ms [REDACTED] to be sitting on his lap as the photograph indicates that she is significantly higher while he is significantly taller than she is. Furthermore he testified there is never a situation where he would have the patient sit on his lap and that the smile he has in the picture is not a smile of comfort.

For the next picture, he testified that Ms [REDACTED] instructed them to look at the child.

He further stated he was a bit uncomfortable and, upon leaving the room, encountered Dr. Chatur. He expressed that he had had an unusual interaction and that he was uncomfortable with that interaction.

Dr. Dicken then commented on his communication with Ms [REDACTED]. He stated that his communication with her was exceedingly brief and that she was very quiet. He sometimes would wonder if she was hearing what he was saying. He frequently would get feedback from the nurses usually in the form of questions that Ms [REDACTED] had and knew on the basis of these questions that she had heard his instructions and was processing them. He testified that he would frequently get calls from her later with questions that were logical and very reasonable.

In contrast, his interactions with Ms [REDACTED] were anything but normal. He described her as being socially uncomfortable with an over-familiarity as soon as he would enter the room. She had an over-degree of focus on the child and if he did not know who the parent was, he would have thought it was Ms [REDACTED]. He felt her behavior, even for a parent, was too much. She had a constant desire to hold the child and manipulate the child and point out things that she thought were right or wrong about the child's care. She then would turn to what he called very borderline type of behavior, asking him personal questions and questions that he felt were invasive.

When asked to elaborate, Dr. Dicken testified Ms [REDACTED] questions were of the nature of did he have children, what they did, what kind of car did he drive, and what he liked to do. He stated that this would often turn to a joking type of banter where she would be flirtatious and ask him why he didn't like to party, why he didn't want to party with them, why he didn't like her, or why did he like Ms [REDACTED] more than her.

Dr. Dicken stated he felt that her behavior was not appropriate for the circumstances and her response to him was always to giggle or suggest that she was just joking. He was unclear on what type of relationship she had with Ms [REDACTED] and what mattered to him was the child getting the appropriate care. He stated he was quite dismissive of Ms [REDACTED] and viewed her behavior as being more of background noise.

Ms [REDACTED] asked Dr. Dicken to identify two photos of males who allegedly worked in the hospital. One was a nurse and the other one was apparently a resident. These photos were on an iPad or phone and he stated he did not know who they were.

He further described how he was made fun of for driving a truck and believes it may have been Ms [REDACTED] who asked him what kind of truck he drove. When he responded he drove a Jeep, she stated that this was not a truck and it was made into a joke.

Dr. Dicken also testified that Ms [REDACTED] and Ms [REDACTED] made a comment to him about why he had only two kids. He replied that is what he wanted, to which one of them responded "you never know." Dr. Dicken stated that he said that this was impossible but was certain he did not volunteer that he had had a vasectomy. During his testimony, he stated the discussion of his vasectomy was embarrassing and was only known by spouse and his urologist.

Dr. Dicken further testified that Ms [REDACTED] made a derogatory comment about his sexuality, which for him was the last straw. He stated he did not even acknowledge it but immediately left the room. Upon leaving the room he walked to the nursing station and encountered both Drs. McGonigle and Chatur. He shared this information with them immediately and signed over care of the patient to them. He made it very clear that the person that was problematic was Ms [REDACTED]

Dr. Dicken then testified about the period of time prior to the G-tube insertion. The child had been admitted to the hospital for viral enteritis and, because of failure to thrive, Dr. Dicken was consulted for a G-tube placement. He testified that he met with Ms [REDACTED] in the preoperative holding area to discuss the procedure and obtain consent. He stated that the main OR desk was approximately 6 feet away and at that desk was a charge nurse and two unit clerks. The area was described as being open with no partitioning. Dr. Dicken specifically recalls Ms [REDACTED] being there but cannot recall Ms [REDACTED] being there.

At this time, he testified that he was not giggling or joking around with Ms [REDACTED] prior to the surgery. He did not view this surgery lightly and to view it as such would be absurd. He denies having any physical contact with Ms [REDACTED] waist or back at this time. He does not recall Ms [REDACTED] saying "I know what is going on here". He also denied telling Ms [REDACTED] that he was attracted to Ms [REDACTED]. Furthermore, he denied telling Ms [REDACTED] or Ms [REDACTED] that he would have to wait a year until he was finished treating [REDACTED] before he would be able to become involved with Ms [REDACTED]. He anticipated that his care of [REDACTED] would probably last a minimum of five years and probably continue into her teenage years.

After the G-tube insertion, Dr. Dicken indicated there was an issue with the G-tube site in January 2014. He received a call from Ms [REDACTED] raising concern with the G-tube site and he advised her that she needed to bring the child to the hospital. When she stated she was unable to do so, he had advised her to seek care at the Westlock Hospital. He testified he was unsure, but he may have asked her to take a picture of the site and send it to him. He did recall getting this picture but was unable to locate it afterwards. He could not recall which media was used to send this picture and acknowledged that it was possible it came through Facebook messaging.

Dr. Dicken acknowledged that he did see [REDACTED] in the clinic on January 4, 2014 for the G-tube. He is unsure when he would have received the call in respect of that clinical visit.

Dr. Dicken denied going to Ms [REDACTED] home to look at the G-tube and stated that he did not do house calls. Dr. Dicken specifically denied ever going to the apartment located at 2320 – 119 Street. He specifically stated he did not go to that apartment at all before January 9, 2014.



Regarding the alleged sexual contact that occurred at around 4 PM on November 29, 2013, Dr. Dicken testified that he was involved in a very complex surgical case that afternoon. He described the procedure as long and complex. He explained the anaesthetic records, submitted as Exhibit 8, shows the patient arriving in the operating room at 1400 hrs. He further describes the finish time at 1700 hrs. Dr. Dicken testified that it is his procedure to be present from the moment that the child arrives in the operating room and until the child leaves the operating room. Immediately he then dictates the operative report. In this particular case, he then went to the intensive care unit to review his operative findings and his expectations with the intensive care physicians. He estimates that this could take anywhere between 20 minutes to half an hour. He then immediately goes to speak to the family about the operative findings and postoperative care. In this particular case he estimates that he spent at least a half an hour afterwards.

He further stated that it would be impossible for him to take a break, go into the hall and tap Ms [REDACTED] on the arm. He further added that on this day the surgical case would have been his last surgery of the day and so after signing out to the intensive care physician and his discussion with the family, he would most certainly have gone to visit the remainder of his inpatients to complete his rounds prior to the end of the day. He stated that this is just his usual routine.

Dr. Dicken then testified that he never met with patients' families in his administrative office. He stated this would not be appropriate for many reasons. Firstly, there is nowhere to sit. The office was very small, very busy and in a high traffic area. Secondly, there was very limited privacy because it was designed as an administrative office only.

Dr. Dicken specifically denied going to his office to meet Ms [REDACTED]. He denied meeting Ms [REDACTED] anywhere within the timeframe of the evening of November 29 to the morning of November 30, 2013. He specifically denied meeting Ms [REDACTED] without [REDACTED] at any time on November 29, 2013. He specifically denied having sexual relations with her on that day. He specifically denied meeting Ms [REDACTED] at any place in the hospital, his office or elsewhere on November 30, 2013. He also specifically denied having sexual relations with her on November 30, 2013.

Dr. Dicken then went on to testify about the discharge summary of November 29, 2013 that was dictated by Dr. Rehana Chator. He stated that when a child is discharged from the hospital, a parent must be present. He further said that the discharge of a child with a G-tube is different from the discharge of a regular child. There are several prerequisites that must occur before the child can be discharged including G-tube teaching. Additionally there is always a review of feeds that need to be administered including quantity, mixture content, and supply. He described the discharge as being very labour intensive.

With respect to the allegation of December 30, 2013 Dr. Dicken stated that on this day he was at home and had rented a movie. He stated that he had extended family visiting from Mexico City for the entire Christmas break as well as the New Year's break. He stated that the visitors stayed with his family in their home and they basically were the entertainment for the two weeks. He stated that they watched their movie at home after renting it through video on demand.

Dr. Dicken then commented on a redacted Shaw invoice that was submitted as Exhibit 9. He stated that on December 30 he watched the movie previously mentioned. On January 4 he had a movie day which is a big deal to his family. He stated he and his wife are very private and don't like to socialize too much but like to watch movies with their kids. So they make a day of it by getting snacks and spending the day watching the movie.

He stated that his wife was a bit of a hoarder and was able to locate the invoice the morning of the hearing. He did state that he was not able to pinpoint the time of day that he watched these movies.

Dr. Dicken denied going to Ms [REDACTED] apartment building on December 30, 2013 at about 12:30 PM and noted it would be highly unusual for him to leave in the middle of the day. He testified that it would be so unusual that his wife would become very suspicious. He continued that if they were to go anywhere they would take one or both of the kids with them because as working professionals the amount of time that they have with their kids is limited.

Dr. Dicken specifically denied going to the apartment at 2320 – 119 Street or meeting Ms [REDACTED] at any place on December 30, 2013. He denied having sexual relations with her on that day.

Dr. Dicken then denied going to Ms [REDACTED] apartment at noon on January 4, 2014. He stated that because of the company that they had visiting, it would be highly unusual for him to disappear in the middle of the afternoon. The Shaw invoice shows that a second movie was rented and Dr. Dicken did not recall the time of day that they watched it. He did state it is a daylong procedure on movie day to get kids sorted out and to get their snacks.

He further stated that he did not go to Ms [REDACTED] apartment on January 4, 2014, denied seeing Ms [REDACTED] and denied asking to speak privately with Ms [REDACTED]. He also denied that this occurred on January 3 or January 5 of 2014. He further denied lying on a mattress in the living room naked with Ms [REDACTED]. He also denied making the comment that he should put some clothes on when it is alleged that Ms [REDACTED] walked past him and Ms [REDACTED] as they were lying on the mattress.

In regards to the allegation of sexual contact on January 8, 2014 at 9 PM, Dr. Dicken acknowledged that he did see [REDACTED] the next day about the G-tube. He recalled assisting a senior colleague on a new surgical procedure for of most of that day. He did not recall specifically what time he would have left the hospital but stated usually he would get home somewhere between 6 and 7 PM. He stated at the time of the allegation he would have been at home.

He denied going to Ms [REDACTED] apartment at around 9 PM or any time on January 8, 2014 to examine [REDACTED]. He denies the allegation that he was in Ms [REDACTED] room with her by herself on that date.

Dr. Dicken stated there were generally three methods of communication to address any questions from Ms [REDACTED]. First she could phone his office and communicate with his secretary, and he would return that call. Secondly, she could page him through the hospital locating. Thirdly, if she had his number, she could phone him.

He further stated he was taken off guard on that one occasion she phoned his cell phone directly.

He stated that he did not remember any specific text messages between the two.

He was referred to Exhibit 7 and a series of text messages records between his cell phone and Ms [REDACTED] cell phone from the period of January 23, 2014 to March 13, 2014.

He stated that during this period of time [REDACTED] was admitted to hospital with an excessive amount of vomiting. This was causing her to lose weight. There was considerable concern amongst the home enteral program, her pediatricians and himself which was leading up to an additional surgery.

Dr. Dicken did not recall the content of these text messages, nor did he have any recollection of sending these messages.

Dr. Dicken testified that he did receive a Facebook message concerning [REDACTED] G-tube but could not recall any other email exchanges or Facebook exchanges between himself and Ms [REDACTED]. When questioned why Ms [REDACTED] was able to access his Facebook to message him he stated that he did not "really know what Facebook meant". He had assumed that it was just like an email but did not realize that it was more of a public forum. He acknowledged that he does have a Facebook account and uses it primarily as a means of communicating with friends in the United States. He further testified that he was not aware of the controls that Facebook had and that this is something that he has since learned. He has subsequently put privacy settings in place on his Facebook account.

Dr. Dicken was questioned by Ms Stratton regarding his interaction with Ms [REDACTED] and her demeanor towards him. He stated he found her withdrawn and very quiet. She did not ask him direct questions and he stated he frequently use closed ended questions with her. He denied feeling uncomfortable in his dealings with her with the exception of one clinic visit where she called him an asshole. He felt this was in response to him chastising her for calling him on his private number.

Dr. Dicken then went on to testify about Ms [REDACTED] demeanor towards him. He described her as overly comfortable and he really did not feel comfortable around her. He believed that she in some way thought that she had some form of personal relationship with him.

Dr. Dicken denied ever receiving any photographs from Ms [REDACTED] apart from the G-tube photograph. He further stated that Ms [REDACTED] did not send any pictures to him but did present him with a collage of pictures after the PSARP and the colostomy closure. He did not think that this was unusual and testified that he still receives annual photographs from families that he treated during his fellowship training.

Dr. Dicken testified that he had not received any of the erotic photos of Ms [REDACTED] contained in exhibit 2. He stated the only picture he received from her was the one of the G-tube and the collage of the child. He went on further to state that the first time he saw those pictures was when he met with his counsel, and as he began to go through them he felt uncomfortable as he viewed it as an invasion of this young lady's privacy.

Dr. Dicken was asked about his phone conversations with Ms [REDACTED]. He stated that the majority of the time these conversations related to the G-tube and stooling issues. He was referred to a series of prolonged and frequent telephone conversations documented by cell phone records contained in the agreed exhibit book that occurred between January 30 and March 24, 2014. He considered these to be regular ongoing treatment calls. They occurred at various times of the days and often into the late evening.

One particular call that came in at 2300 hrs and lasted 20 minutes was memorable for the very nature of the call, and his wife's commentary regarding the call. He testified that he received this call and was required to go through a systemic review of all the issues, including G-tube positioning and leakage, calculating the amount of feeds and questioning the child stooling. He

further testified that he books clinic patients for 15 minutes but on average visits take somewhere between 15 and 30 minutes. Frequently he is not dealing with a single problem and he cannot cut a parent off. He stated that the calls are patient-initiated and they relate to patient care.

Dr. Dicken denied that there were any phone calls of a personal or intimate nature between him and Ms [REDACTED]

Dr. Dicken was then questioned about his Facebook exchange with Ms [REDACTED]. He was asked to clarify why he was thanking her and what he was referring to when he mentioned his reluctance.

He stated that he was trying to be dismissive of her by thanking her in the Facebook exchange.

Furthermore, he described his reluctance as he was not prepared to take any steps outside of his professional obligations boundaries to engage with these two individuals. He testified that he was never tempted to do so. He stated Ms [REDACTED] did not make unprofessional remarks or what he would consider to be inappropriate remarks. He was trying to be non-confrontational in directing it at Ms [REDACTED]

Referring to the friendly banter, he stated that when he would walk into the room there would be an inquisition of personal questions. He was dismissive of those comments but was not rude or confrontational, and was not unprofessional. He again felt that this is his way of being dismissive of them.

Dr. Dicken then went on to testify about the phone call that he received on February 6, 2014 from [REDACTED]. He stated at the time she was quite upset and informed him that she and Ms [REDACTED] had a significant falling out. He responded that he was sorry to hear that but he really was not her social worker and that it was beyond his abilities to deal with the problem. At that point she stated that she could handle [REDACTED] and what he did not understand was that Ms [REDACTED] was going to put in a complaint to the College. He replied that this is clearly a misunderstanding and that he would call her. He stated that his feeling was that he would do what the College advises physicians to do which is to try to settle the dispute by discussing it with the unhappy party.

According to cell phone records, Dr. Dicken called Ms [REDACTED] at 13:21 on February 6, 2014. He stated she informed him that she was busy and unable to talk to him at that time, and advised him to call back later.

He called her back at 21:11 with the purpose of clarifying a communication problem and see if it could be resolved. Ms [REDACTED] had suggested that Ms [REDACTED] was lodging a complaint against him and he was perplexed by that and was really just trying to find information. He stated that this telephone call was placed from the platform of an LRT station as he was returning from a course he attended downtown.

During the playback of the telephone conversation Dr. Dicken was questioned by Ms Stratton about several portions and remarks he made during the call.

When asked about why he kept saying "okay, okay, okay", he testified that he was using this as an acknowledgement that he was listening. He did not imply that he was agreeing with what she was saying. He testified that he felt confused about what was going on regarding some of the comments she made, such as her reference to him being disgusting.



He was also questioned about Ms [REDACTED] using the words "sleeping with" Ms [REDACTED] and his response of "you don't have to agree with it." Dr. Dicken stated he continued to feel confused and did not understand the nature of the call. He was unclear as to what Ms [REDACTED] was trying to state to him.

In regard to Ms [REDACTED] remark about being married with two kids and still wanting to sleep with Ms [REDACTED] Dr. Dicken testified that this was something he could never have anticipated. He compared it to a person being told they have cancer. It was a bomb that was dropped in his lap. He felt that he was trying to gain an understanding as to what was going on here and not acknowledging anything beyond that.

Ms Stratton questioned Dr. Dicken about what he meant by "it's not really for me to judge" during this conversation. Dr. Dicken explained that in his Facebook exchange with Ms [REDACTED] she indicated some discord between Ms [REDACTED] and her mother. He stated that he was trying "dissect" himself away from the situation and it was not for him to judge them.

Dr. Dicken then testified that he had nothing to hide and was not acknowledging Ms [REDACTED] allegations as being in any way accurate or true. He felt he was not at risk of anything and that is why he stated his job was not on the line.

He continued that he did not make any investigation into ethical requirements despite suggesting to Ms [REDACTED] that he had done so during this conversation. He testified that he knows he had not violated those boundaries. He stated he was merely trying to drive home a point that she was mistaken and this was his means of being dismissive of her claim.

He testified that he did not tell Ms [REDACTED] these allegations were false because he was shocked at the nature of the allegations and at the time felt he was being pretty clear in saying that there was nothing going on.

He further testified that Ms [REDACTED] did not understand the relationship between himself and Ms [REDACTED] in the context of purely a doctor-patient relationship. He felt that Ms [REDACTED] had misunderstood this. Dr. Dicken was asked about the following exchange during their phone call:

[REDACTED] Well, I understand that you were walking in, having sex with her, and walking out.

DICKEN: Okay well...I mean that's your observation but you...do you really know about the two of us, or no?

[REDACTED] Well I'm just saying...that's what you were doing.

DICKEN: Okay, yeah. But why would, so why...why not just...let...buy...you know let things be, like what's the...you know? I'm trying to understand what, like where you are.

Dr. Dicken testified that what he was trying to ask is whether she really understood what his relationship was with Ms [REDACTED] It was a professional relationship.

Dr. Dicken testified that when he advised Ms [REDACTED] to let things be he was in no way suggesting that there was something inappropriate or that she should just ignore it. He stated at this particular time Ms [REDACTED] and Ms [REDACTED] had gone their separate ways and were continuing to have their difficulties. His statement was intended to question what was to be gained by this type of behavior.

Dr. Dicken stated he was speechless and could not find words to respond when Ms [REDACTED] stated that he would come in, talk to Ms [REDACTED] for 10 minutes, have sex with her, and leave. He stated he felt he was being appropriately dismissive of her allegation, but it was overwhelming. He stated even now listening to the recording again he still does not hear all her words. He feels this whole ordeal has been overwhelming to him even a year and a half into this process. It has changed everything about him; the way he interacts with his patients, and how he feels about his job. He feels as if everything he says is being measured and catalogued. He has to leave the door open when he talks with patients and finds that they are apologizing to him, thinking that they are making him uncomfortable. He feels this whole ordeal has changed him physically, emotionally and mentally.

Dr. Dicken wished Ms [REDACTED] would have given him an opportunity to address her concerns rather than drop this allegation on him.

He further stated that his relationship with Ms [REDACTED] was strictly professional and at no time did he try to cross a boundary, or even come close to that boundary.

Dr. Dicken was asked about the following further portion of the telephone conversation:

[REDACTED] But then why would you say to her, I'm married with two kids so I can't have a relationship with you but I'd like to keep this going?  
DICKEN: Do you know why?

DICKEN: I actually...the reason that I came over there...was to have that discussion with her. That's why I was there. [Long pause]

[REDACTED] Well then why would you end up in bed?  
[Nervous laugh]

DICKEN: Well, I...[sigh]...I mean that's a good question. I, I, it's...a reasonable question, but that's why I was there.

[REDACTED] Okay, well I means...

DICKEN: And, and...

[REDACTED] ..you know what, you can say something happened that night, but you came to do the same thing like...less than a week later.

DICKEN: Yeah, I know, you're right.

Dr Dicken stated that when he referred to being "there" in this exchange, he was referring to the hospital ward, and that this was a mannerism he used all the time. To him, there is only one 'there' which is the inpatient ward. He specifically denied that he was referring to Ms [REDACTED] apartment, or home.

Dr. Dicken did testify that he tried to convey to Ms [REDACTED] that there are consequences to making an allegation like this. It is not just the physician who suffers through this, but also Ms [REDACTED]. He wondered what the intent of all of this was. He knew that they had an awful falling out but was unclear how he had become the target here. He was aware that this was going to be difficult for him and accepted that, but it also was not going to be easy for Ms [REDACTED].

Dr. Dicken stated that during this telephone conversation he was starting to get angry with Ms [REDACTED]. He did become somewhat facetious with her asking her to spell her family physician's

name. He began to question what her point was in doing this and was trying to say to her that she wasn't just hurting him but also hurting Ms [REDACTED] and certainly going to hurt the interaction that the child has with her physician.

Dr. Dicken stated that he was a professional and it was not in his nature to be rude or confrontational. He does not enjoy confrontation, particularly the emotional nature of this conversation. He stated that he did not fully comprehend that call and probably didn't comprehend until 1 or 2 days later.

Dr. Dicken could not recall what he did after this phone call. Telephone records indicate that he placed a 12 minute phone call to Westlock, but he could not recall who he called. When asked if it was Ms [REDACTED] he called, he said "I don't think so, but I don't know" because the last conversation had been overwhelming.

Dr. Dicken stated that [REDACTED] was admitted to the hospital from February 24, 2014 to March 7, 2014. She was admitted for gastroenteritis and was continuing to vomit. There was discussion between him and the pediatricians about the need for a fundoplication, entailing an additional surgical procedure. Telephone records indicate that there were several phone calls placed to Ms [REDACTED] from Dr. Dicken on February 24, 2014 at 1410 for 13 minutes; on February 26 at 1321, for one minute; and then on February 27 at 2300 for 20 minutes. Dr. Dicken stated that this was to discuss the child's situation and the concept of the sixth surgery.

Dr. Dicken stated that he ultimately performed the surgery on March 18, 2014. He did this despite the telephone conversation he had had with Ms [REDACTED] one month earlier because he had no reason to believe that the complaint was entirely real. Additionally, he stated that it was possible that he may have asked Ms [REDACTED] if she had any knowledge of the February 6 telephone call with Ms [REDACTED] but he did not have specific recollection about this.

He specifically denied talking with Ms [REDACTED] about the call and the information that was shared with him in the context of performing the surgery. He also denied speaking with Ms [REDACTED] prior to March 18, 2014 about the allegations, or about transferring care to a different surgeon.

Dr. Dicken stated that the surgery was much more involved than he anticipated and if it was not performed it would have resulted in growth and development impairment and the child's overall functional development being compromised.

Dr. Dicken stated that he received the College complaint from Ms [REDACTED] dated March 18, 2014, during this hospitalization. He stated that he went immediately to inform Ms [REDACTED] that there had been a complaint and based on this allegation, he was no longer able to provide direct care to her [REDACTED]. He also shared this information with Dr. McGonigle.

Dr. Dicken testified that he responded immediately to the College and faxed his response letter directly from the department of pediatric surgery. It was faxed at 21:16 on March 20, 2014. He denied having any legal assistance in preparing his response.

Dr. Dicken acknowledged at 19:09 and at 20:52 of March 20, 2014 he did contact Ms [REDACTED] as confirmed by telephone records. He stated he was trying to be clear about the clinical care that he provided and to ensure that he was accurate. He specifically denied telling Ms [REDACTED] to tell the College something that was not true. He specifically denied offering her any money. He specifically denied offering her any gifts. He specifically denied providing any favours to Ms [REDACTED].

Dr. Dicken then stated that he no longer had any involvement in the care of [REDACTED]. He stated the morning he received the complaint, he transferred her care immediately to Dr. McGonigle. Because of the specific nature of the complaint, he would no longer be able to provide further surgical care or clinical visits.

Dr. Dicken acknowledged that he had further contact with Ms [REDACTED] after March 20, 2014 to discuss her daughter's care. He stated that although the child had been transferred to another surgeon, he felt an obligation as her surgeon and physician to provide the necessary direction for her postoperative care. He felt it would be unfair for his colleague to have to deal with that. He referred to Dr. Eccles's testimony that was quite clear that once you operate on a patient nobody knows that patient better than you. He testified that the content of all of these telephone conversations was purely medical relating to the management of her daughter.

Dr. Dicken states that his last contact with Ms [REDACTED] was on March 24, 2014. He testified that if he had not received a complaint from the College he would have continued to care for [REDACTED] as he did not have any reason not to provide ongoing care. He stated that there could be a problem with the quality of care for [REDACTED] by moving to a different pediatric surgeon.

Dr. Dickens also testified that he did not document any of the calls to Ms [REDACTED]. He subsequently changed his practice and now documents all telephone calls to a patient's family members.

Dr. Dicken explicitly stated that the nature of the relationship between Ms [REDACTED] and himself was for him to provide care to her daughter. He did not recall embracing her, nor does he recall her embracing him. He denied having any physical contact with Ms [REDACTED] that he could remember. He denied any sexual contact with Ms [REDACTED]. He denied ever meeting Ms [REDACTED] outside of the clinic. He denied ever going to her apartment. He denied ever meeting at a location near her apartment. He denied ever having Ms [REDACTED] go to his office at the Stollery Children's Hospital. He denied ever being naked or semi-naked with Ms [REDACTED]. He denied ever having sexual intercourse with Ms [REDACTED].

Under cross-examination from Mr. Boyer, Dr. Dicken stated that he was married with two children ages seven and 10. He stated his wife was a full-time gastroenterologist. He described his call schedule as 1-in-4, which meant at least one weekend in for covering Friday, Saturday, Sunday and Monday. He described a typical call day as starting from 0600 to 0600 the following morning. When on call he stated he is not required to be at the hospital, but just has to be available. He further stated that during a trauma call he is required to be back to the hospital within seven minutes and for an emergency call required to be back at the hospital within 30 minutes. He admitted he was not certain of this being the exact timeframe.

Dr. Dicken testified that his visitors were visiting from what he believed to be 26 December 2013 to 10 January 2014. He stated that they were visiting from Mexico City and the visitors were his sister-in-law, her husband, and their infant daughter, who were all staying at his house.

Dr. Dicken clarified a letter that was sent by his wife to Ms Stratton, which stated her sister and brother-in-law were visiting from Miami. He stated that his extended family is from Miami, but the couple was stationed in Mexico City. He agreed that they did arrive via Miami.

Dr. Dicken testified that he was unaware whether Shaw On-Demand permitted a period of 48 hours after purchase to watch a movie.



Dr. Dicken stated his last contact with [REDACTED] was in March 2014. To add clarity and to be more specific, he viewed contact as implying a physical proximity. This meant seeing her in the clinic or in the hospital.

Dr. Dicken testified that the time he last spoke with [REDACTED] [REDACTED] was later in March 2014. He previously testified that this was related to postoperative care. He felt an obligation and responsibility to provide at least some degree of continuity of care at that time.

Dr. Dicken further testified that he referred to [REDACTED] mother as [REDACTED] [REDACTED] throughout his testimony under direction from his counsel in the days leading up to this hearing. He'd been informed that she had changed her name to [REDACTED] and was instructed to do the same, which he agreed was in contrast to all medical documentation and his initial response letter to the College.

Dr. Dicken stated that upon first meeting Ms [REDACTED] he found it to be highly unusual that a person he was meeting for the very first time would be so unbelievably friendly and familiar with him. He did not make this comment to her, but simply noted this for himself. He found her to be overly friendly to the point of being unusual. It was his understanding that she was simply the photographer, but she seemed to be present all the time and there were many interactions with her. He did state that on one occasion he found Ms [REDACTED] and Ms. [REDACTED] in the same hospital bed together. Ms [REDACTED] was very giggly and seemingly uncomfortable that he had caught them in that situation. He offered no judgment to that and their relationship was unclear to him. He had wondered if this was more than just a friendship. He had wondered if they were in a lesbian relationship, but was not making assumptions.

In his March 20, 2014 response to the College Dr. Dicken stated that there was no contact between him and either Ms [REDACTED] or Ms Hartlen after [REDACTED] was discharged home on November 29, 2013. Facebook correspondence indicates communication between Dr. Dicken and Ms [REDACTED] on or about November 29. Dr. Dicken testified that he was referring to contact as physical presence. Additionally, he makes reference that he had had minimal contact with the family after operating on the child on March 18, 2014. Again, Dr. Dicken explained that he was focused on physical contact when referring to minimal contact with the family.

Dr. Dicken states that he left out the numerous telephone conversations between himself and Ms [REDACTED] in his College response because the allegations against him related to inappropriate physical contact and he was trying to be clear in his explanation of that. Furthermore, he stated that he responded to the College within 24 hours of receiving the complaint feeling that it was his duty to do so. He did so without the assistance of counsel and admits that he may have left out some details in his haste.

In his response to the College, Dr. Dicken stated that he thought Ms [REDACTED] complaint was a joke, and informed her that it was not funny or appropriate. When referred to the recorded telephone conversation, where Ms [REDACTED] states she wanted him to respect Ms [REDACTED] and wants Ms [REDACTED] to respect herself, Dr. Dicken testified that he did not believe this was an explanation for her actions. He felt that throughout the phone call he knew he had not conducted any inappropriate behavior and that was not the topic of the discussion. He was trying to determine why she would do this, and why she was making such an allegation. Her claim that she was not angry at him was not a reasonable response to his inquiry.

Dr. Dicken acknowledged that he could have used stronger words to explicitly explain to Ms [REDACTED] that there was no physical contact between him and Ms [REDACTED]

He acknowledged in his response to the College where he stated he never made any attempts to meet or communicate with Ms [REDACTED] outside of clinical care, he omitted the numerous phone call communication that he had with her. He explained he understood the word "meet" to refer specifically to a physical meeting, but admits that he could have used different words and acknowledged that he did have communication.

Furthermore, Dr. Dicken stated that when trying to clarify the details of his clinical care in preparation for his College response, he received a phone call from Ms [REDACTED] informing him that there had been a difficult breakup. He acknowledged that this implies a conversation not pertaining to clinical care, but this was initiated by Ms [REDACTED]. He stated that he did not willingly omit this in his response.

Dr. Dicken acknowledged in his second response delivered to the College dated March 28, 2014 was prepared with the assistance of legal counsel. He acknowledged that the reference to the phone call of February 9 was not accurate as he did not have his phone records. When referred to his statement that he did not have any contact with Ms [REDACTED] before or after February 9, 2014, he acknowledged that he did not make mention of the Facebook communication of November 29.

Dr. Dicken was referred to March 20, 2014 cell phone records which showed a nine minute phone call at 7:09 PM and then a 13 minute phone call occurring at 8:52 PM to Ms [REDACTED]. Additionally he was directed to the fax header of his initial College response dated March 20, 2014 which indicates that the fax was sent at 9:16 PM. He acknowledged that the fax to the College with his response was sent moments after he ended his phone call with Ms [REDACTED]. He stated that he was contacting her to confirm the series or sequence of visits with them and was talking about the patient care he provided. He denied that they were talking about his response to the College. He denied that they were speaking to get their stories straight.

Dr. Dicken also denied that he was upset with Ms [REDACTED] during the February 6 phone call because she broke her commitment as outlined in the Facebook communication of November 29, 2013 by telling her family physician about the relationship with Ms [REDACTED].

In regard to his statement to Ms [REDACTED] during the telephone conversation that his job was not in jeopardy, Dr. Dicken denied he and Ms [REDACTED] had already agreed to claim nothing happened and to say that Ms [REDACTED] made up the whole thing.

Dr. Dicken stated that he did not take steps to ban Ms [REDACTED] from the hospital. He has done so on only one occasion and this occurred after his interactions with Ms [REDACTED].

Dr. Dicken did not expect Ms [REDACTED] to record the phone call. He also denied he was trying to bribe Ms [REDACTED] when he repeatedly asked what she wants.

Under re-examination from Ms Stratton and in reference to the letter to Dr. Dicken from the College dated March 18, 2014, Dr. Dicken stated he was shocked to see that he was asked to comment on a sexual relationship with an infant patient's mother. He submitted that he probably did not process it clearly. He felt that he had addressed that all the contact related to the care that he provided to the infant [REDACTED]. He further testified that he did not remember the phone conversation with Ms [REDACTED] from February 6, 2014. He stated that he did not receive a transcript or recording of this conversation during any stage of the investigation and only received it from his own counsel.

Dr. Dicken stated that the conversation played back to him was not as he remembered it to be, because he was pretty emotional when he was having the conversation. Upon hearing the recording again it took him back significantly to that emotion and it was difficult to process.

Dr. Dicken stated he complied with the College and its investigations in providing cell phone records as well as his call schedules. He further stated that he provided all medical records corresponding with the dates of the alleged sexual interactions and willingly met with the College.

Under questioning from the Hearing Tribunal, Dr. Dicken was not able to determine from the Shaw invoice dated January 29, 2014, the time that the movie had been rented.

Additionally, Dr. Dicken stated that he could not remember the specific discussion, but could recall a conversation where it was put to him that Ms [REDACTED] had made another allegation against a physician of the College. He could not recall the specifics of this conversation.

When asked why he did not emphatically deny any sexual relations with Ms [REDACTED] during the phone call, Dr. Dicken stated the purpose of his call to M. [REDACTED] was to clarify the purpose of her complaint or why she had made the complaint. He did not feel that he was defending himself against a sexual allegation, but rather was trying to determine the nature of her complaint and why she was making it. He also felt that he was denying and was being dismissive of the allegation. He states that he may not have been clearly processing what she was saying. Related to this conversation, Dr. Dicken was asked specifically why he did not contradict Ms [REDACTED] when he mentioned "the reason I came over there..." and then when she questioned him on how he ended up in bed. He stated that he believed he was responding to her trying to get his point across in which he refers to "over there" as being the hospital ward. Furthermore, he stated that she interjected with the question of how he ended up in bed, which at the time of the conversation he did not recall her saying. Consequently he did not respond or deny immediately.

In his letter to the College, Dr. Dicken indicated that he recognized the allegations that Ms [REDACTED] was making against him and explained that there was no physical contact at any time. The recorded conversation and Dr. Dicken's testimony is in contrast to this. Dr. Dicken stated in retrospect when he was preparing his letter it was clear what her allegations were. But at the time of the telephone conversation, he was attempting to understand the nature of her complaint and he felt he was being appropriately dismissive of her claim.

Dr. Dicken also stated that his telephone conversation with Ms [REDACTED] was conducted on an LRT platform with significant pedestrian traffic at the time. He denied having a writing pad with him when attempting to record Ms [REDACTED]'s family physician's name. He stated that he was being somewhat facetious with her because he was not convinced that this was a truthful allegation.

Dr. Dicken stated that Ms [REDACTED] became more inappropriate and aggressive over time. He viewed her as being background noise, but there was some level of permission from Ms [REDACTED] to allow her to do this. In his response to the College, Dr. Dicken stated during the November 27, 2013 admission he felt very uncomfortable with Ms [REDACTED] and her comments were very inappropriate. He further stated that he transferred the care of the child to the pediatricians.

Yet, Facebook correspondence between him and Ms [REDACTED] dated November 26 and 29, 2013 indicates a very informal friendly and direct conversation. Dr. Dicken commented that this was

his way of being polite and it was never his intent to be unprofessional or confrontational. He simply stated he felt he was quite clear in that he had been professional and courteous in his communications with Ms [REDACTED] and Ms [REDACTED]

Dr. Dicken also acknowledged that he had told Ms [REDACTED] and Ms [REDACTED] early in their encounters that he was married with two children. However, in the phone conversation which occurred approximately 1 ½ years later there is the following exchange:

[REDACTED] But then why would you say to her,  
I'm married with two kids so I can't have a  
relationship with you.

DICKEN: Do you know why?

[REDACTED]  
DICKEN: I actually...the reason that I came over  
there...was to have that discussion with her. That's  
why I was there.

Dr. Dicken explained he was again being quite clear in terms of what his role was to them as well as what his marital status was. He felt that Ms [REDACTED] behavior was inappropriate and that any discussion around his marital status was closed.

#### **Dr. Tami Masterson**

Dr. Masterson identified herself as a practising pediatrician at the Stollery Children's Hospital and she was qualified as an expert witness in pediatric medicine, including the ethical duties of a pediatric practitioner.

Dr. Masterson testified that in her practice she sees a variety of physical, sexual and emotional abuse. She testified that there are a lot of power dynamics at play between caregivers and professionals involved in the care of children. Many of the families that she has in her practice are parented by young single mothers. Often these mothers are in a power dynamic between Children's Services and the professionals trying to service the kids. These mothers, despite their adversity and vulnerability, are actually very good at caring for their children. They are able to negotiate complex systems to meet the needs of their children. She stated that if people are resilient regardless of their age they tend to do well. Resilience is dependent on things such as education level, cognitive capacity, and factors like a person's ability to have a healthy relationship, to have community supports, and to engage in their environment and ask for help. She testified that age does not necessarily equate directly to capacity.

In reference to an intimate sexual relationship between a patient and a physician, Dr. Masterson testified that this type of relationship is unethical based on the potential for negative consequence. Furthermore, she testified that the potential for negative consequences of such a relationship occurs along a continuum.

She stated the closer the relationship, or the more intimate the relationship, the greater the likelihood of negative consequences. This is why if a physician has a relationship with the patient in their care, she viewed this as having more potential for negative consequences than when a physician has a relationship with the adult caregiver of a pediatric patient.



Dr. Masterson testified negative consequences occur when the wrong medical care or inappropriate medical care is provided. She felt that this occurs on a continuum and is often dependent on the type of care that is provided. When emotion is involved, there is a greater potential for inappropriate medical care to be provided.

She further testified that Dr. Dicken provided quite straightforward preoperative, operative and postoperative surgical care. His involvement with the patient and her mother was when surgical interventions was required. The procedures he performed were required and if the child had not undergone such procedures she may have died or had a significant adverse medical outcome. He performed the procedures in a confident and skillful manner, and she did not think that the child could have been harmed by the alleged sexual relationship between Dr. Dicken and the patient's mother.

Dr. Masterson also testified that she did not have issues with social media, texting or emails in the context of correspondence with patients, if they facilitate timely and appropriate communication between physicians and patients. Younger patients expect social media to be part of their medical care delivery. She stated that patients must understand that it might not be as secure a form of communication such as an electronic medical record.

Under cross-examination, Dr. Masterson agreed that she had a differing opinion to Dr. Eccles when it came to social media but did not disagree with Dr. Eccles' comments on the ethical obligations of a pediatric surgeon.

Under questioning from the Tribunal members Dr. Masterson stated that she did not take any specific training or courses in medical ethics.

Dr. Masterson stated that it would be unethical for a physician to have a relationship of any shape or form with the mother or father of a pediatric patient because of the potential for negative consequences.

#### **Dr. Lyle McGonigle**

Dr. McGonigle identified himself as a pediatrician practising in Edmonton. He testified that he works at the Stollery Children's Hospital and has worked closely with Dr. Dicken for about seven years. He stated he has a very good professional relationship with Dr. Dicken but does not have any social relationship with him.

He stated that he frequently observed Dr. Dicken interacting with patients' families and stated he has always been appropriate. He viewed him as being a good communicator and communicates well with both patients' parents and patients if they were old enough to communicate. He has been professional and appropriate, and seems to have a very good relationship with his patients and their families.

He further stated that he has not seen Dr. Dicken embrace or have any physical contact with the patient other than to examine them.

Dr. McGonigle stated that his and his partner's relationship with their patients is a little bit closer than it would be for a pediatric surgeon because they follow their patients for long periods of time. He stated that Dr. Dicken does not have as close a bond as perhaps he and his partner do with their patients.

Dr. McGonigle stated that he has observed Dr. Dicken deal with professional conflict as acting chair of pediatric surgery. He feels that he has done a very good job of dealing with those kinds of professional conflicts and difficulties involving other people.

He stated he has not seen Dr. Dicken deal with personal conflict in the workplace until this complaint arose. He stated that this has had devastating effects on Dr. Dicken as a result of the process.

Dr. McGonigle stated that he was quite involved with the care of [REDACTED]. He stated he has probably seen her more than 40 times, including looking after her in hospital when she was admitted to Dr. Chatur or Dr. Dicken.

He stated that Dr. Dicken was the surgeon involved with [REDACTED] care and he provided appropriate and skillful surgical and consultative care for [REDACTED].

Dr. McGonigle stated that he first met Ms [REDACTED] in the fall of 2013. He acknowledged that he did not have a lot of memory of her because she was not really that important to him in the care of [REDACTED]. The only significant memory that he could recall was when he had come to visit [REDACTED] while she was admitted to hospital. Ms [REDACTED] was in the room with [REDACTED] mom and had made the remark referring to him as another good looking doctor. He testified that he found this comment to be inappropriate and replied that all doctors at the Stollery are good-looking.

Dr. McGonigle then testified that Ms [REDACTED] made a further comment to the extent that maybe he would date her instead of Dr. Dicken, and how come Dr. Dicken didn't like her. He ignored the remarks and went on to examine the patient.

Dr. McGonigle also testified that he had met [REDACTED] father [REDACTED] on a number of occasions. He stated that he had seen him earlier in her care, in the office and in the hospital for some of the early hospital admissions.

Dr. McGonigle testified that he was never concerned that Dr. Dicken and Ms [REDACTED] had an intimate relationship. Upon receiving information from the College that a complaint had been lodged, he asked Ms [REDACTED] if there had been a relationship. She told him that they had not and that this was as a result of her roommate, Ms [REDACTED] trying to make life difficult for her and Dr. Dicken.

Dr. McGonigle stated that he asked her about this because it may have influenced whether or not Dr. Dicken should be continuing as the surgeon involved in [REDACTED] care.

Dr. McGonigle stated that he found Ms [REDACTED] to be truthful and responsible. She came to appointments when she was supposed to and was always at the bedside in the hospital. He found her to be trustworthy and honest and a very good parent for a young mom.

He further testified that Ms [REDACTED] performed the difficult procedure of anal dilation on her daughter successfully and regularly because it was what she was required to do.

Dr. McGonigle stated that he observed Dr. Dicken interacting with Ms [REDACTED] discussing [REDACTED] case fairly frequently in the hospital. He described their interactions as appropriate and she was appropriate in her interactions with him. He never saw any indication that they had a personal relationship other than as a surgeon and mother of a patient.

He further stated that he never saw Dr. Dicken hug Ms [REDACTED].

Dr. McGonigle recalled two specific events in the fall of 2013 that he would describe as unusual while Dr. Dicken was caring for [REDACTED]. The first was when he received a phone call from Dr. Chatur stating that Dr. Dicken had been trapped into taking a picture with [REDACTED] and her mother. He indicated that he was holding [REDACTED] on his lap, the mom sat on the edge of the chair and leaned in and Ms [REDACTED] snapped the picture. He felt uncomfortable about this, enough so that he was talking to Dr. Chatur about it.

The second occurred during the admission when Dr. Dicken had performed a gastroscopy tube placement on [REDACTED] he came to the nursing desk while Dr. McGonigle and Dr. Chatur were both there and said something very weird had just happened. Dr. Dicken told him that he had been in the room and Ms [REDACTED] had been very inappropriate, sexually flirting word wise with him. He requested that they take over as most responsible physician for this child for the remainder of the hospital admission.

Dr. McGonigle stated that normally, Dr. Dicken would have remained responsible physician because the admission was surgical. He and Dr. Chatur would have been consulted as required. Dr. McGonigle further stated that Dr. Dicken has transferred care of patients on a few occasions when he was going to be out of the city.

Under cross-examination from Mr. Boyer, Dr. McGonigle stated that he has always known [REDACTED] mom as [REDACTED]. He stated that he referred to her as [REDACTED] mom.

In regards to his comment that the Stollery doctors are all good-looking, he acknowledged that this was a kind of joking response to Ms [REDACTED]. He further stated that he did not want this conversation to go on and that he thought that this would stop the conversation. He felt that she was not really important to the care of this child and felt that her comment was inappropriate.

Dr. McGonigle stated that in addition to the medical record, he has reviewed information sent by the College. He stated he has not heard any recordings of conversations involving Dr. Dicken.

Dr. McGonigle stated that when Dr. Dicken came out to the nursing station, he and Dr. Chatur were at the nursing station and Dr. Dicken told him about what he experienced in the room. He did acknowledge that this was not direct experience and he did not see and did not hear the discussion Dr. Dicken described to them.

Under re-examination Dr. McGonigle stated that the care of a very ill child in the hospital can be very stressful for parents and caregivers and light comments can be made to lighten the situation. He further stated that he has never been asked on a date before in these situations.

#### **Dr. Rehana Chatur**

Dr. Chatur identified herself as a pediatrician with a private practice in Edmonton, as well as a hospital-based practice at the Stollery Children's Hospital. She stated she knew Dr. Dicken as a pediatric surgeon at the hospital. He has performed surgeries on her patients and she often refers patients that require surgery to him.

She indicated she did not have a social relationship with Dr. Dicken.

Dr. Chatur stated that she has contact with Dr. Dicken either in person or through phone or text at least for five times a week. She stated they share a lot of mutual patients and if any of those patients are in hospital there is always constant communication back and forth. She stated that she has interaction with Dr. Dicken during hospital rounds both in the morning and in the evening.

She stated that she has observed Dr. Dicken interacting with patients' families and in general views him as being very compassionate. He takes time to explain procedures to families and will answer their questions appropriately and very respectfully. He is able to interact age-appropriately from infants to older teenage children. She stated he is an excellent physician.

Dr. Chatur identified herself as [REDACTED] primary pediatrician. She was referred by Dr. Dicken when [REDACTED] was approximately three months of age. Dr. Chatur continued to follow [REDACTED] throughout her hospitalizations, and in the clinic.

She further stated that Dr. Dicken was the surgeon who performed the surgeries that were required for [REDACTED]. He continued to follow her as an outpatient. She was never concerned with Dr. Dicken's clinical decision-making and his care of [REDACTED]. She never disagreed with any of his surgical or treatment decisions.

Dr. Chatur stated that she has never met Ms [REDACTED]. She stated she has met [REDACTED] father [REDACTED] on numerous occasions. She met him in the hospital on admissions and he would come to the office with [REDACTED] and [REDACTED] for their regular office visits. Her office staff knew him quite well and would offer the family support in the forms of formula and certain supplies that [REDACTED] needed. Dr. Chatur stated that the last appointment [REDACTED] attended was on December 23, 2013. After this there was a lull until either June or July 2014. Ms [REDACTED] told her that he was having some issues with drug use and was in rehab getting help for himself.

She further stated that [REDACTED] mother [REDACTED] also used to come in as well for appointments, as well as in the hospital.

Dr. Chatur stated that she was never concerned that Dr. Dicken and Ms [REDACTED] had an intimate relationship.

Dr. Chatur described Ms [REDACTED] as a loving and caring mother who looked out for [REDACTED] needs. She stated she brought [REDACTED] for medical attention appropriately and in a timely fashion. She attended all of [REDACTED] appointments and followed through with medical management. She was quite knowledgeable about [REDACTED] knowing all her medications and feeding schedule and was well-versed in her daughter's care.

Dr. Chatur recalled two unusual interpersonal issues that arose while Dr. Dicken was caring for [REDACTED]. Based on chart notes, the first occurred on November 27, 2013. Dr. Chatur testified this was the day [REDACTED] had one of her surgeries done, and it was on evening rounds. She stated Dr. Dicken had come out of the room and described an incident in which he was asked to take a picture with [REDACTED]. He took the picture with [REDACTED] but said the photographer, who is [REDACTED] friend, had asked [REDACTED] to get in the picture as well. Dr. Chatur stated Dr. Dicken found it to be very awkward and uncomfortable. She further communicated this information to Dr. McGonigle.

The second occasion occurred the next morning when Dr. Dicken told her and Dr. McGonigle that he felt really uncomfortable providing primary care to [REDACTED] on this hospital admission. He told them that that he was uncomfortable from the photograph the night before and also had just



had an interaction with [REDACTED] friend [REDACTED] that had made him feel uncomfortable. She was told [REDACTED] had asked him questions with regards to his marital status and he just said that he didn't feel comfortable. He asked Dr. Chatur and Dr. McGonigle to assume care of [REDACTED]

Dr. Chatur stated normally, when patients have surgeries, they are kept under the care of Dr. Dicken and she and Dr. McGonigle would follow along as consultants. There may be an episode or incident where if he was to be out of town for a weekend and wanted to make sure that the patient was followed closely that he may transfer care for a weekend. But generally speaking postoperatively, the patient usually remains under the care of the pediatric surgeon.

She further testified this did not mean that he was no longer going to provide surgical care for [REDACTED] should the need arise.

Under cross-examination by Mr. Boyer, Dr. Chatur stated that she reviewed her chart notes from her office, as well as the hospital admission records prior to coming to this hearing. She denied being given any other information including audio recordings to review.

In reference to the comments made by Dr. Dicken in late November 2013, Dr. Chatur stated that she was not in the room and his remarks were relayed at the desk.

Dr. Chatur stated that she could not recall having any interaction with Ms [REDACTED]. She stated that there was no verbal communication and acknowledged that she would not be able to point her out if she was to walk into a room.

Dr. Chatur further stated that she understood [REDACTED] last name to be [REDACTED] and [REDACTED] last name to be [REDACTED]. She has been advised that [REDACTED] has changed her last name within the last six months.

Dr. Chatur testified that she takes pictures with patients and is not upset by that. This may include a parent being in the picture which she testifies is quite common.

Under re-examination by Ms Stratton, Dr. Chatur stated that she thinks the particular picture that upset Dr. Dicken made him feel uncomfortable based on the comments that were made to him and just the fact of the proximity of [REDACTED] to him in the picture.

## **V. SUBMISSIONS**

Mr. Boyer began his submissions by describing the role of the Hearing Tribunal as threefold:

- To hear the evidence and to make findings of fact.
- To identify the standards of conduct.
- To apply the facts that are found against those standards.

Evidence on the professional standard had been presented from both Dr. Eccles and Dr. Masterson. There was very little meaningful difference in the boundary or standard of physician-patient, physician-parent relationship from either witness, in that such a relationship would be a boundary violation.

Mr. Boyer presented the College of Physicians and Surgeons of Alberta Standard of Practice on sexual boundary violations, which clearly indicates the term *patient* includes, where applicable, the patient's legal guardian or substitute decision-maker.

Mr. Boyer outlined that this Hearing Tribunal must determine what the facts are after hearing all the evidence. It is to be determined on a balance of probabilities whether something, an event or an action, has occurred. From this, the Tribunal must determine what evidence is more probable or convincing, more cogent, including if the Tribunal has to make a finding of credibility.

The burden is on the College to prove the allegations based on the balance of probabilities standard.

Citing, *F.H.v.McDougall* in which the court emphasized in paragraph 40:

*... It is time to say, once and for all in Canada, that there is only one civil standard of proof at common law and that is the proof on a balance of probabilities.*

Mr. Boyer added that findings of fact also includes reasonable inferences drawn from the evidence presented. There needs to be evidence to support an inference, and while one may not have direct evidence on a specific conclusion, the conclusion is reached based on a reasonable inference from the facts.

In this matter, the issue is an allegation of sexual intercourse. There are no first-hand statements from the participants and the question for the Hearing Tribunal is whether a reasonable inference from all the evidence can be made to confirm whether or not the allegations occurred.

Mr. Boyer further stated that there is indeed conflicting stories and different versions of what occurred in this matter, and he cited the *F.H.v.McDougall* case, and specifically paragraph 57:

*There is no rule as to when, in the face of inconsistency, such doubt may arise but at the least the trier of fact should look at the totality of the inconsistencies in order to assess whether the witnesses evidence is reliable. This is particularly so when there is no supporting evidence on the central issue.*

Mr. Boyer also stated that corroboration is additional evidence to support what a witness says has happened. He referred to paragraph 80 of the same case:

*Corroborative evidence is always helpful and does strengthen the evidence of the party relying on it... However, it is not a legal requirement and indeed may not be available, especially where the alleged incidents took place decades earlier. Incidents of sexual assault normally occur in private.*

Therefore, a first-hand admission that sexual intercourse occurred is not something the law requires.

In assessing credibility, Mr. Boyer presented *Faryna v. Chorny* as a good summary of the test for credibility. He referred to paragraph 11 which states:

*The credibility of interested witness, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions.*

*Only thus can a Court satisfactorily appraise the testimony of quick minded, experienced and confident witnesses, and those shrewd persons adept in the half-lie and of long and successful experience in combining skillful exaggeration with partial suppression of the truth. Again a witness may testify what he sincerely believes to be true, but he may quite honestly be mistaken. For a trial Judge –*

Mr. Boyer stated that this Hearing Tribunal is in the best position to assess the credibility of a witness. This is based on how the witness came across, their demeanor and how they answered questions all consistent with the evidence presented. He presented *Dr. Q v. College Of Physicians And Surgeons Of British Columbia* to support this notion. In that case, the complainant had knowledge of facts that may have been neutral in isolation but demonstrated knowledge that would not have been anticipated.

In this matter, there is an actual recording of a phone conversation between Dr. Dicken and the complainant, Ms [REDACTED] therefore the Tribunal does not have to look extensively for corroboration. During cross-examination, Dr. Dicken acknowledged that there were pieces of information in his initial response to the College that were not included. Furthermore, certain statements that he made about what was discussed during the phone conversation were not reflected in the recording or the transcript of that phone call.

Mr. Boyer continued that there were a number of questions put to Ms [REDACTED] in particular whether she had been served a cease and desist letter or whether she was involved in any related lawsuits. There has been no Statement of Claim, court order or cease and desist letters to corroborate these suggestions. Furthermore there was the allegation put to Ms [REDACTED] that she took both her phone and Ms [REDACTED] phone and started sending text messages back and forth to create a false record. There has been no evidence to corroborate that this happened.

Additionally there is the question put to Ms [REDACTED] that she made Ms [REDACTED] pose for the erotic photos. Evidence from Dr. Chatur and Dr. McGonigle indicates that they were impressed with her as a mother and mature enough to care for an ill child. To suggest that Ms [REDACTED] compelled her to take these photos does not make sense.

Ms [REDACTED] also stated that M. [REDACTED] wanted to give Dr. Dicken these photographs as a type of gift. Testimony from Dr. Eccles indicated that Ms [REDACTED] would have had significant gratitude and the idea of transference, including the gift of an intimate experience, would be understandable.

Evidence from Dr. Chatur and Dr. McGonigle indicate that they were told by Dr. Dicken that he was uncomfortable when he took the photograph with [REDACTED] and Ms [REDACTED]. Dr. Chatur stated that she referred back to her chart notes and hospital records and indicated that this happened in November 2013. Ms [REDACTED] stated that this photograph was taken in October 2013. In the photographs it is clear that the child has a nasogastric tube and not a G-tube.

Dr. Dicken stated that he did not know when that picture was taken but did acknowledge that Ms [REDACTED] wanted the photo, which is not an unusual request. However he stated to his colleagues Dr. Chatur and Dr. McGonigle that he wanted to transfer care of this child to them because this photo opportunity made him feel uncomfortable. Facebook messaging, which started on November 26, 2013 indicates that he is being warned by Ms [REDACTED] about Ms [REDACTED] mother and his recognition that there is a lot of risk.

Medical evidence indicates that the insertion of the G-tube occurred on November 27, 2013. Mr. Boyer submitted that Dr. Dicken would want to have an explanation to his colleagues as to why he was transferring care. He further submitted that Dr. Dicken did not want to be the responsible physician if he was thinking about pursuing a relationship with Ms [REDACTED]

Mr. Boyer submitted that Ms [REDACTED] was a person who had come from the Maritimes and attended a year of Bible College. She seemed to be someone who was genuine.

With that, in the February 6, 2014 telephone call, Ms [REDACTED] is not looking to extort or blackmail Dr. Dicken. She just feels that Ms [REDACTED] is not respecting herself.

This is in contrast to the notion that Ms [REDACTED] was an aggressive, infatuated person that gets into a very angry, manipulative and fabricated situation when she is rebuffed by Dr. Dicken.

Mr. Boyer submitted that given the totality of the evidence, this story did not fit with what was presented in terms of the audio recording, the text messages that have been sent, the cellular records, and what Ms [REDACTED] has described.

Mr. Boyer acknowledged that there is no first-hand admission that there was a sexual relationship between Ms [REDACTED] and Dr. Dicken. However Ms [REDACTED] testimony that she has seen them lying unclothed on a mattress in the apartment living room, the text message communication between Ms [REDACTED] and Ms [REDACTED] acknowledging sexual intercourse, and the content of the February 6, 2014 phone call all serve as evidence for the Tribunal to make a reasonable inference that there has been sexual intercourse between them.

Mr. Boyer outlined some of the language in the telephone conversation in which Ms [REDACTED] expresses the view that because Dr. Dicken is married with two children and still wants to sleep with Ms [REDACTED] he does not respect her at all. Dr. Dicken responded by saying that was her opinion. Furthermore, he asked her why he didn't say something to him sooner, which must be looked at in the context of the November Facebook messages. Mr. Boyer submitted that Ms [REDACTED] at that point, had told her physician, going back on her word, and he argued that Dr. Dicken is asking her why she didn't say something to him sooner before he got committed into this course of action that was going to be a problem.

He also pointed to the exchange in which Ms [REDACTED] stated that Dr. Dicken was walking in, having sex, and walking out, to which Dr. Dicken replied that this was her observation and questioned if she really knew about the two of them. Mr. Boyer submitted that the "two of us" reflects a comment implying a serious relationship. Dr. Dicken further stated that he did respect her and it was never his intention to hurt or take advantage of her, which was also consistent with a relationship. He further stated that he wanted to have the discussion about him being married with two kids, which further corroborates a relationship.

Dr. Dicken acknowledged that it was a good question when Ms [REDACTED] asked him why he would end up in bed. This was corroborative evidence that there was an intimate sexual relationship.

Mr. Boyer submitted that Dr. Dicken did not tell the College about the various phone calls back and forth with Ms [REDACTED] because, in his view, he was dealing only with physical contact. He stated that this is only half the truth, telling only the part of the story that helps you and not the part that hurts you.

Mr. Boyer also argued that Dr. Dicken faxed his response to the College within moments of talking with Ms [REDACTED] so that he and Ms [REDACTED] could ensure that their stories were



straight. He stated that Dr. Dicken acknowledged that the College was going to talk to Ms [REDACTED] and in his telephone conversation with Ms [REDACTED] when he stated that his job was not in jeopardy, this was because he had a united front with Ms [REDACTED]

Mr. Boyer argued that the evidence presented, which included witness testimony, Facebook message exchanges, text message exchanges, cellular phone records and photographs, was entirely consistent with Ms [REDACTED] description of the events.

Mr. Boyer further submitted that Dr. Dicken viewed Ms [REDACTED] as a liability because of her knowledge and subsequently took steps to try to discredit her.

Mr. Boyer submitted that there is more than ample evidence to demonstrate, on a balance of probabilities, that the allegations against Dr. Dicken are proven and that there has been an improper boundary crossing by Dr. Dicken. A reasonable inference can be drawn from all the evidence identified that there was, in fact, a sexual intercourse relationship between Dr. Dicken and Ms [REDACTED]

Ms Stratton began her submissions by addressing the first allegation against Dr. Dicken.

She submitted that the only evidence of text messages exchanged between Ms [REDACTED] and Dr. Dicken started on January 23, 2014 after the alleged sexual contact. There is no evidence regarding the content of these messages.

The child was experiencing ongoing medical concerns and required follow-up with the pediatric care team which led up to a very complicated surgery on March 18, 2014. There is no basis for the Hearing Tribunal to conclude that these text messages are related to anything other than patient care.

Ms Stratton also stated there were a number of problems with Ms [REDACTED] evidence as it related to the remaining allegations. Ms [REDACTED] acknowledged that she wanted to record Dr. Dicken saying certain things. She kept interrupting and putting very serious allegations to him, to get him to say something. Ms Stratton stated Dr. Dicken sounded confused and uncertain, and was shocked during this conversation. He described it as being akin to hearing a cancer diagnosis, where a patient hears horrible news and just shuts down and doesn't hear what happens next.

Ms Stratton further submitted that there is corroboration that Ms [REDACTED] was texting using Ms [REDACTED] identity as described by Ms [REDACTED] to the College investigator.

Regarding the timing of the photograph with Dr. Dicken, Ms [REDACTED] and the child, it is unclear when this photo was taken. Dr. Chatur believed that this photograph was taken on November 27. It is established that surgery happened on that day when the nasogastric tube was replaced with the G-tube. All that can be said is that the picture was taken in and around the timeframe that the child had the nasogastric tube.

Dr. Dicken did tell Dr. Chatur that he felt uncomfortable with the proximity to Ms [REDACTED]. He told her this at the time it happened. He didn't tell her this after receiving a complaint from the College or when he knew this was going to a hearing. She reported it immediately to Dr. McGonigle as part of their daily patient care report.

Additionally Dr. Dicken described to Dr. Chatur how he felt uncomfortable in his conversations with Ms [REDACTED]. This occurred at the time; not months later when the complaint was received.



Ms Stratton stated that in a 112 minute interview with the complaints investigator, the other participant in these allegations denied all allegations against Dr. Dicken. This came after reassurance that she would not get in trouble, nor would it reflect poorly on her.

Ms Stratton acknowledged that Ms [REDACTED] would indeed feel very grateful to this doctor who provided exceptional care for her child, but not enough to lie for 112 minutes with details to the College investigator.

In the letter from the College to Dr. Dicken dated March 18, 2014, the College specifically asked Dr. Dicken to comment on a sexual relationship with Ms [REDACTED]. Ms Stratton suggested that Dr. Dicken did exactly that in his response. Dr. Dicken then wrote another letter providing more information, provided copies of his cell phone records, was interviewed by the College for 3 ½ hours and provided call schedules, clinical notes and letters to the College. There is no suggestion by the College at any time that he was not cooperating with them.

Given this, Ms Stratton submitted that Dr. Dicken has always been forthright with the College, and to now suggest that his initial response was somehow holding back or to suggest that he has not been forthright and not credible is unfair.

Regarding the telephone calls on the evening of March 20, 2014, minutes before he submitted his response to the College, Dr. Dicken stated that he was filling in the gaps about clinical care as it related to [REDACTED]. To suggest somehow that they were getting their stories straight is also unfair to Dr. Dicken and takes us beyond the ambit of any of the evidence.

Ms Stratton also refuted the suggestion that Ms [REDACTED] may have allegedly been paid off by Dr. Dicken. Ms [REDACTED] specifically denied this in her interview. There would be nothing to gain for Ms [REDACTED] as Dr. Dicken had already advised her that he can no longer provide further care and she had been reassured by Ms Ivans that she was safe to speak freely.

In regards to the November 27, 2013 surgery, Ms [REDACTED] gave evidence that Ms [REDACTED] and Dr. Dicken were giggling in the preoperative holding area. Dr. Dicken's testimony is that the preoperative holding area is an open space with no privacy. He also indicated that this was a life-threatening surgery and this would be the time that he is focused on what he was about to do with little room for friendly conversation.

To accept Ms [REDACTED] evidence that a surgeon as skillful as he was described to be by Dr. Chatur and Dr. McGonigle would be joking around is not realistic. Ms Stratton made the suggestion that Ms [REDACTED] credibility and evidence must be seriously questioned.

Furthermore, she questioned the evidence that Dr. Dicken supposedly said he would have to wait a year until he had finished treating [REDACTED] before he could establish a relationship. Ms Stratton submitted that Dr. Dicken's own evidence was that he anticipated treating [REDACTED] for years to come.

To accept Ms [REDACTED] evidence on this point, the panel would have to believe that a serious minded skillful physician would be so cavalier about performing life-threatening surgery that he would be openly flirting with the patient's mother, publicly and literally minutes before operating on the child. Furthermore, the panel would also have to accept this mother would be flirting back with him.

During this time frame Dr. Dicken also expressed his discomfort about dealing with Ms [REDACTED] to his colleagues. This occurred four months before the complaint was made. Ms Stratton submitted there would be no reason to make that up before a complaint was filed.

Ms Stratton was critical of Ms [REDACTED] evidence in relation to the text messages that she states were sent between Ms [REDACTED] and herself. Ms Stratton stated that these messages are undated, and noted that in Ms [REDACTED] interview with Ms Ivans she described being quite upset that Ms [REDACTED] had been taking her phone and sending messages using her identity.

Ms Stratton also submitted that Dr. Dicken did his best to piece together his whereabouts on the dates in question. Anaesthetic records show that Dr. Dicken was the surgeon for a complex procedure on November 29, 2013 ending just before 5 PM. Dr. Dicken further stated that he had to accompany the child to the intensive care unit, handover the patient and then speak with the patient's family afterwards.

Medical evidence also indicates that [REDACTED] was discharged from the hospital on November 29, 2013. Ms [REDACTED] evidence was that Ms [REDACTED] and [REDACTED] went to Ms [REDACTED] mother's home after the discharge and stayed there.

Ms Stratton submitted that if Ms [REDACTED] evidence for this November 29-30 date was accepted, it would mean that Dr. Dicken left his final surgery on November 29 in the midst of it, tapped Ms [REDACTED] on the arm in the hallway, went back later and had another conversation with her. Ms [REDACTED] would have had to bring her newly discharged baby to her mother's house, then gone back to the hospital where she would have met Dr. Dicken in his administrative office that is barely big enough to fit a desk and is in close quarters with other administrative offices and assistants' desks.

Ms Stratton also stated from Dr. Chatur's evidence that [REDACTED] father attended a clinical visit with Ms [REDACTED] on December 23, 2013 and at that time was still involved in the child's life. In her interview with Ms Ivans, Ms [REDACTED] stated that she was still with [REDACTED] father, although their relationship was on-again off-again.

Regarding the December 30, 2013 allegation, even Ms [REDACTED] evidence states that she saw Dr. Dicken at the apartment, but did not see sexual activity between him and Ms [REDACTED]. Both Dr. Dicken and Ms [REDACTED] provided contrary information that he was not at the apartment and Dr. Dicken provided evidence that he was at home with his wife, children and extended family. Furthermore, Exhibit 11 offers a letter from Dr. Dicken's spouse clarifying his whereabouts at this time. His wife confirms in relation to December 30 that her sister and brother-in-law were visiting from Miami where they spent every day at their home. Evidence from the cable company indicates on-demand movies were rented, but Dr. Dicken acknowledges that he could not pinpoint the exact times or the fact these movies could be watched a couple of days later. Nevertheless, Ms Stratton submitted that this was an all-day family event. Furthermore, in reference to Dr. Chatur's December 23, 2013 clinical notes, evidence indicates that [REDACTED] was sick. Ms Stratton makes the suggestion that it would be inconsistent for Ms [REDACTED] to present to Dr. Chatur's office with a sick child, with her child's father, and then be running around with Dr. Dicken seven days later.

Regarding the January 4, 2014 sexual encounter where according to Ms [REDACTED] she witnessed Ms [REDACTED] and Dr. Dicken lying on the mattress, Ms Stratton submitted that it would be unreasonable to suggest that a man of Dr. Dicken's stature, level and age would engage in sexual activity in the open living room of an apartment while a roommate was home and could walk by. It is contrary to the indication of how private of a person Dr. Dicken is.

Furthermore this was alleged to have occurred while his extended family was visiting. Dr. Dicken would have to leave his family, go off and engage in sexual activity and then return. He indicated that this would have been noticed by his wife, and Ms Stratton argued such behavior was inconsistent and did not make sense.

For the January 8, 2014 allegation, Ms Stratton emphasized that Ms [REDACTED] was concerned about the G-tube site and whether it was infected. She sent a picture of it through Facebook or some communication to Dr. Dicken and arrangements were made for Dr. Dicken to see [REDACTED] in the clinic the next day. Ms Stratton suggested that a responsible mother who puts her child first, and who is sufficiently worried about her child to contact the physician, would not likely be engaging in sexual relations with him only to show up in the clinic the next day.

Ms Stratton commented that Ms [REDACTED] has been portrayed as a woman who cares about her friend and wants to make sure that her friend respects herself. It is very clear that their relationship ended very poorly. Ms [REDACTED] stated that Ms [REDACTED] sent messages criticizing her and sent text messages using her identity. The relationship ended explosively and required police involvement as well as a third person, Ms [REDACTED], to act as an intermediary.

To suggest after this very dramatic and unhappy ending that Ms [REDACTED] is going to be a good friend and report a physician is not accurate. Ms Stratton suggested that Ms [REDACTED] was an angry friend and their relationship was strained.

Ms Stratton argued that in the recorded phone conversation with Dr. Dicken, Ms [REDACTED] did not sound like someone who is trying to protect her friend. She even tells Ms [REDACTED] to have fun with her conversation with Dr. [REDACTED]. This did not sound like the words of a caring friend, but more like somebody wanting to settle a score because of a relationship that ended poorly. She referred to Exhibit 4 which demonstrates hostile text communication between Ms [REDACTED] and Ms [REDACTED]. She submitted that this did not demonstrate the actions of a caring friend but more so the actions of an angry person.

Ms Stratton commented that Ms [REDACTED] Maritime roots and partial attendance at Bible school did not make her more credible, as her words and actions suggested otherwise.

Evidence presented by Dr. Dicken, Dr. McGonigle, and from the interview with Ms [REDACTED] all suggest that Ms [REDACTED] was inappropriate and this was not appreciated by anybody.

Ms Stratton continued that Ms [REDACTED] invited two men back to the apartment and pushed a stranger into the room where Ms [REDACTED] and [REDACTED] were sleeping. Ms [REDACTED] also told Dr. McGonigle that he was good-looking and words to the effect of maybe she should date him instead of Dr. Dicken.

Ms Stratton submitted that these were not the actions of somebody whose credibility ought to be accepted and whose evidence ought to be believed. These are the actions of somebody who is angry with her friend and who acted inappropriately with two physicians involved with the care of her former friend's daughter.

Ms Stratton then argued that the transcript of the recorded interview with Ms [REDACTED] showed that Ms [REDACTED] viewed Ms [REDACTED] as psychotic and jealous after they had moved in together. She denied having any attraction or any relationship with Dr. Dicken that was other than professional. She praised him for his medical competency. Ms [REDACTED] was sickened by the telephone conversation between Ms [REDACTED] and Dr. Dicken because of what she called false accusations that were the substance of the conversation.

Ms Stratton then referred to Dr. McGonigle's testimony that he had asked Ms [REDACTED] if she had a relationship with Dr. Dicken, which she denied. She presented this as additional evidence that there was no relationship between Ms [REDACTED] and Dr. Dicken.

She also argued it was significant that Ms [REDACTED] willingly participated in the investigation of the complaint and that, as the alleged victim, she did not participate whatsoever in making the allegations against Dr. Dicken and has consistently refuted them throughout.

Ms Stratton argued the rationale behind a physician not having an intimate relationship with the patient's decision-maker is that the emotional impact of such a relationship can cloud or impair the physician's judgment. She further stated that this is something that Dr. Dicken strongly believes in as he indicated he would not operate on the children of close friends. Regardless of the allegations, there was no evidence of any negative impact on the care of [REDACTED]

From the evidence presented by Dr. Masterson, Dr. Chatur, Dr. McGonigle and Dr. Dicken himself, [REDACTED] would have died if the surgeries had not been performed. She stated that Ms [REDACTED] was extremely pleased with the quality of care provided by Dr. Dicken and there were excellent outcomes from each of the surgeries.

Ms Stratton concluded that there is no clear and convincing evidence that meets the burden the College bears and therefore the charges against Dr. Dicken ought to be dismissed.

Mr. Boyer responded that, to an objective observer, there is never a situation where a sexual boundary violation appears to be a rational choice. Secondly, the role of the Tribunal as trier of fact is to assess what weight to apply to the evidence presented. Ms [REDACTED] did not come before the Hearing Tribunal, did not testify under oath, and has not been subjected to cross-examination. So the reliance placed on her recorded interview is not as sound as the recording between Ms [REDACTED] and Dr. Dicken.

## VI. FINDINGS

The charge set out against Dr. Dicken was:

- a) That between November 1, 2013 and April 1, 2014 you did fail to maintain an appropriate professional relationship with [REDACTED] [REDACTED] the 18 year old mother of your infant patient, [REDACTED] [REDACTED] particulars of which include one or more of the following:
  - i. Exchanging text messages of a personal nature with [REDACTED] [REDACTED]
  - ii. Attending at [REDACTED] [REDACTED] apartment at 2320- 119 Street for no medical purpose,
  - iii. Lying naked or semi-naked with [REDACTED] [REDACTED] and
  - iv. Having sexually intercourse with [REDACTED] [REDACTED] on one or more occasions.

There was little dispute with respect to the applicable professional standard. The Hearing Tribunal heard evidence from both Dr. Eccles and Dr. Masterson that the appropriate standard for a professional relationship between a pediatric surgeon and the parent of an infant patient would preclude any relationship of intimacy. Dr. Dicken himself testified that his understanding was that there should be no intimate relations at all with the caregiver parents or otherwise.

The Standards of Practice include provisions relating to Sexual Boundary Violations, which explicitly state that:

A physician must not:

- (a) Initiate any form of sexual advance toward a patient or a person with whom the patient has a significant interdependent relationship such as a parent, child or significant other.

The Hearing Tribunal therefore considered whether Dr. Dicken failed to maintain an appropriate professional relationship with [REDACTED] [REDACTED] as the parent of his infant patient. The onus for proving that allegation rests with the College on a balance of probabilities.

The Hearing Tribunal accepts the evidence of the Complainant, [REDACTED] that an intimate relationship had existed between Dr. Dicken and Ms [REDACTED] while [REDACTED] [REDACTED] remained under his care.

The Hearing Tribunal could not accept the evidence of Dr. Dicken as it is not consistent with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in these circumstances.

In particular, the recording of the phone call between [REDACTED] [REDACTED] and Dr. Dicken provided strong evidence that he had carried on an intimate relationship with Ms [REDACTED]. His statements during this conversation were more consistent with acknowledgement and acceptance versus denial and rejection that such a relationship did occur.

Ms [REDACTED] made several references to Dr. Dicken having sexual intercourse with Ms [REDACTED]. Dr. Dicken stated that he did not believe her claim was genuine, and in his attempt to be professional and dismissive, he did not openly deny or confront this allegation. The Hearing Tribunal could not accept this explanation in a matter as serious as this where an allegation he claimed was completely false and unexpected was repeatedly presented to him as fact during this call.

In reference to this phone call, Ms [REDACTED] stated that her main motivation for pursuing this complaint was that she wanted Dr. Dicken to stop and leave Ms [REDACTED] alone. Dr. Dicken explicitly asked why she did not talk to him and express that she was not comfortable with what he has done, or what was doing. The Tribunal felt this question was unreasonable and irrelevant if a relationship did not exist.

Ms [REDACTED] was also critical of Dr. Dicken not respecting Ms [REDACTED]. She cites that he was married with two children and still wanting to continue a sexual relationship with Ms [REDACTED]. She accused him of walking in, having sex with Ms [REDACTED] and walking out. Dr. Dicken responded by stating Ms [REDACTED] did not know him either, or what his circumstances were. He stated that this was only her observation and questioned if she really knew about the two of them.



He advised her that he respected Ms [REDACTED] and it was never his intent to hurt or take advantage of her. He further stated he was going to have the discussion about his marital status with her.

The Hearing Tribunal feels that any explicit and focused discussion regarding his marital status, as Dr. Dicken directly stated was his intent, is not relevant and extraneous in a relationship that is purely professional.

Furthermore, Ms [REDACTED] asked Dr. Dicken why he would end up in bed with Ms [REDACTED] and Dr. Dicken replied by acknowledging this was a good question. The response that this was a "good question" is inconsistent with someone who believes Ms [REDACTED] suggestions were entirely fabricated and without merit. In the tone of the recorded conversation there was no opposition or disagreement to Ms [REDACTED] question.

Dr. Dicken's response tried to explain to Ms [REDACTED] why he was there, amounting to confirmation he was at their apartment. The Hearing Tribunal did not accept Dr. Dicken's testimony that during this conversation when he referred to "there", he was referring to the hospital inpatient unit, and that his use of "there" was a mannerism of his. This suggestion is inconsistent with the conversation and issues Ms [REDACTED] was raising, and was simply not credible.

In response to Ms [REDACTED] follow-up saying that Dr. Dicken had returned to do the same thing less than a week later, Dr. Dicken acknowledged this was correct. His explanation that he was not admitting she was right, but believed he was answering a different question, was not credible based on the tone of this exchange during the recording of the call.

The Hearing Tribunal did not accept Dr. Dicken's testimony that Ms [REDACTED] allegations during the phone call impacted him so much it was akin to a person being told they have cancer. The recorded conversation and transcription shows that Dr. Dicken was actively engaged throughout the entirety of the conversation and, on his own admission, had become somewhat facetious with Ms [REDACTED]

Dr. Dicken also stated that he was a very private man and felt uncomfortable discussing details of his personal life with his patients. Specifically, he stated that only his wife and urologist knew that he had a vasectomy. Ms [REDACTED] testified that Ms [REDACTED] had told her that Dr. Dicken had a vasectomy. Ms [REDACTED] also stated she joked with Dr. Dicken at their apartment, about a friend who got pregnant despite her partner claiming to have a vasectomy. Dr. Dicken testified that he acknowledged that further children was an impossibility during a hospital encounter, but explicitly did not volunteer that he had had a vasectomy.

The Hearing Tribunal feels that Ms [REDACTED] could only have accurate knowledge of this intimate medical detail if she was told either directly or indirectly by Dr. Dicken.

Furthermore, the Tribunal noted that Dr. Dicken failed to describe the numerous phone calls, text messages and Facebook exchanges with either Ms [REDACTED] or Ms [REDACTED] in his March 20 response to the College. The Tribunal did not accept Dr. Dicken's testimony that he interpreted "contact" to refer only to a physical presence exclusively. The Tribunal felt that a reasonable, informed person would interpret contact as being any form of communication including but not exclusively physical presence, and would have in any event identified such communication. Moreover, in the transcript of the recorded phone call Dr. Dicken himself suggests to Ms [REDACTED] that she could have contacted him to let him know how she felt.

Dr. Dicken's explanations for Ms [REDACTED] comments were not plausible in the circumstances presented. The Hearing Tribunal found the testimony of Ms [REDACTED] consistent throughout the hearing. The Tribunal viewed her as credible and unshaken in response to cross-examination.

The Hearing Tribunal accepts that [REDACTED] motive for making the complaint may not have been exclusively out of Ms [REDACTED] best interest as she stated. However, this does not impact on the credibility of those accusations. If she was also motivated in whole or in part by some desire for revenge or other motive following her falling out with Ms [REDACTED] her allegations and the information presented remain credible.

Moreover, her version of events is consistent with other evidence, including text message exchanges with Ms [REDACTED] Facebook exchanges with Dr. Dicken and, most importantly, her phone call with Dr. Dicken.

While Ms [REDACTED] denied the relationship in an interview which was included as an exhibit in these proceedings, the Hearing Tribunal did not find this persuasive in supporting Dr. Dicken's version of events. Aside from the fact her interview was not conducted under oath, there were several inconsistencies in the story she presented.

Ms [REDACTED] explicitly said she had no contact with Dr. Dicken outside of hospitalizations, apart from emailing him a photo of the G-tube site infection. Cellular phone and text message records reveal conflicting information that occurred over a broad period of time. Dr. Dicken also stated in his own testimony that he had contacted her during his preparation for his response to the College regarding clarification of clinical information. Moreover, there were Facebook exchanges on January 6, 2014 between Ms [REDACTED] and Ms [REDACTED] explicitly showing Ms [REDACTED] as the Facebook user, stating she messaged Dr. Dicken for his personal cell phone number after her own cell phone malfunctioned. She stated that Dr. Dicken did provide this number to her.

Additionally, in the recorded interview with the College investigator Ms [REDACTED] stated that she had called Dr. Dicken as his private number had shown up on her cell phone. She stated that she would return displayed numbers if the call had been missed. She further stated that Dr. Dicken got mad at her for using this number, questioning how she got it and why she was calling him. He advised her not to use that number again. Ms [REDACTED] continued that the purpose of Dr. Dicken's call to her was to explain surgery and to obtain consent for a surgical procedure.

This is in contrast to Dr. Dicken's testimony. Dr. Dicken testified that Ms [REDACTED] called him raising a medical concern about the child. He stated that he indicated she should bring [REDACTED] into the hospital, and as he was not on call, he facilitated care for her at the Stollery Hospital.

Ms [REDACTED] also told the College investigator that she knew nothing about Dr. Dicken's personal life. Text message exchanges between her and Ms [REDACTED] indicate that he had notified her that he was divorced, and currently married with two children. Under questioning from the Hearing Tribunal, Dr. Dicken testified on numerous occasions, that he was quite clear in terms of what his role was to them, or to the child, as well as his marital status in discussions with them.

The alternate explanation put forward that Dr. Dicken was the victim of an elaborate frame-up by Ms [REDACTED] was not plausible in these circumstances. A frame-up of this nature would have had to begin well in advance of any erosion of the relationship between Ms [REDACTED] and Ms [REDACTED] whereas the evidence indicates that the two remained on good terms from the time of [REDACTED] birth to shortly after becoming roommates.

Facebook correspondence between Dr. Dicken and Ms [REDACTED] demonstrates a relaxed and informal tone between two individuals that were familiar and amicable with each other. The content of that conversation warned Dr. Dicken not to get involved with Ms [REDACTED] "even on the down low until the time has passed that it wouldn't be questionable". Dr. Dicken's testimony was that this was his way of being dismissive. However, in his next response he openly declares that there is a huge amount on the line for him to lose. She further advises him to delete all texts and messages between the two of them stating that she has been in a relationship like his and knows how bad it could end. She further advises Dr. Dicken not to inform [REDACTED] that she had told him this information.

The Tribunal viewed this Facebook communication as information that could only be shared between two individuals that were friendly and trusting of each other. The Tribunal could not accept Dr. Dicken's testimony that he was somewhat uncomfortable from the beginning of their encounters.

The Hearing Tribunal did not accept the notion that Ms [REDACTED] would steal Ms [REDACTED] cell phone in order to establish a text message chain detrimental to Dr. Dicken. Ms [REDACTED] stated that this occurred while the two women lived in the apartment, yet the submitted exhibits demonstrate a significant exchange, over a time continuum that precedes their cohabitation, with a level of detail that would be difficult and implausible to create or submit retroactively. And as noted above, this would have had to commence at a time when, by all accounts, Ms [REDACTED] and Ms [REDACTED] were on good terms.

Dr. Dicken argues part of [REDACTED] story was refuted because of the timing around the discharge of the child. In her interview, Ms [REDACTED] stated that her mom was frequently involved in [REDACTED] care and that Ms [REDACTED] took her mom everywhere because she felt it was too much to do on her own. The Hearing Tribunal felt it would be plausible for the child to be discharged in the evening to the care of the grandmother, and the timing of Dr. Dicken's schedule on this occasion would not have precluded contact with Ms [REDACTED] following discharge.

Finally, Ms Stratton argued that the actions Ms [REDACTED] alleges were taken by Dr. Dicken were not logical or rational, and that they would have been very irresponsible for someone in Dr. Dicken's position. However, the Hearing Tribunal accepts that people who find themselves in these situations cannot be expected to act rationally at all times, and the Hearing Tribunal accepts that whether rational or not, Dr. Dicken did engage in the inappropriate interactions with Ms [REDACTED] as alleged by [REDACTED] [REDACTED].

The Tribunal accepted the testimony of Dr. McGonigle and Dr. Chatur that Dr. Dicken provided safe, essential and competent surgical care to [REDACTED] [REDACTED].

The Tribunal accepts that the only evidence of text messages exchanged between Ms [REDACTED] and Dr. Dicken started on January 23, 2014 after the alleged sexual contact. There is no evidence regarding the content of these messages and the Tribunal does not have sufficient evidence to conclude that these text messages are related to something other than patient care.

The Tribunal accepts that Dr. Dicken attended at the apartment of [REDACTED] [REDACTED] located at 2320 – 119 Street, between November 1, 2013 and April 1, 2014. The Tribunal also accepts the evidence of Ms [REDACTED] that she witnessed Dr. Dicken lying naked or semi naked on one of those occasions, and on a balance of probabilities also concludes that Dr. Dicken had sexual intercourse with [REDACTED] [REDACTED] on one or more occasions as she had advised Ms [REDACTED].

For the foregoing reasons, the Hearing Tribunal's decision is that between November 1, 2013 and April 1, 2014 Dr. Dicken failed to maintain an appropriate professional relationship with [REDACTED] [REDACTED] the 18 year old mother of his infant patient, [REDACTED] [REDACTED] all of which constitutes unprofessional conduct pursuant to the *Health Professions Act*.

Specifically, the Hearing Tribunal concludes that Dr. Dicken attended [REDACTED] [REDACTED] apartment at 2320 - 119 Street for no medical purpose. Furthermore, Dr. Dicken did engage in an intimate relationship, having sexual intercourse with [REDACTED] [REDACTED] on one or more occasions.

## VII. ORDER

The Hearing Tribunal finds that Dr. Dicken's conduct constitutes unprofessional conduct pursuant to the *Health Professions Act*, and will hear submissions from the College and from Dr. Dicken with respect to sanction.

Signed on behalf of the Hearing Tribunal by  
the Chair

A handwritten signature in black ink, appearing to read 'Naiker', with a stylized flourish at the end.

Dated: November 12, 2015

Dr. Randy Naiker

COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF  
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,  
R.S.A. 2000, c. C-7

AND IN THE MATTER OF A HEARING REGARDING  
THE CONDUCT OF DR. BRYAN DICKEN

**DECISION OF THE HEARING TRIBUNAL OF  
THE COLLEGE OF PHYSICIANS  
& SURGEONS OF ALBERTA REGARDING SANCTION**



## **I. INTRODUCTION**

In its written decision dated November 12, 2015 (“Decision on the Merits”) the Hearing Tribunal described its findings with respect to the allegations of unprofessional conduct as set out in the Notice of Hearing, dated March 4, 2015 against Dr. Bryan Dicken. The Hearing Tribunal found that all allegations were proven.

Based on the findings of unprofessional conduct, the Hearing Tribunal met in person at the CPSA offices in Edmonton on May 27, 30<sup>th</sup>, 31<sup>st</sup> and June 1, 2016 to hear submissions with respect to sanctions.

The members of the Hearing Tribunal were:

- Dr. Randy Naiker as Chair,
- Dr. Douglas Perry, and
- Mr. William Fayers (public member).

Mr. Fred Kozak acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing were:

- Mr. Craig Boyer, legal counsel for the College,
- Dr. Bryan Dicken,
- Ms. Barbara Stratton, Q.C. legal counsel for Dr. Dicken
- Mr. Daniel Morrow, legal counsel for Dr. Dicken
- Ms. Renee Gagnon, legal counsel for Dr. Dicken

## **II. PRELIMINARY APPLICATION**

Ms. Stratton presented Exhibit 12, the Agreed Exhibits of the Sanction Hearing, containing:

1. Psychiatric assessment of Dr. Bryan Dicken on January 24, 2016 by Dr. Pierre Chue with attached curriculum vitae dated April 30, 2016.
2. Psychological assessment of Dr. Dicken on April 15, 2016 by Dr. Norman E. Brodie; report dated April 18, 2016, with attached curriculum vitae dated January 2016.
3. Report of Dr. Tami Masterson dated March 23, 2015 with attached curriculum vitae dated 2016.

Ms. Stratton also prepared a table summarizing the penalty proposed by the College compared with the penalty proposed by Dr. Dicken.

### **III. SUMMARY OF EVIDENCE**

The following individuals gave evidence on behalf of Dr. Dicken: Dr. Pierre Chue, Dr. Norman Brodie, Dr. Rabin Persad, Dr. Lyle McGonigle, Dr. Tami Masterson, Dr. Mark Evans and Ms. Heather Goetz.

Dr. Susan Ulan gave evidence on behalf of the College.

#### **Dr. Pierre Chue**

Dr. Chue identified himself as a clinical psychiatrist with over 25 years of practice experience. He is recognized as a member of the Royal College of psychiatrists in the United Kingdom, a Canadian fellow in psychiatry and an American board-certified psychiatrist. He is a full-time clinician and, as part of his clinical practice, sees patients within the hospital. Dr. Chue also performs third-party assessments for insurance companies, law firms, courts, WCB and federal government agencies such as Immigration Canada and Canada Border Services Agency.

Dr. Chue detailed his extensive experience in clinical practice in sexual boundary issues and sexual harassment. He also works with the Alberta Medical Association's Physician Support Program assisting physicians, family members and medical students with respect to mental health issues.

He stated that he has been qualified to give expert evidence in court and acknowledges that it is his responsibility to provide an objective assessment of an individual or situation that he's been asked to evaluate. He cited an example where his evidence was preferred over the evidence of another psychiatrist in a matter before the Court of Queen's Bench. Dr. Chue has provided assessments on individuals at the request of Justice Canada in a class-action lawsuit against the RCMP. He has also been involved in several class-action lawsuits acting on behalf of both a pharmaceutical company and the patients. He stated his evidence was preferred over the expert's in a successful outcome for litigation.

Dr. Chue was accepted to give expert evidence in the area of psychiatry in this matter.

Dr. Chue outlined the process that is undertaken when he is asked to evaluate a physician. First, he receives written instruction from the referring party which includes a number of questions for evaluation. He conducts a clinical interview with the individual, arranged by himself, and personally prepares the reports so he can maintain a high level of confidentiality.

Interviews consist of a number of components. One of the components involves a review and completion of rating scales by both the physician under review and Dr. Chue. The two sets of rating scales are compared in order to get objective data that otherwise may not necessarily be revealed in the clinical interview.

Dr. Chue's evidence is that his assessments always involve face-to-face interviews.

Dr. Chue testified that he assessed Dr. Dicken on January 24, 2016. He confirmed that the date of November 6, 2015 listed in his report is a typographical error. In his evidence, he elaborated in more detail about his findings contained within his report found in Exhibit 12.

Dr. Chue was tasked with eight questions related to Dr. Dicken. He conducted a comprehensive medical and psychiatric evaluation in his assessment.

He commented that Dr. Dicken found the hearing to be stressful and difficult. Dr. Dicken stated that he never thought that he would be in this type of situation. He described some difficult situations with family members that were upset and sometimes even threatening to him. He also stated that having a chaperone has left him feeling humiliated. Despite this, Dr. Dicken stated that he loves his job and would not quit his job even if he "won the lottery."

Dr. Chue outlined Dr. Dicken's past medical and surgical history as well as medication history. He identified the Dr. Dicken did not take any regular medications or suffer from any major chronic medical illnesses.

Dr. Chue also reported that Dr. Dicken did not suffer in the past from any psychiatric disorder including mood disorders, psychotic disorders, substance use disorders, obsessive-compulsive disorder, eating disorder, attention deficit hyperactivity disorder, or any impulse control problems such as gambling, compulsive spending, shoplifting, or sex addiction. Dr. Dicken has no family history of mental illness. Dr. Dicken indicated that he was an individual who was easy to get along with and not someone who sought attention. He talked about his happiness with his family and how much this was important to him.

Dr. Chue testified that a person's psychosexual history is an important component of the psychiatric assessment. It is also useful in identifying what a person finds attractive in other individuals, which is relevant in forming relationships. During the assessment, Dr. Dicken indicated that he is attracted to women who are the same age or older than him, and who are intelligent, high achieving and self-motivated. Dr. Dicken reported that his wife has the features that he finds attractive.

Dr. Chue also reported that Dr. Dicken had no prior legal history.

Dr. Chue reported that Dr. Dicken had arrived for his assessment a few minutes late because he was provided with the incorrect information by Dr. Chue. His appearance was unremarkable from a psychiatric perspective. He demonstrated good eye contact, rapport and engagement with the absence of any motor abnormalities. His speech was of normal rate, volume and tone. Dr. Dicken's affect was indicative of mild degree of tension and anxiety, but there was no marked lability of mood or excessive or inappropriate emotional distress. He did not demonstrate any features of positive mood shifts, elation or manic features. Overall, his mood appeared mildly depressed. His thought process was within normal limits and admits there was a period between December 2015 and January

2016 where he had some degree of suicidal ideation. He stated that he had lost a significant amount of weight over the past 2 ½ years. Dr. Chue reported that there was no gross abnormality of cognition and that Dr. Dicken appeared to be candid and truthful with a good understanding and appropriate insight.

Dr. Chue then testified that he found Dr. Dicken to be consistent in his account of the events with that of the Hearing Tribunal decision, as well as the CPSA investigation report. He further testified that he evaluated Dr. Brodie's report and agreed with his findings, specifically, that Dr. Brodie had not found any evidence of either neuropsychological or psychological impairment or disorder, or abnormality of personality or impulse control or anything to suggest that Dr. Dicken required treatment.

He identified the sources of information that were reviewed and referenced in compiling his report. This included the DSM-V diagnostic and statistical manual that psychiatrists use to diagnose and evaluate every psychiatric condition, as well as a number of references which address the assessment of sexual behaviours, including physicians and psychotherapists who engage in these behaviours.

Dr. Chue then provided testimony and commentary on the self-rating scales that he had Dr. Dicken complete as part of his psychiatric assessment.

Using the Zung Self Rated Depression Scale, Dr. Dicken scored in the mild depression range. On the same scale, he also scored within the mild anxiety range. Using the Beck Depression inventory, Dr. Dicken scored again within the mild depression range. Using the same inventory, he also scored within the mild anxiety range. Dr. Chue also employed the SF – 36 health survey, which is valuable in obtaining a subjective view of a person's general health and well-being. It is useful in obtaining information from an individual which may be missed during a clinical interview. Dr. Chue also employed the World Health Organization Disability Assessment Schedule, which he stated overlaps with the SF – 36 health survey. This provides a score that is useful in terms of comparing to norms of disability and functional impairment. Dr. Dicken's overall score represented no disability. He also conducted the Sheehan disability scale which indicated that Dr. Dicken had demonstrated marked impairment in terms of the domain of work, moderate impairment in social life and moderate impairment in family life. He also had Dr. Dicken complete a mood disorder questionnaire which was essentially negative for bipolar disorder. He similarly did a questionnaire for posttraumatic stress disorder which was also negative.

Dr. Chue explained the SONAR scale, a Sex Offender Need Assessment Rating Scale, developed in 2001 by the Solicitor General's office. It was developed out of a number of pre-existing scales for assessing the risk of sexual offending that includes both dynamic and stable factors that are a blend of personality, self-regulation, impulsivity, beliefs, values, and norms. The results generate a score which has validated predictability in determining the risk of sexual offense.

Dr. Chue also stated that he administered a number of observer scales including the Hamilton Depression Rating Scale and the Hamilton Anxiety Rating Scale. Dr. Dicken scored in the mild depression range and in the normal anxiety range.

He also administered a Brief Psychiatric Rating (“BPR”) Scale, which is a scale that assesses primarily psychotic symptoms or severe psychiatric symptoms. Dr. Dicken scored 30, with a lowest possible score of 24. Furthermore, the BPR assessment calculated Dr. Dicken’s degree of psychiatric impairment at 5%.

Additionally, Dr. Chue administered a specific scale called the Psychiatric Impairment Rating Scale whereon Dr. Dicken scored a percentage impairment of 1%.

Dr. Chue provided his opinion and conclusions regarding Dr. Dicken. He felt that Dr. Dicken did not suffer from any medical or psychological condition that would impact his medical practice. Specifically, there was no evidence of any psychotic affective or substance abuse disorder or any psychiatric illness. He did show signs of reactive psychological distress to current stressors with mild anxiety and depressive symptoms in conjunction with stress disorder symptoms. This however, in the opinion of Dr. Chue, did not affect his medical practice.

He continued that there were no specific treatment recommendations for Dr. Dicken but would encourage him to maintain contact with his regular family physician to ensure regular health monitoring.

In his opinion, he felt that Dr. Dicken does not suffer from any medical or psychological condition that affects his fitness to practice, and therefore he concluded that Dr. Dicken is fit to practice medicine. Additionally, in his opinion, Dr. Chue felt that there were no additional modifications or conditions on practice required to ensure safe care of patients. Furthermore, medical illness is a uniquely stressful time for patients and caregivers which affects understanding, perception, emotions and behaviours, thus it is prudent for all physicians to ensure adequate expressed consent and the presence of an independent chaperone in the majority of clinical evaluations.

In the opinion of Dr. Chue, Dr. Dicken had a good understanding of the professional boundaries between a physician and his patients, and his patient’s decision makers.

Dr. Chue felt that Dr. Dicken did not present with any of the risk factors commonly observed in sexually exploitative healthcare professionals e.g. abnormal psychosexual development, fragmented ego, poor self-esteem or lack of affectionate relationships/intimacy deficits. In his opinion, there was no evidence of neurosis or significant emotional problems. There was no evidence of impulse control or psychopathic, narcissistic, borderline personality traits, or other personality disorder.

In the opinion of Dr. Chue, Dr. Dicken does not pose a risk to female patients in his practice.



Similarly, in the opinion of Dr. Chue, Dr. Dicken does not present with any risk factors and does not pose a risk to female decision-makers of patients in his practice.

In the opinion of Dr. Chue, there was no recommendation for any ongoing monitoring of Dr. Dicken or his medical practice.

Furthermore, Dr. Chue testified in the absence of any relevant psychopathology, the probability of Dr. Dicken committing future boundary violations is extremely low.

Dr. Chue testified that he was familiar with the Gabbard Centre in Texas and their assessment process in relation to physicians that have been found to have committed boundary violations. He stated that he was not aware that treatment at the Gabbard Centre necessarily applies all of the rating scales that he utilized and discussed in his report. He admitted that there were some similarities between the assessments undertaken at the Gabbard Centre and the assessments that he conducted on Dr. Dicken. However, he commented that a full comprehensive clinical psychiatric assessment must involve a clinical interview conducted by trained and experienced psychiatrists implementing the use of rating scales which look at the aspects of general psychopathology. Furthermore, a proper evaluation requires a more comprehensive neuropsychological evaluation, encompassing personality testing, IQ testing and cognitive testing conducted by a neuropsychologist.

In reviewing reports from the Gabbard Centre, Dr. Chue commented that in his opinion, those reports do not contain the same level of history taking and use of rating scales which are found in Dr. Chue's report. Furthermore, he was of the opinion that the Gabbard Centre reports did not conform to the DSM-V type diagnosis. In order to meet the DSM-V diagnostic formulation, criteria for a particular diagnosis or diagnoses have to be met and clearly identified. The only way to achieve this is through either a scheduled interview or an appropriate rating scale. In his opinion, any assessment that does not conform to the DSM-V is not considered a comprehensive psychiatric evaluation.

Dr. Chue stated that he has not seen a comprehensive assessment of upbringing in Gabbard Centre reports, which he feels is part of a comprehensive psychiatric history. Similarly, the Gabbard Centre reports lack evaluations of psychosexual development.

Dr. Chue testified that the Gabbard Centre utilizes assessments which are no longer regarded as being reliable assessments. Specifically, he referred to the Rorschach ink blot test which, since 2009, has been discredited as it is highly subjective, and yields false positive rates which render it meaningless.

Dr. Chue also stated that based on the reports he has seen from the Gabbard Centre, it is unclear whether or not collaborative information and reports are reviewed at the time the assessment is conducted. He stated that his practice is to report all documents presented to him. When conducting a comprehensive psychiatric assessment, Dr. Chue stated that he would not proceed unless he had all this information.

Dr. Chue stated that the Gabbard Centre's process of conducting telephone interviews for collaborative information is fundamentally flawed as the interviews are largely conducted by a social worker, and not face-to-face.

Dr. Chue also stated that he does not conduct collaborative interviews for his assessments because it is the individual, and the individual alone, who is being assessed. This practice ensures that the information gathered is as pure and as uncontaminated as possible.

However, he stated that where collaborative information and reports are available, he would use that information to guide and structure or restructure questions to pose to the individual. Where collaborative information is consulted, Dr. Chue assesses the degree to which he incorporates that information into his report.

Dr. Chue stated that the Gabbard Centre, to the best of his knowledge, did not employ the SONAR scale as it is a Canadian scale and is used primarily in Canada. This was a concern for him as he believes it is important to have a validated and reliable scale to assess future risk.

Dr. Chue stated that Dr. Dicken did not acknowledge that he had an intimate relationship with this particular patient's mother. He contended that Dr. Dicken's lack of acknowledgement did not impact his decision, as he is assessing psychiatric diagnoses and personality attributes rather than admission of guilt. Even if Dr. Dicken had admitted a relationship, Dr. Chue felt that his recommendation that ongoing monitoring was unnecessary would be unchanged.

During cross-examination, Dr. Chue stated that he had never worked at nor attended at the Gabbard Centre, nor had he spoken with Dr. Gabbard or any member of the assessment team. He acknowledged that he had read a significant number of papers and book chapters that Dr. Gabbard authored.

Dr. Chue admitted that the only Gabbard Centre report that he relied on in his evidence was a single report created in February 2016. He confirmed that this was the only report that he had assessed.

Dr. Chue also stated that in his report, he listed all of the documents he relied on, including phone call between Dr. Dicken and Ms. [REDACTED]. He acknowledged that he had not heard the actual recording of the phone call.

Dr. Chue recognized that his report did not acknowledge the twenty-year age difference between Dr. Dicken and [REDACTED].

Dr. Chue testified that he did not confront Dr. Dicken about the sexual relationship and instead accepted his continued denial. He stated that Dr. Dicken's description of the events were consistent with the information he had on the record, including the investigation report. He stated that his role was not to question the investigation or the

findings of the Hearing Tribunal, but rather to provide a psychiatric assessment that may identify a psychiatric illness, or identify personality attributes that may contribute to this type of behaviour.

Dr. Chue did not consider whether Dr. Dicken's motivation for denying the sexual relationship was due to any impact that such an admission could have on Dr. Dicken's marriage. He felt that Dr. Dicken's comment that his marriage was stable and in good shape was truthful, but admits he did not speak to Dr. Dicken's wife or have any knowledge of whether she agrees with that analysis. Furthermore, Dr. Chue did not consider that his motivation for continued denial of the relationship may have been to avoid Dr. Dicken's children growing up in a broken original family.

Dr. Chue stated that he accepted the Dr. Dicken's responses were truthful, despite that the Hearing Tribunal found that Dr. Dicken was not credible.

The Hearing Tribunal asked Dr. Chue whether Dr. Dicken exhibited any remorse for the relationship with his patient's mother. Dr. Chue replied that Dr. Dicken expressed sentiments that included depression and guilt for having found himself in this particular situation. However, he could not conclude whether Dr. Dicken exhibited remorse as Dr. Dicken did not admit to the relationship during his evaluation. Moreover, Dr. Chue stated that Dr. Dicken's report of feeling helpless, but not worthless, and any guilt he may have felt referred to the Hearing process and not to the relationship itself.

Dr. Chue clarified that the SONAR scale is used within a criminal context but has applicability to a non-criminal context. He identified an inherent limitation with the SONAR scale, which is that an individual who is highly manipulative may be able to influence the score in a particular way. He emphasized that it is not a stand-alone assessment but it is still a very powerful instrument.

#### **Dr. Norman E. Brodie**

Dr. Brodie identified himself as a psychologist who conducted a neuropsychological consultation on Dr. Dicken. He testified that he has performed neuropsychological and mental health psychological assessments for a number of legal matters. These included child welfare cases, brain injury from motor vehicle accidents, employment issues, workplace accidents, fitness to return to active duty for military personnel, and competence after head injuries. He has also been contracted by lawyers to evaluate fitness to stand trial and has often given evidence in court as a qualified expert. He has also performed assessments for various professional bodies.

He further stated that he has clinical experience with individuals with respect to counselling for sexual acting out and sexual addiction. He has also provided evaluations and assessments for the motivation behind these behaviours.

For these individuals, he stated that at a minimum, he would provide a detailed emotional and personality evaluation to determine whether there is an underlying organic basis that might be driving poor impulse control or lack of inhibition.

Dr. Brodie was accepted to give expert evidence in the area of psychology and neuropsychology.

Dr. Dicken was referred to Dr. Brodie for neuropsychological assessment under the recommendation of Dr. Chue. Dr. Brodie was to determine whether Dr. Dicken was suffering from any condition that could impact his fitness for medical practice, and whether Dr. Dicken was intentionally misrepresenting himself or was impaired by any form of mental illness or personality disorder. Dr. Brodie was provided with a copy of the decision of the Hearing Tribunal, Facebook correspondence between Dr. Dicken and Ms. [REDACTED] text message exchange between Ms. [REDACTED] and [REDACTED] a transcript of the telephone call between Dr. Dicken and Ms. [REDACTED] colour photographs of Dr. Dicken and [REDACTED] with her child, and the investigation report prepared by the College of Physicians and Surgeons dated November 12, 2014.

He conducted a semi-structured clinical interview to elicit Dr. Dicken's understanding of the matter and to obtain consent to participate in the assessment. He also asked a series of leading prompts which focused on specific areas including a review of functional status, and an inquiry into symptoms and signs of stress and depression. He was specifically asked to address whether Dr. Dicken had any mental illness, to assess the validity of his responses, and to prepare a personality profile or analysis.

Dr. Brodie testified that he used a standard battery of tests based on the expanded Halstead-Reitan Neuropsychological battery which he stated was the most commonly used, and widely accepted, neuropsychological testing in North America. He also conducted additional testing to evaluate attention, concentration, memory function, processing speed, abstract reasoning and executive function as well as intellectual acumen and emotional personality. He also conducted a neurological assessment of grip strength, sustained motor speed, eye hand coordination, auditory perception and digit vigilance.

Dr. Brodie stated that there were additional tests in his range of tests that he could have performed, however this would lead to diminishing returns as the stress and fatigue of over testing could compromise the validity of the answers. He cited an example of workers under the scrutiny of the Worker's Compensation Board. These workers generated test results skewed by anxiety that were far more valid in a more neutral or supportive environment.

Dr. Brodie testified that he had conducted both a neuropsychological and psychological evaluation for neurological disease or deterioration, as either could have an adverse impact on impulse control, self-restraint, emotional pathology or depression. He further remarked that addictive disorders and personality disorders could also have an impact on the ability to use appropriate judgment and self-restraint.

Dr. Brodie also utilized additional measures from the Wechsler Adult Intelligence Scale to look at the immediate attention span of working memory. Intellectual cognitive function was assessed to determine if there was any question about decay or deterioration of mental function.

Additional self-reporting inventories including the Beck Depression and Beck Anxiety Inventory, Personality Assessment Inventory were also employed.

Dr. Brodie summarized that there was no evidence of any brain disorders, deficits or impairments that could be detected. He concluded that there was absolutely no suggestion of any compromise of neurological function that would result in reduced impulse control, self-awareness or executive function.

Dr. Brodie concluded that he could not detect any evidence of any form of a neuropsychological or psychological impairment or disorder. Clear and compelling evidence indicates that Dr. Dicken's function is fully intact and completely normal. He further stated that there was no sign at all of any neurologically-based interference with self-restraint or control over impulses.

Dr. Brodie testified that colloquially speaking, Dr. Dicken was disgustingly normal.

The only potential diagnosis that Dr. Brodie could make would be that of a mild adjustment disorder which would be appropriate in the context of this hearing.

Dr. Brodie stated that there is no scientifically validated or justifiable basis upon which any kind of psychological test can tell whether a person is telling the truth. However, it is possible to determine whether an individual has applied himself with adequate effort during the course of their evaluation. He concluded that in his opinion, Dr. Dicken did not skew the results.

He also stated that Dr. Dicken was an individual with good emotional resilience and general stress tolerance. He found no evidence to indicate impulse control disorders, or limitations on his capacity for effective self-control.

Dr. Brodie stated that his opinion was unaffected by the findings of this Hearing Tribunal. He also stated that his findings would not be different if Dr. Dicken had told him that he had an intimate relationship with the mother of his patient. He further stated that Dr. Dicken did demonstrate strong evidence of stress, anxiety and traumatization with this Hearing. Dr. Brodie was of the opinion that there is an extremely low probability that Dr. Dicken would in any way be prone to engaging in sexual misconduct in the future. He stated that Dr. Dicken did not demonstrate any indicators of poor impulse control which is a hallmark symbol or sign of increased risk of future acting out. Additionally, Dr. Dicken did not demonstrate severe chronic depression which is often a risk factor for progressive and increasingly more explicit boundary violations.



Regarding the Gabbard assessments, Dr. Brodie testified that the Gabbard Centre employed the Rorschach test which is quite controversial and extremely unreliable in terms of scoring. He also stated in his knowledge, that the Gabbard Centre also conducted collateral interviews in their assessment. This is something that he did not do with Dr. Dicken as he felt there was nothing a collateral source could provide that would be as reliable as the tests he personally administered.

Dr. Brodie stated that the Gabbard Centre also performed the evaluation of the subject's upbringing, psychosexual development and personality trait. Dr. Brodie stated that he reviewed Dr. Dicken's emotional development and history particularly with reference to past mental illness addictions and relationship issues but did not go into the detailed evaluation of psychosexual development. He continued that a detailed analysis of the early psychosexual development would essentially be irrelevant if there was no evidence of a current emotional disorder. Furthermore, he stated that he was not asked to address this issue.

Dr. Brodie's final comment regarding the Gabbard assessments was that they tend to be extremely brief and that it was impossible to determine what was done from a neuropsychological perspective.

During cross-examination, Dr. Brodie confirmed that he had not worked at the Gabbard Centre nor spoken to any healthcare professionals at the Centre.

Dr. Brodie stated that he used his clinical judgment in determining the degree and the extent of testing that was employed with Dr. Dicken. He also restated that there were no scientifically validated double tasks that will determine whether a person is telling the truth or not with regards to an allegation placed against them.

Dr. Brodie stated that he has never been involved in assessments for criminal court during the sentencing phase.

Dr. Brodie raised concern for repeated testing in the highly validated and commonly used Halstead-Reitan battery, as a person is generally more successful in subsequent attempts after having already completed the test, which compromises the validity of testing. He stated that he did not ask Dr. Dicken specifically if he had neuropsychological testing prior to his assessment. Dr. Dicken stated he had a psychiatric evaluation, but did not talk about any prior psychological or neuropsychological testing.

Dr. Brodie stated that he could find no neurological or neuropsychological explanation that led to the sexual boundary violation. He also could not find any indication of an inability to stand up to pressure, including aggressive flirtation from a young mother.

Dr. Brodie also stated that his testing was not specifically normed for healthcare professionals but stratified by age, sex and education level. He confirmed that Dr. Dicken was above average for individuals with advanced university degrees.

Dr. Brodie advised that he has been qualified as an expert in court. He did cite one example where a trial judge preferred a competing psychologist's testimony over his. He did not believe that this was the same as disqualifying him as an expert in court.

### **Heather Dawn Goetz**

Ms. Goetz identified herself as the mother of a patient whom Dr. Dicken treated.

She testified that after her son was born, he experienced a complex medical journey that was filled with numerous complications and prolonged hospital stays.

Dr. Dicken was involved in the surgical aspects of her infant's care.

She testified that Dr. Dicken was fantastic in terms of how he dealt with patients and patient's families. She had several discussions with her mother about how professional he was and how wonderful he was with parents in terms of patient communication. She stated that he was always very involved and continues to be involved in the well-being of her son. She stated that she consistently heard that patients were happy with Dr. Dicken.

Ms. Goetz stated that she had numerous one-on-one interactions with Dr. Dicken without family or her husband present and that she has never felt in the least bit uncomfortable. She stated that she was never treated in a manner that was unprofessional in any way.

She also testified that if her son was to require any surgical care in the future she would want Dr. Dicken to be the surgeon. She felt that if he was not allowed to practice medicine for a period time it would have a significant impact on her son's care as he knows the intricacies of his surgical history, unique anatomy and medical history in general. She further stated that Dr. Dicken also collaborated well with Dr. McGonigle's team and would want her son to continue having this high level of care. She explicitly stated that there would be a huge disservice to the medical community and to his patients if Dr. Dicken was prevented from practising for any length of time.

In cross-examination, Ms. Goetz stated that Dr. Dicken's pager number was the best way to get a hold of him. She denied ever using Facebook or text messaging to communicate with him.

### **Dr. Rabindranath Persad**

Dr. Persad was identified as a pediatric gastroenterologist who has worked with Dr. Dicken since Dr. Dicken started practice. He describes his relationship as purely professional with interactions occurring in the hallway and in various committees that they are both involved in. He stated he had no social interaction with Dr. Dicken.

Dr. Persad testified that each surgical member in the Department of Pediatric Surgery has a particular area of interest, but each physician also provides surgical care for patients on an emergent basis. He testified that Dr. Dicken had expertise in treating achalasia,

surgical reconstruction, perianal disease and surgical liver conditions such as biliary atresia. He further stated that Dr. Dicken was only one of two surgeons at the centre that had expertise in laparoscopic pediatric surgery.

Dr. Persad testified that the patients that he shares with Dr. Dicken tend to be complex and have ongoing medical and surgical problems that are best managed by a surgeon with extensive expertise and experience. He stated that Dr. Dicken fits this profile.

Dr. Persad testified that if Dr. Dicken was removed from the rotation of pediatric surgeons at the Stollery Children's Hospital ("the Stollery"), it would have a tremendous impact on the surgical care of pediatric patients. He stated that surgeons would need to consider whether transfer to Vancouver, Calgary or Toronto would be needed, and that it would not be fair to place other surgeons in a situation where they may not have the same skill and experience as Dr. Dicken. This may have a negative impact on the outcome of the patient.

He stated that the Department itself is facing staffing issues which may contribute to increasing wait times for patient care. He stated that Dr. Lees, the most senior of the surgical group, is planning for retirement this year. His large numbers of patients need to be redistributed for follow-up.

Dr. Persad stated that he observed Dr. Dicken interacting with patients in a variety of settings including emergency and nonemergency situations. He reports that he is very empathetic, willing to listen, and works with patients well. He feels that Dr. Dicken represents progression from the old communication methods of surgeons. He feels that Dr. Dicken's method involves sitting with a patient, having a good dialogue and having a mutual understanding of what is going to happen and what the outcomes and potential problems might be later on. He further added that he has seen Dr. Dicken interact with families of varying age groups including single moms, teenage or younger moms and has handled himself in a professional manner at all times.

Dr. Persad testified that the Hearing Tribunal must recognize that sanctions against Dr. Dicken would have an impact on families of the pediatric population of Edmonton and Northern Alberta and that it would be horrendous if a family needed to relocate because of the impact of this hearing.

Under cross-examination, Dr. Persad felt that Dr. Dicken was a very professional individual and he was surprised to hear that he was found to have had a sexual relationship with a young mother. He did acknowledge that the Department has to deal with absences because of illness, injury, physicians moving to different opportunities, death, substance addiction and retirement and if there was enough notice was given to the Department, it could make plans for those events.

**Dr. Lyle McGonigle**

Dr. McGonigle provided testimony in the initial phase of this Hearing. He stated he has known Dr. Dicken since he was a medical student and was thoroughly impressed with his knowledge. He testified that he has had an extensive ongoing working relationship with Dr. Dicken during his tenure at the Stollery. He stated he has numerous complex patients that often have surgical issues and it is Dr. Lees and Dr. Dicken that do most of the complex surgeries on the pediatric population. Dr. Lees has stepped back from practice and is close to retirement, allowing Dr. Dicken to take over and fulfil much of this role.

Dr. McGonigle stated that Dr. Dicken has developed; and continues to use, minimally invasive surgical techniques in the pediatric population. He describes this as a preferred method of surgical treatment as surgical trauma is lessened and the recovery time is lessened, which results in shorter hospital stays.

He also stated that Dr. Dicken is willing to juggle surgical times in order to get surgical procedures done. He will often operate at night and on weekends and if he agrees that a child needs surgery, he will find a way to achieve that in the fastest way possible.

Dr. McGonigle stated that there will be a significant blow to the care of pediatric patients of northern and southern Alberta, British Columbia, Saskatchewan, and the Northwest Territories if Dr. Dicken is removed from the pediatric surgical service. This would be further amplified by the fact that Dr. Lees is planning to retire within the next several months.

He believes that continuity of care, which is very important in pediatrics, would be compromised and that patients requiring surgical care would have to be sent out of the city, or perhaps out of province.

Dr. McGonigle stated that he continues to see the infant patient and her mother. He testified that he views the mother as demonstrating good maturity, good decision making regarding her child and following through with what she is asked to do.

He also stated that as a professional colleague, he views Dr. Dicken as being a very bright, intelligent and extremely skilled surgeon. Many patients have benefited from Dr. Dicken's brilliance and surgical care.

He also testified that the infant patient continues to do well, and that the mother of the infant continues to do well, but it is Dr. Dicken who has suffered severely through this process. He further commented that an appropriate penalty would not be to deprive Dr. Dicken of doing what he does so very well and consequently to deprive the pediatric population of his skills and knowledge.

**Dr. Tami Masterson**

Dr. Masterson was accepted as an expert witness in pediatric medicine. She has extensive clinical experience in pediatrics as well as in medical education including an educational role in relation to boundaries and ethics. She also provided testimony in the initial phase of this Hearing.

She stated that an intimate sexual relationship between a patient and physician would be considered unethical because of the potential for negative medical consequences to the patient. The potential negative consequences occur along a continuum of varying degrees of potential harm to the patient. She testified that if the patient is in a relationship with a physician that is caring for him or her, there is a greater potential for harm than if the physician was in a relationship with the adult decision-maker of a patient.

Dr. Masterson testified that anytime emotion is involved in the care of a patient, it can adversely affect a person's judgment or medical decision-making. This creates a potential for harm. Furthermore, while some forms of medical care are rather straightforward, other forms by their nature, are ethically and emotionally charged, such as a physician providing care at the end of life. Situations with more emotional involvement lead to a higher potential of harm.

Additionally, consent is also an important factor in the analysis of degree of harm. A relationship with a non-consenting individual or an individual that is incapable of consenting could cause harm at the far end of the continuum.

Boundary violations that occur within the clinical setting are also considered to be on the farther end of the harm continuum. This is because the patient is coming into the clinical environment expecting a certain level of respect and protection.

Dr. Masterson stated that [REDACTED] was able to provide day-to-day care and negotiate complex medical care for her infant daughter. In her opinion, she demonstrated the capacity to care for her child. Furthermore, she did not feel that age equated to capacity.

She summarized that Dr. Dicken provided competent preoperative, operative and postoperative surgical care to this patient, and that the patient required the surgical procedure. She testified that if this patient did not have the surgical procedure, she would have likely passed away or had significant medical consequences. For this reason, she believed that the infant patient was not harmed by the sexual relationship between Dr. Dicken and the patient's mother.

In cross-examination, Dr. Masterson stated that she still felt it would be unethical for a physician to have a relationship in any form with the mother or father of the pediatric patient, but noted that her determination would be along a continuum. She continued that with respect to Dr. Dicken's sanction, the sanction should fit and match the intensity of the relationship along that same continuum, rather than a sanction that is reflective of zero tolerance, black and white sanctions.



**Dr. Mark Gordon Evans**

Dr. Evans was identified as a pediatric surgeon working at the Stollery. He is also the divisional lead for pediatric general surgery, the divisional director for the division of pediatric surgery, and the surgeon chief at the Stollery.

He stated that he has known Dr. Dicken for approximately 16 years since the start of Dr. Dicken's residency training. He works with him on a day-to-day basis and has a very close professional relationship with him. They do not socialize outside of work other than at hospital functions and professional society gatherings.

He stated that the Stollery services a large portion of Western Canada including all of Alberta north of Red Deer, most of the Northwest Territories and Nunavut, northern British Columbia, northern Saskatchewan and even Manitoba. He estimates that there are roughly 50,000 emergency room visits, with approximately 8000 admissions to the pediatric wards per year. He stated that there were approximately 10,000 operative procedures done per year with 2000 of those being general surgery procedures. He reports that the workload is split approximately equally over the four surgeons that work at the Stollery.

He testified that the general surgery group within a department of surgery fulfils the basic functions of that department because the general surgery group is responsible for managing trauma, acute care and cancer surgery.

He stated that pediatric patients with relatively straightforward procedures would be referred to a surgical member and would be seen by that member. The procedure would then be performed and the surgeon would conduct a follow-up, which concludes surgical care.

There are a complex group of patients, however, that require complex procedures in which the surgeon assumes an extended management of those patients. He stated that these patients are typically followed until they are 17 years of age, at which point they are transferred to an adult service.

He stated that ongoing involvement or care of chronic complex patients is typically done by the operating surgeon as there is nothing to be gained by transferring that care to another physician.

He confirmed that Dr. Dicken is an expert in minimally invasive surgery within the pediatric population. He also has expertise in both thoracic and abdominal procedures and has brought some new procedures to the group which were not previously practiced by the other surgeons.

Dr. Evans stated that minimally invasive pediatric surgical procedures are becoming an increasingly important component of pediatric surgical management. At this point, Dr. Dicken has fulfilled that role and future recruits will likely be required to have expertise in this area.

Dr. Evans testified that if Dr. Dicken had an absence from the surgical team, it would have a profound effect on pediatric surgical management as they do not have a mechanism in both short-term and long-term to replace a person without advance planning.

He stated that Dr. Lees is scheduled to retire at the end of October 2016 which would reduce the number of pediatric surgeons from 4 to 3. A new graduate of pediatric surgery would not be able to replace him until the summer of 2017.

He further stated that pediatric surgery training in Canada has resulted in a significant shortage of available surgeons as only 2 to 3 Canadian graduates are trained every academic year.

Consequently, the loss of Dr. Dicken would result in a significant shortfall for the other pediatric surgeons. Two surgeons would be doing the work of four. This would be a tremendous increase in workload for the remaining pediatric surgeons. He stated that this would be unworkable and unsustainable.

Dr. Evans testified that patients would also have to be relocated to get the expertise and surgical management. He further noted that these procedures may not be offered in other centres.

Dr. Evans also stated that there would be a loss of mentorship amongst professional colleagues as well as residents and students in Dr. Dicken's absence.

Dr. Evans testified that Dr. Dicken has extensive involvement in international committees for the children's oncology group. His absence would shake the credibility and stature within the research world for the Stollery Children's Hospital.

Dr. Evans stated that four pediatric surgeons is a comfortable number of surgeons in relation to the group's function within the hospital. Eventually, he would like to see five or six surgeons but the current number is comfortable in terms of on-call obligations.

Dr. Evans also stated that the surgery is a practical specialty, and if a surgeon does not perform surgery on a regular basis, that surgeon will lose necessary motor skills. He stated that no surgeon would willingly take a prolonged period of time off from clinical practice and not expect to have some problems upon return. In his own view, he felt that if he were to take a break from surgery for two months, he would have issues upon his return. He stated there would be a loss of intuitive judgment and an element of skills.

Both would take time to reacquire. He stated in his career four weeks was the most time he had ever taken off at any point in time. Beyond that, it would be illogical for him to expect to take more than eight weeks off and not have it affect him to some degree.

He stated that any length of time beyond 2 months would result in a significant amount of skill deterioration. He stated that there was no science behind it, however with prolonged absence, it is logical to assume that skills would deteriorate as a function of time. Moreover, he stated that if a person was absent for four or six months of clinical practice there would be a potential threat to the individual's career.

Dr. Evans stated that with respect to monitoring Dr. Dicken in the future, the Department would do whatever it felt was necessary or whatever was mandated as a sanction. He stated that the Department would be interested in any measure that would be workable in order to get Dr. Dicken back into clinical practice as quickly as possible.

Dr. Evans stated that despite that this has been an extremely difficult time for Dr. Dicken; he has never asked to reduce his call obligation. He has carried his load and has provided exemplary care. Throughout this time, he has not been concerned that Dr. Dicken is a risk to patients at the Stollery or their families.

Dr. Evans felt that he could not overstate the impact of losing Dr. Dicken as a colleague. He could not overstate the impact that the sanction would have on Dr. Dicken's career as; in his opinion, Dr. Dicken has the potential to be outstanding both clinically and academically and has the potential to rise to a chairmanship position or even a Dean's position.

Dr. Evans also stated that removing a surgeon who is heavily involved in active clinical care would have a tremendous negative impact on patient care, patient waitlists and the load that other colleagues have to bear. This means that other surgeons will do more work, and their ability to function as administrators, teachers or researchers would be diminished.

In cross-examination Dr. Evans stated he has discussed delaying Dr. Lees retirement, however Dr. Lees remains uncommitted to remaining beyond his proposed retirement date.

Under questioning from the Hearing Tribunal, Dr. Evans was unclear whether he is required to undertake disciplinary action either as Chief of Surgery for Alberta Health Services or as part of his role in the division within the University against Dr. Dicken. He stated that he assumed that he would be flagged at the level of hospital privileging which would fall under the jurisdiction of AHS. He presumed that it would also trigger a review of some sort but did not know the consequences of that.

**Dr. Susan Ulan**

Dr. Ulan is an Assistant Registrar of the Physician Health Monitoring Program at the College of Physicians and Surgeons of Alberta. She oversees the triplicate program on behalf of the College and also provides executive support for the standards of practice development.

In her function, she often deals with physicians who have committed sexual boundary violations. She testified that after a physician has been found guilty of a sexual boundary violation, the College requires an assessment of fitness to practice. Based on this assessment of fitness to practice, the College enters into an agreement with the physician outlining treatment recommendations, further requirements for ongoing monitoring and any conditions or restrictions on practice.

Dr. Ulan stated that the primary criteria is to get an independent, multidisciplinary assessment of fitness to practice. When utilizing a program, the College strongly prefers programs that have experience assessing physicians who have experienced boundary violations.

She testified that the programs that the College uses are the Gabbard Centre in Houston, Vanderbilt in Tennessee, Acumen in Kansas and most recently a comprehensive multidisciplinary assessment program in Alberta overseen by Dr. Janet Wright.

Dr. Ulan stated that the College provides a great deal of comprehensive information including information from the Hearing Tribunal, investigation reports, hearing decisions, information and records from the treating physician and colleagues, memos and any additional conversations that have occurred. She stated that the more information that is provided, the more accurate and thorough the assessment can be.

She stated that assessments are typically done over 2 to 3 days and usually involve two psychiatrists, and may include a forensic psychiatrist, depending on circumstances. She also stated that there are usually two psychologists and a collective opinion is formed that answers the question posed by either herself or the Complaints Director.

Additionally, she stated that the reports will often include collateral information obtained from interviews with family members and colleagues. This is because self-reporting may have gaps.

The reports are used to create an agreement and the parameters under which the physician is monitored and receives treatment, which is used to formulate the practice permit.

Dr. Ulan stated that the College has been using Caniff and Associates for further boundary monitoring. She stated that Caniff and Associates is a monitoring group and not a therapeutic group. This ensures that the physicians are compliant with their practice restrictions, are taking care of their own health, and addressing their needs so that there is no risk to the public with respect to further boundary violation.

She further outlined that a typical monitoring agreement is five years. She stated that sexual boundary violations in particular do not occur in isolation and are often made by a physician who is vulnerable. She stated that there are complex circumstances often complicated by personal stressors, personality or psychological issues. These issues take time to work through and are not issues that are easy to fix or easy to address. Furthermore, the College is obligated to ensure that the public is protected, and must create a monitoring program to ensure that a physician is compliant and safe.

Despite this, Dr. Ulan testified there have been additional boundary violations which have occurred during or after the monitoring process.

Dr. Ulan stated that she reviewed the reports from Dr. Chue and Dr. Brodie. She was critical of both reports in that neither professional declared a significant amount of experience with physician assessments for fitness to practice in the context of a boundary violation.

Dr. Ulan was also critical of Dr. Chue's report because of its reliance on self-reporting and the lack of collateral information. Additionally, Dr. Dicken's testimony differed quite significantly from that of the findings of the Hearing Tribunal and there was no exploration of the inconsistency between this testimony and the evidence that was presented.

During cross-examination, Dr. Ulan stated that there is no specific literature that supports continuing care agreements lasting five years. She stated that the College's concern is to ensure that sufficient monitoring over a sufficient time period is attained to ensure that underlying health conditions, personal situations and vulnerabilities that allowed a boundary violation to occur in the first place are addressed.

She further elaborated and that College wants to be able to rely on who is monitoring the physician and how they are monitored in order to accumulate a body of evidence that ensures the physician is safe and fit to return to practice. This may include information from treatment providers, colleagues and databases such as those maintained by Alberta Health Services. The goal is to ensure reliable monitoring and to feel comfortable that a boundary violation will not occur during the period of monitoring, nor in the future. Concerns and conditions that have led to the violation are appropriately addressed and that condition is removed only when there is no concern of risk to the public. She further stated that it is not uncommon for boundary violations to have ongoing restrictions on practice that are not necessarily tied to a five-year period.

Dr. Ulan stated that she is often required to monitor physicians during the complaint process. She said the College will often restrict a physician's practice in some way, typically with chaperones. This type of monitoring may begin while the complaints process is being investigated, but she explicitly stated she is not part of the investigation.



She further stated that from the College's perspective, a boundary violation, regardless of whether it was consensual or not, is still a sexual boundary violation. She did acknowledge in severe cases of non-consensual boundary violation, there has been a voluntary and temporary withdrawal from practice pending a hearing.

She did acknowledge that in the case of Dr. Dicken, there was no voluntary withdrawal from practice.

Dr. Ulan also acknowledged that her training is not in psychiatry. During her tenure as Assistant Registrar, she has not had any reports from Gabbard, Vanderbilt or Acumen reviewed by an independent psychiatrist, or independent psychologist. She acknowledged that she was not certain whether the test administered by the various centres met scientific scrutiny based on current psychiatric and neuropsychological research. Additionally, she acknowledged that she would not be able to provide an opinion on whether a psychiatric assessment should contain diagnoses that are based on the DSM-V criteria.

Dr. Ulan acknowledged that she does not choose the psychiatric test administered by Gabbard or the other assessors, and relies on those assessors to choose the psychiatric test that will be administered. She stated that she often receives raw data from those tests, but acknowledges that she is not trained to interpret that data.

Moreover, Dr. Ulan stated that it is outside of her expertise to determine whether collateral interview should or should not be part of the psychiatric assessment. She stated that it is standard process for the multidisciplinary assessments that are used by the College and she knows that Dr. Wright's group will not do a multidisciplinary assessment if they do not have collateral information. She testified that an assessment that is totally reliant on the physician self-reporting raises concerns about the validity of the results.

Dr. Ulan stated that she was aware that Dr. Chue and Dr. Brodie received and reviewed the investigation report, Facebook message exchanges between Dr. Dicken and Ms. [REDACTED] copies of text message exchanges between Ms. [REDACTED] and [REDACTED] the decision of the Hearing Tribunal, transcript of the telephone call between Dr. Dicken and Ms. [REDACTED] as well as colour photographs of Dr. Dicken, [REDACTED] and her child. She also testified that she was aware that Dr. Chue used Dr. Brodie's report in formalizing his own opinion.

Dr. Ulan stated she was concerned that this report was not available as part of Dr. Chue's interview and that there was no re-interview based on the information contained in Dr. Brodie's report.

Dr. Ulan also stated that it would not be feasible for a physician to fly to an assessment centre such as Gabbard, then to return sometime later for subsequent additional assessment. She reported that centres like Gabbard will often offer collaborative solutions to complete testing, and may even travel to Alberta for physicians who are unable to travel. She stated that Gabbard's process is to conduct psychological and

neuropsychological testing well in advance, so that the psychiatrist coming from Texas could review this information prior to their meeting and assessment with the physician. This enables the assessors to incorporate multidisciplinary management and to address findings contained in the psychological and neuropsychological reports.

Under re-examination Dr. Ulan stated that in the reports that she has seen from the various assessment centres, there is reference to both the DSM-IV and the DSM-V diagnostic manuals.

In response to a question from the Hearing Tribunal, Dr. Ulan stated that amongst the centres in the United States that the College has used in the past, she finds that all centres use similar processes and protocols. She did state that Acumen takes longer to issue their reports which often become a barrier.

She acknowledged that the cost to the physician being assessed ranges between \$9,000 to \$10,000 USD. On top of this are travel expenses. She acknowledged that Dr. Wright's assessment is approximately \$10,000 but does not involve travel costs.

Dr. Ulan did highlight that the Alberta Medical Association does maintain a compassionate fund which physicians can access.

#### **Closing Submissions of Mr. Boyer**

Mr. Boyer first stated that the Hearing Tribunal has not heard Dr. Dicken either directly or indirectly acknowledge sexual contact between himself and [REDACTED], nor has there been any statement of remorse.

Specific to Dr. Chue, Mr. Boyer was critical that Dr. Chue did not challenge Dr. Dicken about the relationship, despite having the Tribunal findings available to him. He also did not inquire as to what caused him to have the sexual relationship. Mr. Boyer was also critical that Dr. Chue did not consider the factors put to him that denying the relationship was to protect his children and to protect his marriage.

Mr. Boyer criticized Dr. Chue for providing an opinion about the Gabbard program with limited personal knowledge and no contact with any of the assessment team at the facility and based solely on a single report.

Mr. Boyer suggested that Dr. Chue had very little experience in doing assessments for a professional regulatory body.

Mr. Boyer was also critical of Dr. Brodie, who also did not confront Dr. Dicken about the denial of the relationship with [REDACTED]. Mr. Boyer submitted that he would not expect a neuropsychologist to use the term "disgustingly normal" when assessing a 45-year-old surgeon who had a sexual relationship with a 19-year-old mother of an infant patient.

He also highlighted Dr. Brodie's testimony concerning the validity of results where a person has previously undergone neuropsychological testing. Dr. Dicken, by virtue of undergoing testing with Dr. Brodie, has subsequently affected the validity of any testing that may be used by an independent, objective, multidisciplinary assessment program that could be utilized by the College. In conducting his own testing, he has created a challenge to the validity of further neuropsychological testing.

Mr. Boyer also criticized Dr. Brodie's obligations as an expert witness because he failed to maintain objectivity when assessing Dr. Dicken. He pointed to *Teichgraber v. Gallant*, 2003 ABQB 58, where Dr. Brodie was rejected as an expert because he was found to have violated the principle of maintaining objectivity as an expert witness.

Mr. Boyer then referred to the Supreme Court of Canada ruling in *White Burgess Langille Inman v Abbott and Haliburton Co*, 2015 SCC 23, which outlines the duties of an expert. The Supreme Court of Canada noted that a decision-maker, court, or Hearing Tribunal can reject a witness out-right if they feel that the witness has failed to meet the duties of an independent expert. Furthermore, if a decision-maker does not feel that it is so egregious to reject an expert, they can certainly put weight on that expert's evidence.

Mr. Boyer made the suggestion that upon review of case law, both Dr. Chue and Dr. Brodie, in accepting Dr. Dicken's denial in the face of the findings of this Hearing, have failed to be objective and independent. Consequently, they both have failed to fulfil their duties as expert witnesses and do not provide any independent and objective advice that is of use to the Hearing Tribunal.

Furthermore, neither Dr. Chue nor Dr. Brodie addressed the factors that drove Dr. Dicken to his decision to have a sexual relationship with his patient's mother. Despite this omission, both provided the recommendation that no monitoring, no treatment and no conditions on practice were required.

Referring to the Provincial Court's decision in *R v Graham*, 2008 ABPC 227, the Court respected the experience and qualifications of the psychologist Dr. Dalby, however was critical of the acceptance of Mr. Graham's denial of the offense. The Court subsequently rejected Dr. Dalby's opinion that Mr. Graham did not require psychological counselling. The court stated that when an expert accepts the denial of a person found guilty, the expert fails in its duty to provide the court with the necessary independent and objective expert opinion.

Mr. Boyer referred to Dr. Ulan's testimony where she stated that most boundary violations are as a result of an irrational decision. He noted that bright people with promise, seniority and experience do not rationally make a decision to have a sexual relationship with a patient's mother. Dr. Brodie and Dr. Chue did not address Dr. Dicken's decision making process, and consequently their assessments are of little value to the Hearing Tribunal because they do not help the Tribunal understand why Dr. Dicken had the sexual relationship with Ms. P., and how the factors that drove the decision can be prevented.

Mr. Boyer also stated that testimony from Dr. Dicken's colleagues and Ms. Goetz described him in a manner that is uncharacteristic for him to have done what he has done. Mr. Boyer submitted that character evidence does not prove or disprove an event and is not relevant for sanction.

The character witnesses also described that if Dr. Dicken were away for more than a few weeks; there would be serious negative consequences to the pediatric department, Dr. Dicken's own surgery skills, and to Dr. Dicken's pediatric patients and their families. Mr. Boyer suggested that the notion that a lesser sanction should be imposed due to the importance of Dr. Dicken's skills and his role in the pediatric department at the Stollery Hospital is a flawed legal argument. He referred to *Visconti v. The College of Physicians and Surgeons of Alberta* 2912 ABCA 46, where the Court of Appeal rejected the idea that a physician who practices in an area where physicians are in high demand should be held to a lower standard of accountability than other physicians.

In terms of determining sanctions, Mr. Boyer made reference to *Jaswal v. Newfoundland (Medical Board)*, [1996] NJ No 50 at para 36 which provided a non-exhaustive list of factors that ought to have been considered when imposing a proper penalty applicable to the case at hand. These factors are:

1. The nature and gravity of the proven allegations.
2. The age and experience of the offending physician.
3. The previous character of the physician and in particular the presence or absence of any prior complaints or convictions.
4. The age and mental condition of the offended patient.
5. The number of times the offense was proven to have occurred.
6. The role of the physician in acknowledging what had occurred.
7. Whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made.
8. The impact of the incidents on the offended patient.
9. The presence or absence of any mitigating circumstances.
10. The need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine.
11. The need to maintain the public's confidence in the integrity of the medical profession.
12. The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, and being the type of conduct that would fall outside the range of permitted conduct.
13. The range of sentences in similar cases.

Mr. Boyer acknowledged that while there may be a spectrum of sexual boundary violations, it is quite clear that a sexual relationship between a pediatric surgeon and the parent of an infant patient is completely unacceptable. This was corroborated by testimony from both Dr. Masterson and Dr. Eccles.

Mr. Boyer also stated that Dr. Dicken was 42 years old at the time of the relationship. He was not a new and inexperienced physician. Conversely, he was much more established in his life and had resources available to know his professional obligations to maintain an appropriate boundary.

Dr. Dicken has had no previous disciplinary findings against him.

██████ was known to be an unmarried 19-year-old mother facing the daunting task of caring of a new baby with a serious medical condition. This contributed to significant power imbalance between ██████ and Dicken.

The Hearing Tribunal found that the sexual relationship with ██████ occurred on a number of occasions.

Dr. Dicken steadfastly denied an inappropriate relationship with ██████. This denial continues even after the findings of this Hearing Tribunal. Mr. Boyer referred to *Quaidoo v. Edmonton (Police Service)*, 2015 ABCA 381 where the Alberta Court of Appeal stated:

Moreover, the presence or absence of insight, acceptance of responsibility or remorse at a hearing are properly considered at sentencing.

As Dr. Dicken has not shown remorse or acknowledged his actions, his continued denial must be considered in the Hearing Tribunal's decision for sanctions.

In regard to factor 7 above, Mr. Boyer submitted that there have been no penalties or sanctions imposed on Dr. Dicken to date. There has been no evidence of any Alberta Health Services or hospital privileging consequences that have been imposed on Dr. Dicken.

Because ██████ has not testified, there's been no evidence presented indicating the impact of the incidents upon her.

Mr. Boyer submitted that there were no mitigating factors in the favour of Dr. Dicken that have been submitted as evidence.

Mr. Boyer also submitted that there is a significant need for both specific deterrence to Dr. Dicken, and to the profession at a large in order to ensure the safe and proper practice of medicine, thereby ensuring protection of the public.



In relation to factor 11, he submitted that the public must have confidence that the members of the medical profession will act ethically and professionally at all times. The public must also have confidence that the College will protect their interests when a physician has been found to have acted unprofessionally in having a sexual boundary violation. As noted by Dr. Ulan, this includes monitoring the physician over a significant period of time to ensure there is a reliable body of proof that the risk of re-offending has been addressed.

Mr. Boyer stated that a sexual boundary violation is universally and totally unacceptable and has been since the dawn of the profession of medicine. This point was also supported by Dr. Eccles and Dr. Masterson.

In regards to the range of sentences in similar cases, Mr. Boyer provided a chronological outline of previous discipline matters involving boundary violations. He highlighted that sanctions on the low end of the spectrum were dated and they were reflective of Council's decisions and the decisions upheld by the Court of Appeal in recent years.

Mr. Boyer submitted that Dr. Dicken continues to deny the existence of the sexual boundary violation and both Dr. Chue and Dr. Brodie did not provide any explanation of why the sexual relationship occurred. He continued that this is a glaring omission and a question that needs to be addressed by a multidisciplinary team, instructed by the College and given the full record along with collateral information.

Mr. Boyer proposed that the Hearing Tribunal should order:

1. Dr. Dicken's practice permit shall be subject to a suspension of 18 months, of which Dr. Dicken shall serve a period of 16 months of active suspension from the practice of medicine starting on a date determined by the Complaints Director, with the balance of the suspension being held in abeyance pending his successful completion of the terms and conditions ordered by the Hearing Tribunal.
2. Dr. Dicken, at his own cost, to complete a boundaries course which is acceptable to the Complaints Director, by December 31, 2016 or such later date which is acceptable to the Complaints Director.
3. Dr. Dicken shall, at his own cost, attend and fully cooperate in a multidisciplinary assessment conducted at the Gabbard Centre, in Bellaire, Texas, under the supervision of Dr. Glen Gabbard (or one of the other programs utilized by the College) (the "Assessment"), and the Assessment shall be completed no later than 120 days after the issuance of the Hearing Tribunal decision on sanction. The Assessment will be coordinated by Dr. Susan Ulan, Assistant Registrar responsible for the Physician Health Monitoring Program of the College, and Dr. Ulan shall provide a copy of the Assessment report, and any further reports from the Assessment team, to Dr. Dicken and to the Complaints Director.

4. In the event that the Assessment finds that Dr. Dicken is unfit to practice medicine, Dr. Dicken's practice permit shall be suspended effective immediately, and shall remain suspended notwithstanding the suspension imposed in accordance with paragraph (a) having expired, until such time as Dr. Dicken has demonstrated to the satisfaction of Dr. Ulan that Dr. Dicken is fit to return to the practice of medicine.
5. In the event that the Assessment recommends that Dr. Dicken should have one or more conditions imposed on his practice permit, Dr. Ulan shall impose the condition(s) On Dr. Dicken's Practice Permit in Accordance with the Assessment, and if Dr. Dicken does not accept Dr. Ulan's interpretation of the assessment when imposing a condition on Dr. Dicken's practice permit, the Hearing Tribunal determine if one or more conditions should be imposed on Dr. Dicken's practice permit, and if so, the nature, scope and duration of the condition(s).
6. Dr. Dicken shall undertake and fulfil, at his own cost, any treatment program that may be recommended by the Assessment, and if there is any need for clarification regarding the nature, scope or duration of the treatment, the clarification shall be provided by the Assessment team and the Hearing Tribunal reserves the right to determine the nature, scope or duration of the treatment, recommended by the Assessment team, to be under taken by Dr. Dicken.
7. Notwithstanding any other term of the Order of the Hearing Tribunal, Dr. Dicken's practice permit shall be subject to the condition that he shall see any female parent of a patient or any female patient over the age of 15 only in the presence of a chaperone, who is successfully completed a chaperone training course approved by the College, and this condition shall remain on Dr. Dicken's practice permit until it is determined by Dr. Ulan that a chaperone is no longer required.
8. Dr. Dicken shall be responsible for the full cost of the investigation undertaken by the College and the hearing before the Hearing Tribunal with such costs to be paid in full within thirty (30) days of the date of the Order of the Hearing Tribunal, or on such terms that are acceptable to the Complaints Director.
9. Dr. Dicken, at his own cost, shall enter into and fulfil the terms of a continuing care agreement with the College for participation in the Physician Health Monitoring Program for boundary violators for minimum period of five (5) years after the date the continuing care agreement is signed.
10. If the Complaints Director believes that Dr. Dicken has not fulfilled any requirement of the Order of the Hearing Tribunal, or he has breached a condition on his practice permit arising from the Order of the Hearing Tribunal, the Complaints Director, on written notice to Dr. Dicken, can request the Hearing

Tribunal to determine if Dr. Dicken shall serve all or a portion of the unexpired portion of the suspension imposed in accordance with paragraph (a) above.

The Hearing Tribunal questioned Mr. Boyer regarding whether he was aware of any specific examples of boundary issues involving the relatives of patients. Mr. Boyer cited the example of Dr. Healley, where the patient terminated the doctor-patient relationship and prior to the onset of the sexual relationship, however Dr. Healley continued to treat the children of the former patient. He also cited Dr. Faul as a similar example as well as the matter involving Dr. Bell, which was not sexual intercourse, but was touching. In that example, Dr. Bell continued treating the husband and children while the relationship was ongoing. Mr. Boyer stated that he has not seen the exact fact scenario presented in this case involving a pediatric surgeon involved in a relationship with the mother of an infant patient.

#### **Closing Submissions of Ms. Stratton**

Ms. Stratton began her submissions by responding to Mr. Boyer's suggestion that Dr. Brodie's testimony should be afforded less weight due to the fact that his evidence was not accepted by the Court civil case 13 years ago.

Ms. Stratton cited *Kube v Edmonton Police Service*, 2013 ABCA 438, where the Law Enforcement Review Board found that it was improper for the Tribunal, that is the Presiding Officer in the police disciplinary hearing, to discount Dr. Brodie's evidence based on the earlier decision referred to by Mr. Boyer. She continued that the Alberta Court of Appeal stated it was unreasonable for the Presiding Officer to put no weight on Dr. Brodie's evidence and ignore the other evidence. The matter was returned to the Law Enforcement Review Board for redetermination and ruled that it would be unreasonable to discount Dr. Brodie's evidence against the backdrop of other evidence presented.

In regards to their objectivity, Ms. Stratton stated that Dr. Chue and Dr. Brodie were asked to conduct psychiatric assessments and neuropsychological assessments respectively, and that regardless of the findings of the Hearing Tribunal, each practitioner would still need to undertake the same analysis to arrive at their conclusions.

In regards to ongoing monitoring and the College's proposal of a five-year continuing care agreement, Ms. Stratton submitted that there has already been a condition in place in excess of two years that Dr. Dicken have a chaperone. She also submits that a one-year continuing care agreement is appropriate. She noted Dr. Evan's evidence that the department is prepared to do whatever is necessary and whatever is mandated including continuation of the chaperone and formal monitoring of Dr. Dicken's patients.

Ms. Stratton addressed the issue of Dr. Dicken's lack of remorse and lack of acknowledgment of the boundary violation. She stated that every physician faced with an allegation of misconduct is entitled to defend himself throughout the entire hearing process. Dr. Dicken defended his actions throughout the proceedings and has maintained

that no sexual relationship with the mother of his patient occurred. Dr. Dicken maintained this position throughout his psychiatric and neuropsychological assessments and, for him to now admit otherwise would be inconsistent with the detailed information that he provided during the investigation and under oath at the hearing. The Hearing Tribunal's decision, while respected by Dr. Dicken, does not make it incumbent upon him to agree with the panel's findings. It does not require him to be remorseful. It does however require him to be respectful of the process and to cooperate throughout.

Dr. Dicken has remained cooperative and respectful throughout the entire investigation and the initial hearing process, and continues to do so through the sanction phase. He has remained respectful and cooperative with the College and has acted in a courteous manner throughout.

Ms. Stratton submitted that although a guilty plea and apology may be a mitigating factor in certain circumstances neither denial of guilt nor lack of remorse can be considered an aggravating factor with respect to sentencing in a professional disciplinary situation. She continued that Dr. Dicken is entitled at law to defend and to continue to defend the charge throughout the disciplinary process, without in any way jeopardizing his position when it comes to sentence. She stated that it would be an error in law for the Tribunal to impose a harsher sentence because Dr. Dicken availed himself of his right to deny the allegation and to defend himself throughout the process.

She referred to *The College of Physicians and Surgeons of Ontario v Gillen*, [1993] OJ No 947, at para 6:

It is not clear from the reasons whether the Committee was “punishing” the doctor for denying the charges or if it had concluded that the only way to adequately protect the public was to revoke his license and force them to get psychiatric treatment before applying for reinstatement. In either event the Committee would be wrong. Any doctor is entitled to deny allegations made against him or her and to require the College to establish such allegations. If he or she chooses to admit the allegations, that may be taken into account in the appropriate circumstances in setting a penalty, but in no circumstances should denial serve to increase what would otherwise be an appropriate penalty.

Ms. Stratton referred to *Quaidoo*, cited by Mr. Boyer, and submitted that the Court's comments were misinterpreted. She stated that the Court's comments do not provide judicial authority for increasing Dr. Dicken's sentence in this case because of his continued denial and failure to show remorse. She argues that this case does not provide authority for the Hearing Tribunal to view this as an aggravating factor.

Ms. Stratton submits that *Quaidoo* arose out of professional investigation into the conduct of a police officer charged with using excessive force and deceit. The officer assaulted a young person in custody and proceeded to lie about it in his police report.

This lie continued throughout the entire disciplinary process. The ongoing nature of the deceit which paralleled the deceit charge arising from the false report was the basis for the presiding officer's decision to treat the process history as an aggravating factor.

Ms. Stratton submits that this is entirely different than the facts in this matter, where Dr. Dicken has defended himself throughout the process as he is entitled to do. To confirm with the *Quaidoo* case, Ms. Stratton submits that Dr. Dicken would have had to engage in continuing relationships with the mothers of other patients during the investigative process and throughout the entire hearing, which has not occurred.

Ms. Stratton submitted that the College's proposal of an 18-month suspension with two months held in abeyance is unreasonable and unsustainable. She referred to *Gillen*, which involved nonconsensual sexual conduct with an unwilling, anaesthetized female patient. The physician had an unblemished record, outstanding academic achievement, and very high references from character witnesses who held him in the highest esteem. In addition to the disciplinary process, this case was also subject to a criminal prosecution. The Ontario Court of Appeal held that a nine-month suspension for nonconsensual sexual conduct of a criminal nature was appropriate given that it was a first offense and the outstanding achievements in the prior characteristics of the physician.

Ms. Stratton also cited *The College of Physicians & Surgeons (Ontario) v Boodoosingh*, [1993] OJ No 859, held in Ontario Divisional Court. In that case, the physician, a psychiatrist, had commenced treatment of a 30-year-old female patient who was very depressed and anxious as a result of her prior sexual affairs. There was a mutual agreement of a single act of intercourse. The discipline committee revoked Dr. Boodoosingh's license, however on appeal, the Ontario Divisional Court noted that a reprimand alone is devastating to the recipient and the penalty imposed is more serious than many penalties imposed for criminal offenses. The court held that the discipline committee failed to give proper weight to the background of the doctor and reduced the penalty to a reprimand and a three-month suspension. The Court concluded that the penalty of revocation was too harsh and was not consistent with the evidence placed before the committee. The Ontario College of Physicians & Surgeons appealed the decision and the Ontario Court of Appeal dismissed the College's appeal.

Ms. Stratton submitted that the facts of *Boodoosingh* are far more egregious than the findings in this matter. In particular, the physician engaged in a sexual relationship with his patient, as opposed to the mother of his patient. In that case, the physician was the patient's psychiatrist, and therefore used his knowledge of her vulnerabilities and her mental condition to pursue relations and ultimately engage in consensual sexual intercourse. Those facts warrant a longer suspension than the facts concerning Dr. Dicken. In that matter the suspension ordered was three months.

Ms. Stratton stated that the College must balance patients, physicians and the public in determining the proper outcome. From Dr. McGonigle's testimony, the infant is thriving, growing and developing. Additionally, there is no suggestion that [REDACTED] was in any way harmed by Dr. Dicken.



The College wishes to show that boundary violations by physicians must be sanctioned; therefore Ms. Stratton argues that a suspension sends a strong message to the public. However, in this case, the length of a suspension must also balance another aspect of the public that needs significant consideration. As described by Dr. McGonigle, the pediatric population of northern Alberta, Saskatchewan, Northwest Territories, Manitoba and even Southern Alberta may be harmed by Dr. Dicken's prolonged suspension. Dr. Evans testified that the removal of Dr. Dicken from the group would result in an unsustainable, unworkable 2-to-1 on call schedule. Additionally, minimally invasive procedures could no longer be performed at the Stollery for the period of the suspension.

Ms. Stratton stated that these factors are considerations that must be highlighted when determining the period of suspension for Dr. Dicken. She maintained that this consideration does not require the panel in any way to lower the suspension for any reason other than what is set out and reflected in case law.

Ms. Stratton also noted that Dr. Evans' evidence was that any prolonged period would result in a surgeon losing his surgical skills and his intuitive judgment. Dr. Evans testified that in his opinion, approximately four weeks is the maximum time that a surgeon can take off, beyond which a surgeon's surgical skill set deteriorates.

Ms. Stratton submitted that Dr. Dicken has agreed to undergo many of the stringent conditions set out in the penalty chart submitted to the Hearing Tribunal at the outset of the hearing. With regards to cost, Dr. Dicken has agreed to pay the cost of the investigation and hearing which is estimated to exceed \$100,000. Dr. Dicken has had a chaperone for in excess of two years and the existence of this condition is recorded on the College's website and accessible by the members of the public. This continues to be an ongoing source of embarrassment for Dr. Dicken. Evidence submitted by Dr. Brodie, Dr. Chue, Dr. McGonigle and Dr. Evans confirms the Dr. Dicken has suffered greatly through this investigation and continues to suffer. He has lost his privacy and is currently mildly depressed. The decision in sanction of this matter will become a matter of public record and knowledge, which is in itself significant punishment for a practitioner with an unblemished record.

In regard to further assessment requirements, Ms. Stratton submitted that the College is not satisfied that Dr. Dicken is free of underlying psychopathology. She stated that the behaviour reflected in the findings can and does happen in other professional occupations and situations. It is not the type of behaviour that requires underlying psychopathology.

Ms. Stratton stated that Dr. Chue is a highly accomplished psychiatrist with significant experience in assessing individuals, including professionals. He has given expert evidence in court numerous times, spoken at length about the nature of the assessments that he performs including the SONAR test, and that all diagnoses should be made under the DSM-V criteria.

In contrast, Dr. Ulan testified that the Gabbard Centre inconsistently uses DSM-V, and was unfamiliar with the SONAR tests.

Ms. Stratton stated that Dr. Brodie is an experienced psychologist with extensive clinical practice including assessing individuals involved in sexual acting out. He holds a teaching position at Concordia University where he teaches the practice of administering neuropsychological assessments. He performed a variety of tests and provided detailed professional explanation of their results. Dr. Brodie cautioned against over testing and testing as a “hired gun” as both circumstances can provide invalid results.

Ms. Stratton emphasized Dr. Brodie’s evidence, which is that Dr. Dicken has an extremely low probability of engaging in future conduct of this nature. He has been so traumatized by the process that he is fearful of going through this process again. Dr. Brodie stated that in his opinion, Dr. Dicken has none of the risk factors that would lead to future sexual transgression.

By contrast, Dr. Ulan testified that she relies on the assessors to choose, administer, and interpret tests. Furthermore, their reports are not reviewed by an independent psychiatrist or an independent psychologist to ensure their integrity. Additionally, there are concerns surrounding the application of the DSM-V criteria in the reports obtained from the multidisciplinary centres used by the College.

Ms. Stratton submitted that competent assessments have already been performed on Dr. Dicken and should not be repeated as they are repetitious, unnecessary and risk invalid test results due to repeated testing and retesting under adverse conditions.

She stated that if the panel wishes to have Dr. Dicken tested, she would submit that Dr. Wright’s organization undergo this testing rather than putting Dr. Dicken to the additional expense of having an American assessment, and the stress of being away from his family.

Ms. Stratton stated that experts in this hearing have outlined that sexual boundary violations occur along a continuum and that a physician relationship with a patient is further along that continuum carrying a greater risk of harm, than a relationship involving the patient’s decision maker. Consequently, Ms. Stratton argued that the Hearing Tribunal should weigh evidence that has been given during the penalty portion of this hearing, consider related policy issues at play, and should exercise its right to come up with a penalty that is proportional to the events. She submitted that the suspension sought by the College is entirely disproportionate to the findings.

She made reference to The College of Physicians and Surgeons of Ontario decision regarding Dr. Javad Peirovy. In this matter, Dr. Peirovy was found to have conducted five medical examinations on five separate complainants that violated their sexual integrity. Two of these exams resulted in a criminal conviction of sexual assault. The findings of the panel for these nonconsensual boundary violations was five months, and the matter was referred to the Attorney General for consideration of criminal charges.

Ms. Stratton then provided a summary of several boundary violation cases and the length of suspension associated with those cases.

In the Dr. Ferrari suspension decision, there was a three-month sexual relationship with a current or recent former patient. There was also failure to make arrangements for the continuation of the patient's care after deciding that he would no longer be her physician. It was unclear whether inappropriate conduct occurred during medical exams but nonetheless a consensual sexual relationship was established. In that case there was a 12-month suspension, with six months to be actively served.

The second example provided was the *Gillen* decision. In this matter, there was nonconsensual sexual contact resulting in a nine-month active suspension. It was unclear whether or not there were criminal charges or a referral to the Attorney General for criminal charges.

The third example of case law was the Dr. Faul disciple matter. This involved a three-year consensual sexual relationship that began after the patient left Dr. Faul's medical care. The physician continued to provide medical care to the patient's husband and three children during the relationship. The determination was nine-month suspension.

The Dr. Forestal matter involved a three-month consensual sexual relationship which included three occasions of sexual intercourse. During the relationship the individual remained a patient. The sanction was a suspension of nine months with six months of active suspension.

In the Delacruz decision, there was nonconsensual sexual contact between the physician and a minor aged patient. The physician received a six-month active suspension and the matter was referred to the Attorney General for criminal charges.

In the Haraphongse matter, there was a seven-month consensual sexual relationship where the patient remained under the care of the physician during the relationship. This resulted in a six-month suspension with two months of active suspension. It was not referred for criminal charges.

The Tsujikawa decision was an 11-month inappropriate personal relationship where the patient remained under the care of the physician during the relationship. The patient ultimately moved in with the physician confirming a consensual relationship. The suspension was six months with three months of active suspension.

The Holder decision involved a consensual sexual relationship where the patient remained under the care of the physician during the relationship. There were no criminal charges and the suspension was three months and three weeks actively served.

The Hunter decision involved a consensual relationship where the physician terminated the doctor-patient relationship. The couple later married, but the physician was suspended for two months with one month being actively served.

The Hearing Tribunal questioned Ms. Stratton about whether it was a cost consideration, or time consideration that formed the basis for opposition to further assessments. She

explained that there were concerns with the Gabbard's assessment and were mindful that the hearing panel may wonder if there are psychological or neuropsychological issues with respect to Dr. Dicken. She felt that having a fulsome independent assessment by a psychiatrist and psychologist would be able to answer the College's questions and address their issues. By conducting independent assessments early in the process, the Hearing Tribunal would have some understanding as to whether there was underlying psychopathology or a psychiatric condition.

While the decision to send Dr. Dicken for further assessment is entirely at the discretion of the Hearing Tribunal, Ms. Stratton explained that it would seem to be unnecessary and repetitive to place him at further expense which he would otherwise not have to face.

### **Questions by the Hearing Tribunal**

The notion of delaying the commencement of suspension in order to accommodate recruitment of a new surgeon was rejected by both parties. Mr. Boyer stated that the risk is always whether or not the recruitment actually comes to fruition and what the course of action would be if it did not occur. Ms. Stratton stated that Dr. Dicken is seeking a timely disposition of all aspects including the decision of the suspension, so that he does not have this decision lingering and being subjected to additional stress.

The Tribunal also asked Mr. Boyer whether or not he had any concerns with Dr. Wright's firm conducting further assessment if directed by the Hearing Tribunal. He acknowledged her method is being used in Alberta and could be an option.

The Hearing Tribunal also made reference to the discipline decision of Dr. Stewart wherein that physician was permitted to practice during a certain number of days within his period of active suspension. The Hearing Tribunal inquired of both counsels whether this could be an option for Dr. Dicken. Both parties were somewhat opposed to this notion and Mr. Boyer stated it would create logistic issues with practice permit issuance and may create more problems rather than solve problems. Ms. Stratton expressed the same sentiments highlighting issues with the practice of surgical medicine including on-call obligations.

## **IV. ORDERS**

The Hearing Tribunal has carefully considered the submissions of both Mr. Boyer and Ms. Stratton, and makes the following orders pursuant to s 82 of the *Health Professions Act*:

### **1. Period of suspension**

Dr. Dicken will be suspended for a period of nine months where three months will be actively served with the balance held in abeyance pending successful completion of all other terms and conditions.

**2. CME**

Dr. Dicken shall complete a boundaries course by January 31, 2017.

**3. Assessments**

Dr. Dicken shall attend a multidisciplinary assessment with Dr. Wright's organization. The assessment is to be completed prior to the conclusion of the active suspension at Dr. Dicken's expense.

**4. Practice Permit**

If Dr. Wright's assessment deems Dr. Dicken unfit to practice medicine, the Practice Permit shall be suspended effective immediately until Dr. Dicken has demonstrated to Dr. Ulan that he is fit to return to the practice of medicine.

**5. Conditions Imposed on Practice Permit**

If Dr. Wright's assessment recommends that Dr. Dicken should have one or more conditions imposed on his Practice Permit, those shall be imposed, subject to Dr. Dicken bringing this before the Hearing Tribunal for determination

**6. Attendance at Treatment Program**

Dr. Dicken shall undertake at his own cost any treatment program recommended by Dr. Wright's assessment.

**7. Chaperone**

The Hearing Tribunal does not order a requirement for a Chaperone.

**8. Cost of Investigation and Hearing**

Dr. Dicken shall be responsible for the cost of the Investigation and Hearing to be paid within 90 days of the date of the Order or on such terms that are acceptable to the Complaints Director.

**9. Continuing Care Agreement**

Dr. Dicken shall enter into, at his own cost, a Continuing Care Agreement to participate in the Physician Health Monitoring Program for Boundary Violators for a period of two years after the date that the continuing care agreement is signed.



## **10. Failure to Fulfil Any Requirement**

If Dr. Dicken fails to fulfil any requirement of the Order and condition of his Practice Permit, the Complaints Director, on notice to Dr. Dicken, can request the Hearing Tribunal to determine if Dr. Dicken shall serve a further period of active suspension or any other sanction.

## **V. REASONS FOR ORDERS**

The Hearing Tribunal considered the parties' submissions regarding the factors that should be considered in determining the appropriate orders. In considering the orders to be imposed, the Tribunal referred to *Jaswal v. Newfoundland (Medical Board)*. The Hearing Tribunal finds that the following factors are relevant when considering what orders should be imposed pursuant to s. 82 of the HPA.

### **1. Nature and gravity of the proven allegations:**

Dr. Dicken was found guilty of a serious violation of physician ethics by having a relationship with the mother of a pediatric patient for a five month period between November 1, 2013 and April 1, 2014. The College of Physicians and Surgeons of Alberta Standards of Practice is very clear that a physician must not sexualize any interaction with the patient, initiate any form of sexual advance towards a patient, respond sexually to advances made by patient, terminate a physician-patient relationship in order to pursue a sexual or personal relationship, or initiate any form of sexual advance towards a previous patient where there is a risk of "power imbalance" from the previous physician-patient relationship.

More relevant to this matter, the College of Physicians and Surgeons of Alberta includes in its definition of *Patient*, the patient's legal guardian or substitute decision-maker.

While the Hearing Tribunal recognizes that there is a continuum of boundary violations as outlined by Dr. Chue and Dr. Masterson, Dr. Dicken's actions were still in violation of the CPSA's standards of practice and the Canadian Medical Association's code of ethics.

However, the Hearing Tribunal accepts the evidence of Dr. Chue and Dr. Masterson that the boundary violation in Dr. Dickens case falls on the low end of the spectrum.

The Tribunal also recognizes that the relationship was consensual and no criminal activity occurred. The Tribunal also recognizes that Dr. Dicken provided competent and necessary surgical care to the infant patient and accept that there is no evidence that her care was jeopardized in any way.

Given the nature of the boundary violation, the sanction imposed upon Dr. Dicken must be commensurate with the fact that the boundary violation was on the low end of the spectrum.

## **2. Age and experience of the member:**

Dr. Dicken was 43 years old at the relevant time period he had been practising pediatric surgery since 2009. The Hearing Tribunal accepted that he is an experienced pediatric surgeon. The Hearing Tribunal accepted Dr. Chue's testimony that Dr. Dicken had a good understanding of the professional boundaries between the physician and the patients and the patient's decision makers.

Even though Dr. Dicken understood his professional boundaries, he nevertheless engaged in conduct amounting to a sexual boundary violation. This type of conduct is unacceptable for any physician, and it is especially troubling given Dr. Dickens medical experience, position within his department, and his knowledge of his professional obligations. Despite the fact that this is Dr. Dicken's first citation with the College, Dr. Dicken is not a recent graduate with a limited appreciation of his professional and ethical obligations. Based on the evidence of Dr. Chue, there is no doubt that Dr. Dicken ought to have known that his relationship with [REDACTED] was outside of appropriate professional boundaries.

The period of suspension imposed on Dr. Dicken must be more than a nominal one month suspension as suggested by his counsel. Dr. Dicken was aware of the rules and clearly violated them. This factor militates in favor of the more stringent sanctions as suggested by the College.

## **3. Previous character of the member and presence or absence of any prior convictions:**

Dr. Dicken had no prior complaints or convictions with the College. Character evidence was provided by professional colleagues as well as a family member of a treated patient. Those witnesses hold Dr. Dicken in high regard for his leadership, expertise and patient communication skills. Those witnesses also testify that this behavior is uncharacteristic of Dr. Dicken.

The Hearing Tribunal has also heard that Dr. Dicken is a valuable member of the Stollery pediatric surgical team, and displays exemplary surgical skills and a high standard of patient care.

The Hearing Tribunal does not have any evidence before it regarding the reasoning behind Dr. Dicken's decision to engage in an inappropriate relationship with [REDACTED]

## **4. Age and mental condition of the offended patient:**

[REDACTED] was 19 years old at the relevant time period. Evidence heard indicates that she was a responsible parent capable of making complicated decisions for the care of her daughter. The Hearing Tribunal accepted that [REDACTED] was a mature, competent adult who engaged in a consensual relationship with Dr. Dicken. There is no evidence to indicate

that there was coercion of any type, or any other external pressure or factor that contributed to this relationship.

The Hearing Tribunal, however, is also conscious of the evidence of Dr. Eccles that [REDACTED] was a young single mother facing the daunting task of caring for a new baby with a serious medical condition that required multiple surgeries to correct. The Hearing Tribunal accepts Dr. Eccles' evidence that this led to a significant power imbalance between Dr. Dicken and [REDACTED].

**5. The number of times the offense was proven to have occurred**

As set out in the Notice of Hearing dated March 4, 2015, Dr. Dicken failed to maintain an appropriate professional relationship with [REDACTED] including sexual intercourse on one or more occasion between November 1, 2013 and April 1, 2014. This is a significant boundary violation.

**6. Role of the member in acknowledging what occurred:**

The Tribunal recognizes that Dr. Dicken cooperated fully with the College during the investigation of this matter.

The Tribunal also recognizes that Dr. Dicken has agreed to pay the full cost of the investigation and hearing.

Dr. Dicken has not admitted that this relationship occurred and consequently has not exhibited any remorse for the relationship. The Hearing Tribunal does not view Dr. Dickens continuing to maintain his innocence as an aggravating factor when determining sanctions. However, the Hearing Tribunal is mindful of the fact that Dr. Dicken has been found guilty of a sexual boundary violation with the mother of an infant patient. In considering *Quaidoo v Edmonton (Police Service)*, the Alberta Court of Appeal has noted that it is appropriate to consider the absence of insight and the acceptance of responsibility or remorse at sentencing, which can be mitigating in relation to the sanction imposed.

The Hearing Tribunal agrees with both counsel for the College and counsel for Dr. Dicken that Dr. Dicken's lack of acknowledgment and remorse amounts to the lack of a mitigating factor in determining his sanction.

**7. Whether the member has suffered other serious financial or other penalties as a result of the allegations:**

The Hearing Tribunal heard evidence from Dr. Chue and Dr. Brodie indicating that Dr. Dicken has suffered significant emotional distress over the complaint, investigation and subsequent hearing of this matter. The record also reflects that Dr. Dicken has complied with the requirement for a chaperone for his patient encounters which Drs. Chue and

Brodie suggest has contributed to Dr. Dicken's embarrassment, stress and subsequent mild depression.

The Hearing Tribunal accepts Mr. Boyer's submission that the chaperone requirement was imposed as a protection to the public during Dr. Dicken's continued practice until his sanction was determined. The previous requirement for a chaperone is not a penalty or sanction imposed by the Hearing Tribunal as a result of the boundary violation finding against Dr. Dicken.

One benefit of a continued chaperone would be general deterrence as other physicians would be dissuaded from engaging in misconduct with the knowledge that a chaperone would be imposed. The Hearing Tribunal feels that this outcome has likely already been satisfied as the evidence of Dr. Dicken's colleagues indicates their awareness of the chaperone requirement since the complaint was made.

The Hearing Tribunal does not find it necessary or appropriate to order that Dr. Dicken see any patient over the age of 15 with a chaperone. The Hearing Tribunal feels that Dr. Dicken is not likely to engage in boundary violations in the future, therefore promoting specific deterrence through the requirement of a chaperone is unnecessary in this case.

Dr. Evans testified that there would likely be additional sanctions from a privileging perspective passed down from Alberta Health Services. The Hearing Tribunal notes that this is speculative given Dr. Evans' evidence that he would not be the one to impose sanctions or to limit privileges, and that there has been no evidence on this point from Alberta Health Services or any superior within the department who would have the power to impose an additional sanction.

As mentioned, Dr. Dicken has also agreed to be responsible for cost of the investigation and hearing. This amount is expected to exceed \$100,000.

#### **8. The impact of the incident on the offended patient:**

Dr. McGonigle testified that [REDACTED] and her child are doing well, however we have no direct evidence from [REDACTED] or any other evidence regarding the emotional impact this incident may have had on her. This factor is therefore neutral.

#### **9. The presence or absence of any mitigating circumstances:**

Dr. Dicken was found to have no underlying psychological or neuropsychological pathology that contributed to this boundary violation. However, the Hearing Tribunal is not satisfied that the factors leading to the boundary violation were explored fully in the psychiatric and neuropsychological assessments. This may be due in part to the fact that these assessments were initiated by Dr. Dicken's defense counsel with specific questions to be answered in the assessment by the respective professionals.

While the Tribunal did apply some weight to the testimony of the respective professionals, the Tribunal does not view these assessments as being complete and comprehensive. Therefore, the Tribunal orders that Dr. Dicken attend the independent multidisciplinary program managed by Dr. Wright – a program mutually agreed to by both parties.

Dr. Dicken's counsel submitted that Dr. Dicken's exceptional reputation, his significant contributions to the pediatric surgical community, his status as a top-tier member of the department of surgery, and his role as a teacher and mentor in clinical and research activities should amount to a significant mitigating factor. The Hearing Tribunal does not accept this argument and instead follows the direction of the Court of Appeal in *Visconti v College of Physicians and Surgeons of Alberta*.

The Hearing Tribunal is sensitive to the needs of the pediatric surgical population, but is not influenced by the notion that a physician as specialized as Dr. Dicken should be exempt from meeting professional standards for ethical behaviour. The Court of Appeal in *Visconti* specifically rejected the idea that a physician who practices in an area where physician are in high demand and short-staffed should be held to a lower standard of accountability than other physicians.

#### **10. Need to promote specific and general deterrence:**

In terms of specific deterrence, the Tribunal feels that the sanctions imposed on Dr. Dicken by way of active suspension, costs, and further assessment by Dr. Wright will reinforce the importance of meeting his obligations to the College and his expectations as a professional.

The Hearing Tribunal finds that Dr. Dicken understands the boundary between a physician and the patient and the patient's decision-maker. The Hearing Tribunal accepts the evidence of Dr. Chue and Dr. Brodie that he is at low risk for future boundary violation recurrence. This leads the Hearing Tribunal to accept that the need for specific deterrence in this case is low. However, The Tribunal also accepts Dr. Ulan's testimony that most boundary violations are as a result of an irrational decision. This issue was not assessed thoroughly by either Dr. Chue or Dr. Brodie; therefore, the Hearing Tribunal does not have enough information to determine that specific deterrence is definitely not an issue in this case.

Consequently, this Tribunal orders the Dr. Dicken enter into a Continuing Care Agreement to participate in the Physician Health Monitoring Program for Boundary Violators for a period of two years commencing upon completion of the active suspension. The Tribunal feels that this will meet the College's needs in gathering a body of evidence in determining an unrestricted return to practice.

For the reasons above, the Tribunal also concludes there is no requirement for an ongoing chaperone.



The need for general deterrence is more pressing in this case. Sexual boundary violations of this nature are very serious, and the physician community should be well aware that this type of conduct will be met with significant sanction. The fact that Dr. Dicken will be subject to a period of active suspension and will be subject to a continuing care agreement will bring public awareness to the significant consequences that are imposed if a physician is found to have committed a boundary violation. Dr. Dicken's sanction is illustrative of the harmful effects on the physician's skills, practice and professional reputation, as well as the significant effects on patient care that occur where a physician engages in unprofessional conduct deserving of sanction.

**11. The need to maintain the public's confidence in the integrity of the profession:**

While there may be a spectrum of sexual boundary violations, it is quite clear that a sexual relationship between a pediatric surgeon and the parent of an infant patient is completely unacceptable. This Hearing Tribunal accepts that the public must have confidence that the members of the medical profession will act ethically and professionally at all times. The public must have confidence that the College will protect the public's interests when a physician has been found to have acted unprofessionally.

Counsel for Dr. Dicken urged the Hearing Tribunal to balance the need to maintain public confidence that physicians will not be permitted to commit boundary violations against the loss of public confidence in the surgical team and/or the deleterious effects on patient care at the Stollery Children's Hospital. The function of the Hearing Tribunal is to address the loss of public confidence in the profession due to a physician's misconduct by imposing an appropriate sanction. It is not the function of the Hearing Tribunal to address the public's confidence in the healthcare system due to a lack of surgical staff.

The sanction imposed upon Dr. Dicken is appropriate notwithstanding any gaps that may arise in patient care as a result of his absence. It is the role of Alberta Health Services to ensure adequate staffing regardless of the cause of a physician shortage, whether it be through conduct sanctions, retirement or otherwise.

**12. The degree to which the offensive conduct was outside the range of permitted conduct:**

There is no dispute that the boundary violation that occurred in this case is well outside the range of permissible conduct by a physician.

**13. The range of sentences in similar cases:**

There was no case law presented to this Tribunal which specifically demonstrated a consensual, noncriminal boundary violation between a pediatric surgeon and the guardian of the patient. However, the Hearing Tribunal was provided with a number of cases by both counsel for the College and counsel for Dr. Dicken that are helpful in determining a just and appropriate sanction.

Given the seriousness of the boundary violation which occurred in this matter, the Hearing Tribunal felt that a suspension comprised of both active suspension and suspension held in abeyance is appropriate in this case. The Hearing Tribunal is mindful that many of the cases referenced by Mr. Boyer involve more significant periods of active suspension; however, the Hearing Tribunal also notes that many of these cases involve more egregious misconduct which occurred over a longer period of time than occurred in this case.

Dr. Dicken was not subject to any criminal proceedings as a result of his conduct, no harm came to his patient, and there was no finding that Dr. Dicken violated the sexual integrity of [REDACTED]

The Hearing tribunal also notes that the boundary violations in most of the cases cited involved patients rather than caregivers of patients.

Further, some of the cases referenced, such as Dr. Forrester's case, referred to the physician seducing of the patient. We have no evidence of that in this case, and the only evidence before the Hearing Tribunal is that the relationship between Dr. Dicken and [REDACTED] was consensual.

The Hearing Tribunal accepts that the conduct involved in this case is most closely aligned with the conduct of Dr. Haraphonagse and Dr. Hunter. The Hearing Tribunal is also mindful of the fact that no mitigating factors exist in considering the appropriate sanction.

The Hearing Tribunal finds that suspension for nine months, with three months actively served and the rest held in abeyance pending completion of all terms and conditions, along with independent assessment and future Continuing Care Agreement monitoring is appropriate to sanction the unacceptable conduct of Dr. Dicken that compromised the integrity of the medical profession.

Signed on behalf of the Hearing Tribunal  
by the Chair



Dated: November 7, 2016

\_\_\_\_\_  
Dr. Randy Naiker