COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. ALTAF KHUMREE

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA REGARDING SANCTIONS

I. INTRODUCTION

[1] The Hearing Tribunal consisting of Dr. Alasdair Drummond as Chair, Dr. Erica Dance and Mr. Jim Lees, Public Member held a hearing into the conduct of Dr. Altaf Khumree on January 30, 2020. The Tribunal issued its decision finding Dr. Khumree to have engaged in unprofessional conduct on May 13, 2020. The parties agreed to adjourn the Tribunal's determination of sanctions pending the outcome of a physician assessment process. The sanctions stage of the hearing was later scheduled for June 7, 2021.

[2] The sanctions hearing commenced on June 7, 2021 and was continued on August 9 and 10, 2021. This is the Hearing Tribunal's decision on sanctions.

II. PRELIMINARY MATTER

[3] The Complaints Director called two witnesses on June 7, 2021, but Mr. Boyer advised that he also planned to call Ms. Kristy Ivans, an investigator for the College of Physicians and Surgeons of Alberta. Mr. Boyer indicated that he had planned to call the patient, [redacted] to testify but she declined to participate. Mr. Boyer therefore proposed to call Ms. Ivans to testify about her 2016 interview with [redacted], a May 30, 2016 memorandum Ms. Ivans had prepared regarding the interview and regarding communications between [redacted] and the College. Ms. Prather and Ms. Singh, counsel for Dr. Khumree objected to Ms. Ivans' proposed evidence, primarily because the proposed evidence would be hearsay and they would be unable to cross-examine [redacted]

[4] The Hearing Tribunal then received submissions from the parties in relation to the objection.

Submissions on behalf of Dr. Khumree

[5] Ms. Prather and Ms. Singh provided written and oral submissions in support of their objection to Ms. Ivans' testimony and the May 30, 2016 memorandum. Ms. Prather submitted that Ms. Ivans' testimony and the memorandum would be irrelevant, unreliable, unnecessary as well as lacking in probative value, but highly prejudicial to Dr. Khumree. She submitted that introducing the evidence would be unfair.

[6] Ms. Prather submitted that the memorandum summarizes Ms. Ivans' interview of [redacted] It was not taken under oath and there is no indication that [redacted] was asked to verify the contents of the memorandum. The memorandum includes [redacted] description of her relationship with Dr. Khumree and makes numerous, highly inflammatory accusations about Dr. Khumree. Ms. Prather submitted that the College has been aware of these accusations since May of 2016, but they remain unproven and unsubstantiated. These accusations were not the subject of the charges in the Notice of Hearing, so they are irrelevant to the determination of sanctions in this case.

[7] Ms. Prather acknowledged that section 79(5) of the *Health Professions Act*, RSA 2000, c. H-7 provides that evidence may be given before the Hearing Tribunal in any manner that it considers appropriate, and it is not bound by the rules of law respecting evidence

applicable to judicial proceedings. Nevertheless, the Hearing Tribunal must conduct its proceedings fairly, in accordance with procedural fairness and natural justice. Ms. Prather submitted that the Tribunal must consider whether it would be fair to admit Ms. Ivans' testimony and the memorandum and to allow the evidence to affect the Tribunal's decision. This is particularly so in professional discipline cases since a "high standard of justice is required when the right to continue in one's profession or employment is at stake…" and a "disciplinary suspension can have grave and permanent consequences upon a professional career."[1]

[8] Mr. Prather then submitted that relevance is central to the admissibility of evidence. Information that is not relevant to a material issue is not admissible. In addition, hearsay evidence is presumptively inadmissible since there can be no meaningful, contemporaneous cross-examination of the source of the information. While hearsay can be admitted in some circumstances, where it meets the joint criteria of necessity and reliability, Ms. Prather submitted these criteria should not be considered to have been met in this case. She referred to previous cases in which hearsay evidence was found to have negatively impacted the fairness of the proceedings.

[9] Ms. Prather submitted that in *New Brunswick v. Bond*,[2] a hospital attendant was dismissed from employment based on a patient's complaint of sexual assault. The patient did not testify in the resulting grievance proceeding and the adjudicator relied on the hearsay evidence of others about what the patient had told them. The New Brunswick Court of Appeal held that the adjudicator was close to relying solely on hearsay evidence and thus failed to ensure the fairness of the proceedings. The decision was quashed.

[10] Similarly, Ms. Prather submitted that in *Murray v. Saskatchewan Veterinary Medical Association*,[3] the Discipline Committee had admitted a videotaped interview statement into evidence and used it in finding the veterinarian guilty of unprofessional conduct. On appeal, the Saskatchewan Court of Appeal held it was inappropriate to have admitted the videotaped statement because it was unnecessary. The regulator could have compelled the witness shown on the videotape to attend the hearing and testify, but it chose not to do so. The Court held that mere inconvenience is not sufficient to establish the necessity of admitting hearsay evidence.

[11] Ms. Prather concluded that the vast majority of Ms. Ivans' proposed testimony and the memorandum would not be relevant to the issues in the sanctions hearing. Since Dr. Khumree had admitted the allegations against him, the facts of his personal relationship with ███, his self-prescribing and his failure to report to the College are not disputed. Ms. Prather acknowledged that the memorandum would be relevant to the extent that it speaks to the impacts of Dr. Khumree's actions on ███ as this is a factor relevant to the determination of sanctions in professional discipline cases, but the majority of the memorandum goes beyond these impacts and is irrelevant, highly prejudicial and lacking

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[1] *Baker v. Canada (Minister of Citizenship & Immigration)*, 1999 SCC 699 at para. 25, citing *Kane v. University of British Columbia*, [1980] 1 SCR 1105 at p. 1113.
[2] *New Brunswick v. Bond*, 1992 CanLII 2434 (NBCA)
[3] *Murray v. Saskatchewan Veterinary Medical Association*, 2011 SKCA 1.

in probative value. The evidence would serve only to paint Dr. Khumree in a bad light and risks biasing the Tribunal against him. It would therefore be procedurally unfair to admit and rely on Ms. Ivans' proposed testimony or the memorandum.

[12] Ms. Prather submitted that Ms. Ivans' testimony and memorandum are also hearsay and therefore presumptively inadmissible to prove that the statements attributed to are true. Ms. Prather submitted that it is unnecessary to admit Ms. Ivans' proposed testimony and the memorandum because lives in Calgary and she could be compelled to testify. Alternatively, she could have been asked to provide a victim impact statement. Ms. Prather also submitted that Ms. Ivans' evidence would be unreliable and it would be unfair to Dr. Khumree for the Hearing Tribunal to rely on it. was not under oath when she spoke with Ms. Ivans, nor is there any indication that she verified the contents of the memorandum. There are no indicia of reliability that might justify the admission of this evidence.

[13] Ms. Prather submitted that procedural fairness requires that Dr. Khumree be afforded the right to cross-examine an opposing witness. If the Tribunal receives Ms. Ivans' testimony and the memorandum, it would deny Dr. Khumree the ability to cross-examine the source of the information, which was This would damage Dr. Khumree's ability to defend himself against the inflammatory and unproven allegations attributed to Receiving Ms. Ivans' testimony and memorandum would also amount to permitting the College, which is the complainant in this case, to create evidence for the purposes of a hearing. Ms. Prather suggested that this would also be procedurally unfair since the evidence is likely to be self-serving and incomplete and subject to a reasonable apprehension of bias.

Submissions on behalf of the Complaints Director

[14] On behalf of the Complaints Director, Mr. Boyer submitted that Ms. Ivans' testimony and memorandum are relevant to the matters before the Hearing Tribunal; the Tribunal has the authority to admit evidence in any manner it considers appropriate and it is not bound by rules of evidence; and the Tribunal is capable of assessing the evidence before it and assigning an appropriate amount of weight to that evidence. Mr. Boyer submitted that the Hearing Tribunal should allow Ms. Ivans to testify and admit any exhibits tendered during her evidence. Mr. Boyer suggested the Tribunal could determine the weight to apply to Ms. Ivans' evidence as it deems appropriate.

[15] Mr. Boyer submitted that Ms. Ivans' evidence would speak to the effect that the discipline process has had on and her reasons for declining to participate any further.

[16] Mr. Boyer referred to section 79(5) of the *Health Professions Act* and argued that it demonstrates the legislature's intention that the rules of evidence applicable in Court should not apply to proceedings before the Hearing Tribunal. Mr. Boyer submitted that the provisions of the *Health Professions Act* must be given precedence over the common law, including principles of natural justice and procedural fairness. He explained that "it

is not open to a court to apply a common law rule in the face of clear statutory direction", citing *Ocean Port Hotel Ltd. v. British Columbia (General Manager, Liquor Control and Licensing Branch*.[4]

[17] Mr. Boyer then referred to the *Murray v. Saskatchewan Veterinary Medical Association* case provided by Ms. Prather, where the Saskatchewan Court of Appeal discussed a tribunal's ability to accept and consider hearsay evidence when it is not bound by the rules of evidence. The Court was discussing legislation similar to section 79(5) of the *Health Professions Act*. The Court of Appeal held at paragraph 26:

> Section 22(4) grants to the Committee the power to accept any evidence it considers appropriate and further provides it is not bound by the rules of laws concerning evidence. Thus, the Committee has the power to admit hearsay evidence and does not therefore need to determine whether the hearsay evidence is reliable as a precondition to admitting it. The weight and probative value given by the Committee to the admitted evidence may ultimately lead to other issues of procedural fairness…
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> > Tribunals that are not subject to the common law rules of evidence may rely on hearsay evidence even if it deprives the other party of any possibility to cross-examine or challenge the witness. The hearsay evidence must, however be relevant and the decision-maker must give it appropriate weight given the circumstances. Nevertheless, it may be an error for the decision maker to base its decision solely on hearsay evidence, unless the decision maker has valid reasons for doing so. The tribunal will also err if its decision is based on insufficient or no evidence, or on irrelevant considerations. In such circumstances, the decision may be set aside.
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> > However, at this initial stage, the Committee has the power to admit evidence which it may ultimately find to be unreliable.

[18] Mr. Boyer asserted that the Hearing Tribunal is not bound by the rules of evidence that apply in Court, so the Tribunal is not required to apply common law evidentiary rules, such as the need to consider the reliability of the evidence. The Tribunal should determine whether the evidence would be relevant, and if so it should determine the appropriate weight to place on the evidence in its deliberations.

[19] Mr. Boyer then submitted that Ms. Ivans's testimony and her memorandum are logically probative to the issues before the Hearing Tribunal. He explained that the Tribunal must consider the impact of Dr. Khumree's conduct on the affected individual, and Ms. Ivans' evidence is relevant to this. Mr. Boyer also noted that the Hearing Tribunal had not yet been provided with Ms. Ivans' memorandum or heard her testimony. It would be difficult for the Tribunal to assess the relevance of the evidence without having seen it, but Ms. Prather had acknowledged that portions of Ms. Ivans' memorandum would be

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[4] *Ocean Port Hotel Ltd. v. British Columbia (General Manager, Liquor Control and Licensing Branch*, 2001 SCC 52

relevant and admissible. Mr. Boyer submitted it would therefore be appropriate to admit and hear the evidence, and then assign it the appropriate amount of weight. Mr. Boyer said it could be unfair for the Hearing Tribunal to refuse to consider evidence that is admittedly relevant.

Reply Submissions on behalf of Dr. Khumree

[20] In their reply submissions, Ms. Prather and Ms. Singh acknowledged that specific sentences in the memorandum summarized [redacted] information about the impacts of Dr. Khumree's actions on her, but the vast majority of the memorandum contained highly inflammatory and unproven allegations that would be irrelevant. Their proposal to admit a redacted version of the memorandum was refused, and the Complaints Director had failed to justify admitting the entire memorandum into evidence. They submitted that the Complaints Director's only reason for seeking to introduce Ms. Ivans' evidence was to unfairly prejudice Dr. Khumree.

[21] Ms. Prather acknowledged that section 79(5) of the *Health Professions Act* ousts the requirement to strictly apply the rules of evidence that would apply in court, but she submitted that natural justice and procedural fairness still apply. The Legislature did not intend to oust these principles before the Hearing Tribunal. Ms. Prather also acknowledged that the Tribunal is not required to determine the reliability of Ms. Ivans' evidence at this stage of the process, but she pointed to the Alberta Court of Appeal's decision in *Wright v. College and Association of Registered Nurses of Alberta*.[5] In that case the Court held that determining the admissibility of evidence involves an assessment of its reliability. It is possible to evaluate this as well as necessity and relevance just based on the general nature of the proposed evidence. It is not necessary for the Tribunal to see and assess the evidence before making a decision. A tribunal faced with an objection to the admissibility of evidence may reject the evidence, just as it could admit the evidence but decide to give it no weight.

[22] Ms. Prather also submitted that it would not be sufficient to admit Ms. Ivans' testimony and the memorandum and then assign weight to the evidence. This would not account for the inherent prejudice that Dr. Khumree would suffer if irrelevant evidence of inflammatory and unsubstantiated allegation is introduced.

Decision on Preliminary Matter

[23] On June 28, 2021 the Hearing Tribunal advised the parties through an email from Mr. Sim that it had made a decision on the preliminary objection to Ms. Ivans' evidence. The Tribunal advised that it had decided to hear Ms. Ivans' evidence and that its reasons for its decision would follow.

[24] On August 6, 2021, following an inquiry from Ms. Prather, the Tribunal advised the parties through a further email from Mr. Sim that it would also close the portion of the hearing dealing with Ms. Ivans' testimony pursuant to section 78(1) of the *Health*

[5] *Wright v. College and Association of Registered Nurses of Alberta,* 2012 ABCA 267

Professions Act. The Tribunal indicated that reasons for this decision would also be provided.

[25] The Hearing Tribunal's reasons for these decisions are as follows. The Tribunal understood that Ms. Ivans' proposed testimony and the memorandum summarizing her interview of [redacted] would contain hearsay evidence, although the Tribunal had not yet heard the testimony or seen the memorandum. Hearsay evidence is presumptively inadmissible in judicial proceedings in court because it is not given under oath and there is no opportunity for the opposing party to cross-examine the true source of the information about its veracity. Hearsay evidence may be admitted into evidence in judicial proceedings in court if it meets a recognized exception to the exclusionary rule, or if it meets the dual criteria of necessity and reliability.

[26] Proceedings before the Hearing Tribunal are subject to the *Health Professions Act*. Section 79(5) of the *Health Professions Act* expressly provides that the Hearing Tribunal is not bound to apply the rules of law respecting evidence in judicial proceedings. Section 79(5) states that evidence may be given before the Hearing Tribunal in any manner that it considers appropriate.

[27] A provision similar to section 79(5) was at issue in *Murray v. Veterinary Medical Association (Saskatchewan)*.[6] The Saskatchewan Court of Appeal held that the provision empowered the Tribunal to accept any evidence it considered appropriate, including hearsay evidence. It was not necessary to first determine the reliability of the evidence, or to ensure the other party could effectively cross-examine the true source of the evidence. In other words, the provision ousted the application of common law rules of evidence applicable in judicial proceedings. The Court of Appeal held that it was still necessary for the evidence to be relevant and the Tribunal was required to assign the appropriate weight to the evidence in the circumstances. It was also necessary to ensure the proceedings were fair. The failure to assign the evidence appropriate weight might lead to other concerns about procedural fairness. The Court concluded that the Tribunal could admit the impugned evidence and then assess the amount of weight to place on it, if any. The Tribunal may ultimately find the evidence to be unreliable and discount it, but that decision could be made during the Tribunal's deliberations. It did not need to be made prior to admitting the evidence into the record.

[28] The Hearing Tribunal could therefore decide to admit hearsay evidence and to consider it, including assigning it the appropriate amount of weight in its deliberations. It was not necessary for the evidence to be under oath, or for the true source of the information to be available for cross-examination. The Hearing Tribunal is bound to ensure that proceedings before it are fair to both parties. In this case Dr. Khumree had acknowledged through his counsel that at least some parts of the memorandum would be relevant to issues before the Hearing Tribunal. While other parts would not be relevant, the Hearing Tribunal was prepared to carefully review the memorandum and disregard irrelevant portions, particularly any accusations that are not the subject of the allegations against Dr. Khumree.

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[6] *Murray v. Veterinary Medical Association (Saskatchewan)*, supra note 3

[29] Section 78(1)(a) of the *Health Professions Act* permits the Hearing Tribunal to hold part of a hearing in private on its own motion. The prescribed grounds to hold a hearing, or part of it in private include section 78(1)(a)(iii): because not disclosing a person's confidential personal information outweighs the desirability of having the hearing open to the public.

[30] The Tribunal had not yet heard Ms. Ivans' evidence or reviewed a copy of her memorandum, but the Tribunal understood that the proposed evidence would address highly sensitive details of ████ relationship with Dr. Khumree and may include highly inflammatory accusations that are not the subject of the allegations against Dr. Khumree. The Tribunal was satisfied that maintaining the confidentiality of this type of information would outweigh the desirability of having this portion of the hearing open to the public. The Tribunal determined that the hearing would be re-opened after Ms. Ivans' evidence had been completed and the rest of the hearing would then remain open to the public.

Proceedings on August 9, 2021

[31] When the hearing resumed on August 9, 2021, Mr. Boyer advised the Hearing Tribunal that he would call Ms. Ivans, but her evidence would be different than previously contemplated. Ms. Ivans' would not testify to her memorandum. She would only describe her efforts to obtain a victim impact statement from ███ Mr. Boyer said that the Hearing Tribunal should understand the efforts that were taken to obtain the victim impact statement and then determine the relevance of it.

[32] Ms. Prather stated that she had seen the victim impact statement and Dr. Khumree would consent to its admission into evidence. Ms. Prather asserted that it was then unnecessary for Ms. Ivans to testify as ████ victim impact statement could speak for itself. The efforts to obtain a victim impact statement could not be relevant to Dr. Khumree's sanctions. Ms. Ivans might give additional hearsay evidence that would be inappropriate.

[33] The Hearing Tribunal deliberated and decided that we would hear Ms. Ivans' testimony. The Hearing Tribunal can assess the relevance and weight of testimony and other evidence as it is received. The Hearing Tribunal can also hear and determine objections to specific questions that either party finds objectionable. It would be premature to rule a witnesses' testimony to be irrelevant or unnecessary before hearing any of her testimony. As Ms. Ivans' testimony was not expected to cover the memorandum she had prepared of her interview with ███ the Hearing Tribunal no longer felt it necessary to close the hearing during Ms. Ivans' testimony.

[34] A victim impact statement from ███ was entered into evidence when Ms. Ivans subsequently testified.

III. EVIDENCE

Complaints Director's Witnesses

Dr. Lioubov Kazatchenko

[35] Mr. Boyer called witnesses in relation to the sanctions to be imposed by the Hearing Tribunal. He first called Dr. Lioubov Kazatchenko. Dr. Kazatchenko attended medical school in Russia before immigrating to Canada and attending the University of Calgary family medicine program. She has been practicing in Alberta since 2010.

[36] Dr. Kazatchenko said she met Dr. Khumree when they were working at the same Airdrie clinic. Dr. Kazatchenko left to open her own clinic in July of 2013 and Dr. Khumree followed her there, beginning work in February of 2014. Dr. Kazatchenko confirmed that Dr. Khumree was also her patient at her new practice.

[37] Dr. Kazatchenko described the first few months working with Dr. Khumree at her clinic as a honeymoon period. Then her staff began to complain that Dr. Khumree smelled of alcohol and that he would regularly cancel patient appointments. She said that he just wouldn't come to work. Dr. Kazatchenko said she met with Dr. Khumree and he agreed to go through treatment for alcohol use, but his behaviour did not improve. He made repeated abusive telephone calls to the clinic staff and his conduct was reported to the police and to the College. Dr. Khumree's behaviour had a large impact on the clinic's practice.

[38] In cross-examination Dr. Kazatchenko could not recall when she first heard a complaint about Dr. Khumree coming to work smelling of alcohol. She acknowledged this but added that she had observed Dr. Khumree having withdrawal symptoms herself. She said that it was March 17, 2015 when she and an office staff member met with Dr. Khumree and she offered to help pay for him to attend treatment. She could not say whether she had recorded this in Dr. Khumree's patient chart.

[39] Dr. Kazatchenko agreed she was Dr. Khumree's physician until June 1, 2015 and that he was constantly complaining about difficulties sleeping. She prescribed the sedative zopiclone beginning on January 25, 2012. She was aware of Dr. Khumree's problematic alcohol use. In April of 2013 she learned that Dr. Khumree was charged with driving while under the influence ("DUI"). She also learned from talking with Dr. Khumree after he joined her clinic in 2014 that he had financial issues that contributed to his difficulties sleeping.

[40] Dr. Kazatchenko agreed that she prescribed regular dosages of zopiclone for Dr. Khumree until September 2013, when he began to see Dr. Teman, a psychiatrist specializing in sleep medicine. After this Dr. Teman was supposed to be prescribing Dr. Khumree's sedative medications, but Dr. Kazatchenko said that as a specialist he wasn't always available to refill prescriptions.

[41] Dr. Kazatchenko agreed she received an extensive report from Dr. Teman on September 5, 2013 and she was aware of Dr. Khumree's significant alcohol, financial and legal issues including around his immigration status, and stress. She also learned from Dr. Teman's report that Dr. Khumree's DUI charge could have related to the sublinox medication that she had prescribed for him in addition to the zopiclone.

[42] Dr. Kazatchenko saw Dr. Khumree again on September 26, 2013. She acknowledged that she convinced Dr. Khumree to reduce the dosage of zopiclone that Dr. Teman had prescribed and she gave him a prescription for 120 tablets of zopiclone, even though he was seeing Dr. Teman for the same issue. Dr. Kazatchenko said Dr. Khumree had told her he was out of the medication.

[43] Dr. Kazatchenko also agreed she received a letter dated December 11, 2013 from Dr. Teman on December 12, 2013. In the letter Dr. Teman had said he gave Dr. Khumree a prescription for 180 tablets of zopiclone at 3 tablets per day and asked him to follow up in two months. Despite this, Dr. Kazatchenko saw Dr. Khumree less than two months later, on January 24, 2014 and prescribed him more zopiclone.

[44] Dr. Kazatchenko also received a February 4, 2014 consult letter from Dr. Teman confirming that he had prescribed 360 tablets of zopiclone for Dr. Khumree at a dosage of 2-3 tablets per night, which should have lasted about four months. Dr. Kazatchenko agreed that on March 28, 2014, approximately two months later, she prescribed additional zopiclone.

[45] After receiving an April 14, 2014 consult letter from Dr. Teman, Dr. Kazatchenko saw Dr. Khumree on May 21, 2014 and prescribed an additional medication seroquel. She said Dr. Khumree had told her that he didn't want to increase the dose of zopiclone.

[46] Dr. Kazatchenko received a consult letter from Dr. Teman dated July 25, 2014, which said he had given Dr. Khumree a prescription for 540 tablets of zopiclone. This should have been a six month supply.

[47] Approximately two weeks later, on August 13, 2014 Dr. Kazatchenko saw Dr. Khumree after he had been discharged from the emergency department following an overdose. She also received the emergency department discharge summary which confirmed that Dr. Khumree had taken an excessive number of zopiclone tablets at once and that he needed help for an alcohol use disorder. She said she discussed this with Dr. Khumree but agreed she had not documented it in Dr. Khumree's patient chart.

[48] Dr. Kazatchenko saw Dr. Khumree again on October 14, 2014. She agreed she was aware that his driver's license had been suspended and that he was suffering from anxiety and depression. She also agreed that despite her knowledge of Dr. Khumree's consumption of an excessive number of zopiclone tablets in August, she again prescribed zopiclone and seroquel for Dr. Khumree. Dr. Kazatchenko continued to prescribe these medications for Dr. Khumree up to June 1, 2015.

[49] Dr. Kazatchenko said that by June 10, 2015 she had determined that Dr. Khumree was "out of control" and there was no other option but to report him to the College. The College then arranged for Dr. Khumree to cease practice and attend treatment. During his time in treatment Dr. Kazatchenko notified him that she was terminating their contractual relationship and she contacted the College for advice on how to handle his panel of approximately 1800 patients. Dr. Katatchenko had no further direct contact with Dr. Khumree.

[49] Dr. Kazatchenko said that Dr. Khumree attempted to retaliate against her by complaining to the College about her handling of his patients. This complaint was dismissed.

Dr. Janet Wright

[50] Dr. Wright is a psychiatrist. She practiced from 1987 to 2005 when she joined the College as an Assistant Registrar. After leaving the College in 2015 she returned to inner city practice focussing on assessments like the one she and her team performed on Dr. Khumree and described in her Comprehensive Occupational Assessment Program ("COAP") report dated October 9, 2020.

[51] Dr. Wright's COAP report explained that Dr. Khumree was referred to her by the College for assessment following the Hearing Tribunal's decision finding him to have engaged in unprofessional conduct.

[52] Dr. Wright explained her assessment that Dr. Khumree did not suffer from any acute psychiatric condition. He had suffered depression, but she found that it was well-managed with anti-depressant medications. She found that Dr. Khumree had a history of alcohol and sedative use disorder but he was abstinent at the time of her assessment. Dr. Wright also found that Dr. Khumree met the criteria for avoidant personality disorder with compulsive traits. Her report stated that Dr. Khumree had a historical pattern of coping by maladaptive avoidance through "numbing" with alcohol and prescription drug misuse. At the time of the COAP assessment, Dr. Wright wrote that Dr. Khumree's avoidant personality manifested mostly by physical and psychological withdrawal. Dr. Wright commented that Dr. Khumree's avoidant personality also likely contributed to his difficulties with his relationship with his mother and with ███ and his decisions to write prescriptions for ███

[53] Dr. Wright and her team concluded that Dr. Khumree was fit to practice medicine, but they identified some concerns. They noted that his avoidant personality and compulsive traits could impact patient interactions. For example, Dr. Khumree had responded to scenarios drawn from other cases involving challenging patients by refusing to see them anymore or asking his clinic staff not to book them anymore. In the COAP report Dr. Wright noted that Dr. Khumree failed to appreciate the impact this could have on a patient, asking "Is that my problem?". Dr. Wright said her team felt this could lead to difficulties in Dr. Khumree's practice in the future.

[54] Dr. Wright explained that it was very difficult to assess Dr. Khumree's risk of engaging in unprofessional conduct again. There were a number of factors that contributed to his unprofessional behaviour, including his avoidant personality disorder. She said that Dr. Khumree was managing by leading a solitary life and avoiding personal relationships. This can work in the short term, but life inevitably involves challenges and avoiding all personal relationships would put Dr. Khumree at risk if and when he faces challenges in his personal or professional life. In the COAP report Dr. Wright noted that Dr. Khumree displayed limited insight into his own vulnerabilities and risk factors. In particular, Dr. Wright noted that Dr. Khumree's socially isolated state could increase his risk of engaging in an inappropriate relationship and a boundary violation should he not learn to better manage his avoidant style. The risk would also increase if Dr. Khumree were to relapse in his use of substances. Dr. Wright testified that there was more work to be done to ensure Dr. Khumree would be able to maintain appropriate patient boundaries.

[55] Dr. Wright had been asked to recommend a treatment plan for Dr. Khumree. Her team recommended that he continue to see his family physician for treatment of his major depression and that he abstain from alcohol and substances. Her team also recommended some form of ongoing monitoring such as voluntary engagement in periodic bodily fluid or breathalyzer tests. Dr. Wright acknowledged that the Alumni Agreement between Dr. Khumree and the Physician Health Monitoring Program would satisfy this suggestion. There was also a recommendation for Dr. Khumree to see a therapist or personal coach for solution focused, or cognitive behavioural therapy to help him address his avoidant personality style and the challenges in personal relationships. The team also supported education, a professional mentor, and ongoing limits on the number of patients Dr. Khumree sees and refraining from any relationships with his patients.

[56] In cross-examination Dr. Wright acknowledged several facts pointing to Dr. Khumree's efforts and personal growth. She acknowledged that her team had heard from interviewees that Dr. Khumree socialized with co-workers. She also acknowledged that it would be a positive sign of growth for Dr. Khumree to reinitiate a relationship with his mother. She characterized Dr. Khumree's alcohol and substance use disorders as being in remission or early remission from 2018 to the date of her assessment. She acknowledged that Dr. Khumree completed a boundaries violation course through the College of Physicians and Surgeons of British Columbia. She agreed the risk that Dr. Khumree might engage in unprofessional conduct in the future was not a significant risk, or she would not have assessed him as fit to practice.

[57] Dr. Wright acknowledged she was not aware that Dr. Khumree had agreed to voluntary monitoring through an Alumni Agreement with the College's Physician Health Monitoring Program. Dr. Wright also agreed that it could be difficult for Dr. Khumree to be absent from practice for a long time, but she said she was not commenting on the appropriateness of a suspension.

Ms. Kristy Ivans

[58] Ms. Ivans works in the College's Professional Conduct Department as an investigator. She conducted the investigation in this matter. She was also involved in obtaining a statement from [redacted] describing how [redacted] relationship with Dr. Khumree impacted her. Ms. Ivans explained that obtaining the victim impact statement took some effort. In April of 2018 [redacted] had been willing to testify, but she expressed frustration at how long the process was taking. By January of 2020 when the first hearing dates were set, [redacted] was suffering stress over the slow scheduling progress and she was unable to get time off work to testify. Despite several attempts to speak with [redacted] about it, by January of 2021 she was declining to testify. It took several more attempts at contacting [redacted] for her to agree to provide a victim impact statement. Ms. Ivans said that she had prepared the statement for [redacted] after some discussions with her and [redacted] signed it.

[59] In cross-examination Ms. Ivans acknowledged that she had no formal training in obtaining victim impact statements. She used a form with a set of questions developed by the College and followed advice from Mr. Boyer. Ms. Ivans had spoken with [redacted] about the questions and then typed the statement. She sent it to [redacted] for review, but [redacted] had no substantive changes. Ms. Ivans confirmed that she did advise [redacted] of the College's patient relations program. She could not recall whether she told [redacted] that the College instructed Dr. Khumree not to communicate with her. She did not advise [redacted] that Dr. Khumree had successfully completed treatment and had been monitored by the College's monitor over the preceding five years, as Ms. Ivans was not aware of that at the time. Ms. Ivans acknowledged that [redacted] had only ten days advance notice of the January 2020 hearing dates and this had caused frustration and anxiety for her. During her testimony Ms. Ivans struggled to recall the timeline of her involvement with this case and the steps that she took, even when referring to her notes.

Dr. Khumree's Witnesses

Dr. Altaf Khumree

[60] Dr. Khumree completed his medical training in South Africa in 2008. He then completed a two-year internship before immigrating to Canada in 2011.

[61] When asked, Dr. Khumree confirmed he received some boundaries training in South Africa, but it was very limited. He said he was just taught that sexual relationships with patients are inappropriate and shouldn't happen. He said it was described to him as being "black and white", but this is easier said than done. Dr. Khumree said that it can be a slippery slope. He said that when you are trying to help someone it can eventually lead to a boundary violation and it is hard to define this as black and white.

[62] When Dr. Khumree arrived in the Calgary area he was 28 years old with no savings beyond what he needed for a couple of months of expenses. He had no family in Canada. Dr. Khumree initially met an employer, [redacted] who owned several clinics. Dr. Khumree became friends with [redacted] and began working at one of his clinics, the East Oasis Medical

Clinic in Airdrie. Dr. Khumree said that professionally the work was exciting, but he found it hard to meet new people. At the East Oasis Medical Clinic Dr. Khumree met Dr. Kazatchenko as she was also working there, and she agreed to become Dr. Khumree's own physician. persuaded Dr. Khumree to invest the first $100,000 he earned in Canada into clinics, but this investment went poorly and the money was largely lost. Dr. Khumree described feeling used. He said that was repaying part of his investment to him over time.

[63] Dr. Khumree rented a room he located online in Airdrie. He became acquainted with his landlord who would sometimes invite him to family dinners in Calgary. It was there that Dr. Khumree met who was his landlord's sister.

[64] When Dr. Kazatchenko left the East Oasis Medical Clinic to open her own clinic, Dr. Khumree was the only remaining physician. He found the remaining patient load to be overwhelming, so he agreed to leave when Dr. Kazatchenko offered him a job at her new clinic. Dr. Khumree described Dr. Kazatchenko as a colleague but not a mentor. He said she was only slightly senior to him and she used to come to Dr. Khumree for advice on her patients.

[65] Initially Dr. Khumree enjoyed working at Dr. Kazatchenko's new clinic, but as time went on he felt that Dr. Kazatchenko wanted him to see more patients than he was comfortable seeing. He said she also began to make unwelcome inquiries about his life outside of the clinic.

[66] Dr. Khumree described the development of his relationship with Dr. Khumree said he was spending a lot of time with his landlord and at their parents' house. Initially Dr. Khumree and were friendly. was in a long-term relationship with someone else. At one point asked Dr. Khumree for a favour. She said her family physician had retired and she needed a prescription. She and her then boyfriend attended an appointment with Dr. Khumree and asked for a prescription for dexadrine to help her focus on school. Dr. Khumree obliged and he and remained friendly until Dr. Khumree learned from his landlord that and her boyfriend were no longer together. Dr. Khumree confirmed this with when she attended for an appointment with him on September 10, 2011. Dr. Khumree said that he and began their intimate relationship in late September, October or early November of 2011.

[67] Dr. Khumree said that he continued to treat as a patient after their intimate relationship began. Initially he assumed her prescription request was an isolated incident and that she would seek out another physician. did not seek out another physician and this led to arguments between them. Dr. Khumree said that he knew it was wrong to have a relationship with at the time. He said it was his responsibility to ensure understood they could not have a relationship. He denied knowing that he was obligated to report his relationship with to the College.

[68] Dr. Khumree said he tried to help find another physician. He made appointments for her and drove her there, but he also continued to see and treat her himself. For

example, Dr. Khumree saw ███ on May 2, 2014 and wrote in his notes that she had been seeing another physician who had prescribed her zopiclone, but only enough for 7.5mg per night. Dr. Khumree also wrote that he had already referred ███ to Dr. Teman in February of 2014 and she had an appointment with him set for the following week. Despite these facts, Dr. Khumree gave ███ a prescription for 40 tablets of zopiclone 7.5mg.

[69] Dr. Khumree's personal relationship with ███ deteriorated over time. They argued over her requests for prescriptions, her reluctance to see another physician and her desire not to disclose their personal relationship to her brother, Dr. Khumree's landlord. Dr. Khumree also said that he and ███ both had untreated depression and ███ was quite a heavy drinker. Dr. Khumree admitted that he developed alcohol and sedative medication use disorders. He used alcohol when he felt the sedative medications weren't working. He acknowledged these issues had a hugely negative impact on him. His poor financial decisions also contributed to the worsening of his medical and social situation, his withdrawal and to his suicide attempt by consuming drugs that he had on hand as well as alcohol in August of 2014.

[70] Dr. Khumree said he treated ███ multiple times and only some of these encounters occurred in the clinic. In cross-examination he acknowledged that other treatment encounters occurred at home, or on the phone. Dr. Khumree's last encounter with ███ as a patient was on April 6, 2015. On this occasion he refilled her prescription for dexadrine as she would not be able to see her regular physician until the following Saturday.

[71] Dr. Khumree then addressed the allegations he had admitted in the Notice of Hearing. He admitted to self-prescribing. He said these were refills of prescriptions initiated by others. He did prescribe Tylenol #2 for himself, which contains codeine, but he could not recall why he had done this. He said he never prescribed himself any triplicate medications.

[72] Dr. Khumree said he knew it was wrong not to answer the College's registration renewal questions about relationships with patients honestly, but he was afraid of the consequences of disclosing the truth. He said he answered the question honestly on his 2016 renewal and he instructed Ms. Prather to report the boundary violation to the College on his behalf. He then undertook to have a chaperone present for all intimate exams with female patients and he took a boundary violation course through the College of Physicians and Surgeons of British Columbia.

[73] Dr. Khumree said he didn't respond affirmatively to the question on the 2014 renewal form about prior criminal charges because the charge had been dropped when Dr. Teman provided an opinion that the sublinox medication Dr. Khumree was taking at the time could cause amnesia. Dr. Khumree said he understand this was the equivalent of a pardon which the form lists as an exception. Dr. Khumree said he didn't report his May 2014 DUI charge on the College' 2015 renewal form because he was ashamed of it and

afraid of the consequences. Dr. Khumree did disclose his January 2015 DUI conviction on his renewal form for 2016. He said by that point the College was already aware of it.

[74] Dr. Khumree explained the College's response to his disclosures. He was suspended and offered a psychiatric assessment or residential treatment for substance use disorder. He agreed to treatment and attended a residential program in British Columbia from June to September of 2015.

[75] Dr. Khumree described his experience in residential treatment. He had limited communications with anyone outside and no access to his own phone or a computer. He overcame denial that he had a problem with alcohol. He said he found group treatment to be effective.

[76] After his discharge Dr. Khumree found life to be difficult. He was without a home and his belongings were all in storage. He lived in a sober halfway house until January of 2016. He was not working and had few resources during this time. He said he depended on the food bank and lived on the modest repayments from █ of part of his investment.

[77] In order to be reinstated with the College, Dr. Khumree agreed to a five-year monitoring agreement with the College's Physician Health Monitoring Program. This included twice daily SoberLink breath samples, 52 weeks of regular counselling and a workplace monitor. Dr. Khumree completed these program requirements as confirmed by a June 7, 2021 letter from Dr. Beach, Assistant Registrar of the College. Dr. Beach also confirmed that on December 22, 2020 Dr. Khumree entered a voluntary monitoring agreement with the College's Physician Health Monitoring Program. Dr. Khumree said that he has remained sober since his discharge from treatment in September of 2015.

[78] Dr. Khumree said that he took a position at the Pinnacle Medical Clinic in Strathmore, Alberta where he has been building a new patient panel. It has taken him about two years to develop his practice to the point that he could support himself. Dr. Khumree disputed Dr. Wright's suggestion that he lacked empathy for complex patients. At the Pinnacle Clinic, Dr. Khumree said he has undertaken additional training in opioids and addiction medicine. He said he is the only physician prescribing methadone in the Eastern Calgary area. He said he is also developing a practice in botox treatment for chronic migraines, which he had trained for while working in Airdrie. Dr. Khumree described his patient panel at the Pinnacle Clinic as extensive, with a large First Nations population and chronic pain patients. He described advocating to the local Primary Care Network for First Nations patients to receive additional resources such as specialized counselling services. He also described teaching medical residents in family medicine. Dr. Khumree said he would discharge patients from his practice if they were to breach an opioid agreement or if they were to refuse to cooperate with his recommendations, but this is just setting appropriate boundaries; it is not because of a lack of any empathy.

[79] Dr. Khumree also responded to Dr. Wright's concerns with his solitary lifestyle. Dr. Khumree said that he is now very content. He enjoys spending time with his dogs, reading and seeing friends. He said he has also reconnected with his mother and he has

been in a personal relationship with another individual over the past four months. Dr. Khumree described having matured over the past several years while identifying and dealing with his addictions.

[80] Dr. Khumree responded to ████ victim impact statement, and particularly to the suggestion that he had not accepted responsibility for his actions or tried to apologize to ███ Dr. Khumree said that his counsellor and the College had both suggested that he refrain from communicating with ███ This was because their relationship had been detrimental to Dr. Khumree and contacting ███ could have aggravated a difficult situation.

[81] Dr. Khumree was asked about the potential impact of a lengthy suspension. He said that other physicians at his clinic could see some of his patients, but they wouldn't be able to handle all of them. He said that he had a panel of about 3000 patients, but this has expanded as colleagues have left and transferred their patients to him. He said he now has approximately 5000 patients in his practice. Dr. Khumree also said he is also the only physician at his clinic with complex opioid patients, having approximately 300 of them, the only methadone physician in the area and the only physician in the area performing botox for chronic migraines. He said that when his admissions of unprofessional conduct were made public his patients became aware but to his knowledge none of them stopped seeing him. Dr. Khumree also said a lengthy suspension could cause him to lose his house and possibly return to India which would mean living with his mother and this would be detrimental to him. Dr. Khumree said that a suspension would not benefit anyone and he proposed making a contribution to a victim's fund as an alternative.

[82] In cross-examination Dr. Khumree acknowledged his admitted unprofessional conduct that resulted in the findings of unprofessional conduct against him. He acknowledged knowingly providing false information to the College. He acknowledged carrying on an intimate relationship with ███ and even living with her beginning in February 2013 while he was continuing to treat her and that he knew it was wrong to do so. He acknowledged continuing to prescribe an addictive amphetamine for ███ during this time even though he felt she was misusing them. Dr. Khumree admitted that he couldn't say "no" to ███ and she had clouded his judgment.

[83] In response to questions from the Hearing Tribunal Dr. Khumree said that he didn't believe finding a new physician for ███ resolved his boundary violation. He acknowledged that the boundary violation had occurred.

[84] At the conclusion of Dr. Khumree's testimony, Mr. Boyer sought to mark an October 24, 2018 Independent Medical Examination ("IME") report prepared by Dr. Charl Els concerning Dr. Khumree. Mr. Boyer submitted that Dr. Els' IME report had been before Dr. Wright when she completed her assessment and Dr. Khumree had been cross-examined on parts of it so the report should be included in the evidence.

[85] Ms. Prather objected that Dr. Wright had made only one reference to Dr. Els' assessment. She disagreed that Dr. Els' IME report was part of the foundation for Dr. Wright's report. Dr. Els had not been called to testify or be cross-examined so it would not be appropriate to admit his whole report with his opinions into evidence. Ms. Prather suggested there would be no problem with entering the pages from Dr. Els' report that Dr. Khumree was asked about in his cross-examination. These could be used to assess Dr. Khumree's testimony for any contradictions.

[86] Both counsel agreed that the Hearing Tribunal could receive the pages from Dr. Els' IME report that had been put to Dr. Khumree in cross-examination, and that these were pages 1-7 and 11. These pages were marked as an exhibit.

[87] Dr. Khumree was subsequently recalled and permitted to add to his direct testimony. He said that he had forgotten to mention that he wanted to apologize to the profession for what he had done. He said he recognized that his actions affect the whole profession and the whole community. Dr. Khumree also said he wanted to apologize to ██ as he could see that she was still quite negatively affected. Dr. Khumree said he was sorry for what he did. He said that he understands it was his responsibility to set the boundary and not enter a relationship with her.

Mr. ██

[88] Mr. ██[7] is a retired homebuilder and rancher residing in the Strathmore area. He is married with two grown daughters, one of whom is disabled and resides with Mr. ██ and his wife. Mr. ██, his wife, daughters and his son-in-law all see Dr. Khumree as their family physician. Mr. ██. described Dr. Khumree as providing very good care for his family. Mr. ██ said that Dr. Khumree has been assisting his daughter to recover from opioid dependency brought on by other physicians over-prescribing pain medications for her. Mr. ██ said that he was aware of Dr. Khumree's admissions of unprofessional conduct and Dr. Khumree had been quite open with Mr. ██ about it. Mr. ██ said that if Dr. Khumree was to be suspended it would impact his family greatly. He said he would have to start all over on his path towards back surgery and he didn't know how it would affect his daughter. Mr. ██ said he decided to testify on Dr. Khumree's behalf because of the difficult time they had finding a good doctor.

Dr. Gongdu (Jerry) Zhang

[89] Dr. Zhang is a family physician with a special interest in occupational medicine. Following residency he worked in family practices including the Pinnacle Medical Clinic in Strathmore. It was during his time working in Strathmore that he met Dr. Khumree. Dr. Zhang saw Dr. Khumree as a mentor-figure because he was very well-read with respect to medical literature and experienced with local resources. Dr. Zhang also said that Dr. Khumree keeps excellent notes and provides excellent care to his patients.

[7] Patients have been identified in this decision by initials to protect their personal health information.

[90] Dr. Zhang described Dr. Khumree's practice. He said it was in a heavily underserviced region, so physicians tend to have large patient panels. Dr. Zhang said he began seeing walk-in patients who couldn't get appointments with Dr. Khumree. He estimated that approximately 25% of his days were spent seeing other doctor's patients, including Dr. Khumree's. Dr. Zhang said Dr. Khumree had a complex practice including lots of chronic disease, substance use issues, cannabis consulting, some cosmetic procedures and several hundred indigenous patients in his panel. Dr. Zhang described seeing one of Dr. Khumree's patients who wouldn't talk to him. Eventually she revealed that she had chronic pain and social anxiety making it difficult to communicate with a new physician. Dr. Zhang said that in order to pick up Dr. Khumree's patients a physician would need a lot of passion and a deep knowledge of medical literature.

[91] Dr. Zhang confirmed he was aware of the allegations in the Notice of Hearing and that Dr. Khumree had admitted them. Dr. Zhang also confirmed that the allegations against Dr. Khumree had been published in the Calgary Herald and some of Dr. Khumree's patients had raised this with him. He said the patients had been concerned that Dr. Khumree could be suspended leaving them without care. Dr. Zhang offered his own view that Dr. Khumree's patients would be affected if he was to be suspended. He said they would be unable to obtain a new physician and would end up attending the emergency department. Dr. Zhang suggested the Hearing Tribunal should consider alternatives to a suspension because it would lead to more harm. Dr. Zhang acknowledged he had no role with Alberta Health Services administration.

Mr. Shawn Owen Nicol

[92] Mr. Nicol is the owner and director of business development for Peak Medical Group, which owns and operates the Pinnacle Medical Clinic in Strathmore. Mr. Nicol said that there are four family physicians working at the Pinnacle Medical Clinic. In addition to Strathmore, the Peak Medical Group operates medical clinics in about 20 locations with about 115 physicians including in Calgary, High River, Okotoks and in Edmonton.

[93] Mr. Nicol described the medical needs of the Strathmore area. He said that smaller centres like Strathmore have unique challenges recruiting and retaining physicians. The lack of local specialists also means that family physicians end up handling more complex, chronic issues. Mr. Nicol said Dr. Khumree is a hard worker with a very diverse practice, and experience with complex issues such as subloxone and cannabis. Mr. Nicol said that his staff and their patients and particularly their indigenous patients have come to appreciate and benefit from Dr. Khumree's versatility and dedication.

[94] Mr. Nicol explained that he is aware of the allegations in the Notice of Hearing and that Dr. Khumree had admitted them. Mr. Nicol also described how Dr. Khumree had contacted him about a fresh start working with Peak Medical Group in Strathmore and disclosed his substance use issues; that he was in treatment in British Columbia; and his relationship difficulties. Mr. Nicol was prepared to give Dr. Khumree a fresh start and his performance has been solid. He is the only physician at Pinnacle Medical Clinic

working 5 days a week. Mr. Nicol said he keeps in regular touch with Dr. Khumree to ensure things are running smoothly but there have been no complaints.

[95] Mr. Nicol said that if Dr. Khumree were to be suspended for any length of time the Pinnacle Medical Clinic would carry on, but it would be a severe blow to the patients. There are not enough family physicians for all of the patients who need one. This issue is amplified in Strathmore where the population is "under-doctored". He said Dr. Khumree has a large panel of about 2500 patients who would have to be released. In cross-examination Mr. Nicol acknowledged that he could work with Alberta Health Services to recruit physicians if needed. Mr. Nicol also acknowledged that he had never before worked with Alberta Health Services or the College to engage a locum physician to cover during a physician suspension. Mr. Nicol said that the options to obtain locum physicians are diminished.

Ms. ███

[96] Ms. ███ is an insurance broker living in Strathmore with her husband and three children. She said that upon moving to Strathmore from Saskatchewan, her husband began to see Dr. Khumree and suggested that she might also like him. Ms. ███ said that she saw Dr. Khumree and appreciated his approach. She explained that she has hypertension, low level anxiety, depression and migraines. She was pleasantly surprised that Dr. Khumree had read her file and knew it when they met. She described him as trustworthy, witty, well-prepared and making good use of time. She credited Dr. Khumree with creating a plan to reduce her medications, stop smoking and improve her lifestyle. She also began to have her other family members see him. Ms. ███ said that she accompanied her family members to their appointments and was pleased with Dr. Khumree's ability to communicate effectively with every age-group and care for them.

[97] Ms. ███ described Dr. Khumree's reputation in the community as good, including among those who she has referred to him. She said she is aware of the allegations in the Notice of Hearing and that Dr. Khumree has admitted them. She said she learned about it in the newspaper. She asked him about the newspaper article and he was very candid with her. He didn't deny anything. Ms. ███ acknowledged that she was unaware of the impacts of Dr. Khumree's admitted conduct on ███. Ms. ███ said that if Dr. Khumree is suspended then her family would have to look for a new physician and build trust with someone all over again if they could even find a new physician. Ms. ███ added that testifying at the hearing was important to her and her family since the sanctions would affect her family and her community.

Application to Introduce Rebuttal Evidence

[98] Following the conclusion of Dr. Khumree's witnesses, Mr. Boyer proposed to call the Complaints Director as a rebuttal witness. Mr. Boyer said the Complaints Director would speak to the process for arranging coverage for physicians during suspensions. Ms. Prather objected, arguing that the Complaints Director had been on notice that Dr. Khumree would lead evidence about problems finding coverage for his patients during

any suspension. The issue had been foreseeable and the Complaints Director should have called evidence about it as part of his case.

[99] The Hearing Tribunal decided not to hear the Complaints Director's rebuttal evidence. Rebuttal evidence may be appropriate where the Complaints Director could not have anticipated an issue arising during the physician's case. In this case the potential impact that a suspension might have on Dr. Khumree's patients was foreseeable. More importantly, the proposed rebuttal evidence would be hypothetical evidence about a process that could be followed. The Hearing Tribunal did not think the proposed rebuttal evidence would be likely to influence its determination of the appropriate sanctions for Dr. Khumree.

[100] SUBMISSIONS ON SANCTION

Submissions on behalf of the Complaints Director

[100] Mr. Boyer began the Complaints Director's submissions on sanctions by emphasizing Dr. Khumree's inappropriate sexual relationship with ███ Dr. Khumree admitted a sexual relationship with ███ while seeing her as a patient both at his clinic and more often outside of it over a period of about three years. Dr. Khumree's conduct was dishonest. He misled the College in his renewal application forms. Mr. Boyer characterized Dr. Khumree's admitted unprofessional conduct as demonstrating a stunning lack of insight and very serious. It was not in a "grey area". It called for significant sanctions.

[101] Mr. Boyer also pointed to ███ vulnerable state and Dr. Khumree's privileged position. ███ was suffering from mental health and substance use issues herself. ███ was dependent on dexadrine, she had an alcohol use disorder, and her own mental health issues. ███ submitted an impact statement that revealed that ███ was especially vulnerable to Dr. Khumree and she now suffers doubts about trusting physicians.

[102] Mr. Boyer also suggested that while Dr. Khumree acknowledged his unprofessional conduct, he saw himself as the victim. Dr. Khumree attempted to blame others such as ███ for refusing to see another doctor while he provided her with increasing amounts of medication. This is unacceptable. Physicians should not assign blame to their vulnerable patients. Dr. Khumree also refused to accept Dr. Wright's assessment team's report that he had an avoidant personality. Dr. Khumree took the course at the College of Physicians and Surgeons of British Columbia but be sought no treatment for the psychological factors that underlay his issues, such as cognitive behavioural therapy. Mr. Boyer suggested that the sanctions should include this type of therapy and ongoing boundary violation monitoring.

[103] Dr. Khumree was out of practice and unable to earn a livelihood while he attended residential treatment in British Columbia, but this was to address his substance use disorder. It was not a punishment that should militate against more serious sanctions for Dr. Khumree's admitted unprofessional conduct. Mr. Boyer argued that Dr. Khumree still had not suffered any real consequences. In order to achieve the necessary deterrence,

clear sanctions would be required. Mr. Boyer suggested that a suspension would be an appropriate sanction to impose to demonstrate that the public interest had been served.

[104] Mr. Boyer referred the Hearing Tribunal to several prior cases noting that sexual boundary violations justify lengthy suspensions, but Dr. Khumree's other admitted unprofessional conduct aggravated the situation.

[105] Mr. Boyer then addressed Dr. Khumree's argument that his practice is too busy and vital to the community for him to serve a significant suspension. Mr. Boyer referred to *Visconti v. College of Physicians and Surgeons*, 2012 ABCA 46 at para. 13. The Alberta Court of Appeal rejected a similar argument that physicians in short supply in areas of high demand should be held to a lower standard of accountability than other physicians. The Court held that patients are not disentitled to good quality of care by reason of the fact that their physician has a busy practice.

[106] Mr. Boyer also countered Dr. Khumree's argument by noting that if he had engaged in the admitted conduct today, his revocation would be automatic due to the new provisions of the *Health Professions Act*. Mr. Boyer suggested that a serious suspension is therefore warranted to maintain public confidence in the medical profession.

[107] Mr. Boyer submitted the following sanctions would be appropriate to impose in this case:

1. A 12-month suspension, to commence on a date acceptable to the Complaints Director;
2. A sexual boundary violation monitoring program with terms and conditions to be guided by the COAP assessment report;
3. The Hearing Tribunal should reserve jurisdiction in the event that Dr. Khumree and the Physician Health Monitoring Program are unable to agree on the terms and conditions of the monitoring program;
4. A practice permit condition requiring a chaperone for any sensitive examinations of female patients;
5. A $5,000 fine;
6. Payment of 75% of the costs of the hearing and investigation on terms acceptable to the Complaints Director.

Submissions on behalf of Dr. Khumree

[108] Ms. Prather began Dr. Khumree's submissions on sanctions by describing his relationship with [redacted] Their relationship was toxic and volatile. It was fueled by alcohol, prescription drugs and untreated major depression. Ms. Prather said that Dr. Khumree and [redacted] are both to blame for the emotional pain they caused each other, and this should be differentiated from the impacts of the doctor-patient relationship on [redacted] Ms. Prather acknowledged that Dr. Khumree's unprofessional conduct was very serious, and the harm caused by Dr. Khumree to his patient is his responsibility alone. He was not blaming

That being said, Dr. Khumree was not a predator. His relationship with was a consensual and long-standing adult relationship even though it was inappropriate. There was no significant age discrepancy between Dr. Khumree and Further, there was no evidence that was suffering any mental condition before her relationship with Dr. Khumree began and therefore no evidence that Dr. Khumree exploited any mental health issues.

[109] Dr. Khumree's personal circumstances exacerbated his situation. He was a new immigrant to Canada when he began practicing medicine in Alberta. He was only 28 years old, and he had been practicing medicine for less than one year when he met

[110] Dr. Khumree struggled to establish himself financially. He made poor investment decisions. He had a difficult relationship with his mother and remorse over his failed relationship with his father. He was lacking emotional supports. These circumstances contributed to his substance use disorder and his depression. Dr. Wright opined that Dr. Khumree's substance use disorder and depression contributed to his unprofessional behaviour. Ms. Prather submitted that the question of sanctions should be assessed through the lens of someone suffering major depressive disorder and substance use disorder. Dr. Khumree was also not receiving the best medical care between 2011 and 2015. Ms. Prather said that even Dr. Kazatchenko was surprised by how much she had continued to prescribe for Dr. Khumree.

[111] After struggling for four years, Dr. Khumree went to treatment, attending a three-month residential program in British Columbia. This was a new beginning for him. He successfully controlled his substance use disorder through the program, weekly counselling and with the assistance of the Physician Health Monitoring Program. Dr. Wright opined that Dr. Khumree had been well-treated, including for his avoidant personality disorder and he was fit to practice medicine. The evidence demonstrated that he had re-connected with his mother and that he was able to form personal relationships.

[112] Yet Dr. Khumree's residential treatment program caused him to lose his patient panel and a significant amount of income during and after the treatment. It took about two years to build it back up in a new location. This impacted Dr. Khumree's patients as well. The evidence showed that Dr. Khumree makes real differences in his patients' lives.

[113] Dr. Khumree made the decision to self-report his relationship with as a boundary violation in 2016 and this led to the investigation into his conduct. This demonstrated Dr. Khumree's insight and his role in acknowledging his unprofessional conduct. This should be considered a mitigating factor on sanctions. On March 2, 2016 Dr. Khumree signed an undertaking to have a chaperone present for all sensitive examinations of female patients. This has remained in place ever since. The Complaints Director has never attempted to suspend Dr. Khumree pending this hearing, or asked Dr. Khumree to submit to sexual boundary monitoring, or a sexual boundary violation course. It would not make sense to impose those types of sanctions now, some six years later. It would not be appropriate to mandate cognitive behavioural therapy now either, given the evidence that Dr. Khumree connects well with his patients.

[114] Dr. Khumree is a passionate and caring physician providing critical care to the population in Strathmore. He is no threat to the public. Ordering a suspension or sexual boundary violation monitoring program or a course now would be purely punitive and without justification. Even Dr. Wright suggested that a suspension might increase the risk of his substance use disorder relapsing.

[115] Ms. Prather commented on the cases cited by the Complaints Director. She said that none of them involve a physician dealing with substance use disorders or untreated depression. Ms. Prather argued that the Hearing Tribunal must take into account the duty to accommodate. Where the need for discipline arises because of behaviour driven by an addiction, or other mental health concerns, sanctions should be approached from the perspective of accommodations and focus on treatment: *Wright v. CARNA*, 2012 ABCA 267. Ms. Prather then referred to additional cases addressing sanctions in cases where the physicians required accommodations.

[116] Ms. Prather said that Dr. Khumree's failure to report the criminal charge against him and his self-prescribing were relatively minor compared to his sexual boundary violations with ███ His failure to report his criminal charges was fueled by guilt, shame and judgment clouded by addiction. He was also of the mistaken belief that he wasn't required to disclose his first criminal charge.

[117] Ms. Prather acknowledged the need to deter Dr. Khumree's proven unprofessional conduct but she urged the Hearing Tribunal to judge this case on its own facts. Dr. Khumree has no prior discipline history with the College and thus no need for a harsh sentence. He has already lived this case for several years. Ms. Prather argued that sexual boundary violations with patients today result in revocation so there is no need for general deterrence. In the case of Dr. Khumree specifically, his conduct since 2015 demonstrates no need for sanctions to deter him.

[118] Ms. Prather submitted that the Hearing Tribunal could signal that Dr. Khumree's conduct was serious by imposing the maximum fine of $50,000 along with a suspension with credit for the time Dr. Khumree had already taken away from practice. She suggested that this would be significant for Dr. Khumree, who was still digging himself out of his financial troubles. She argued that everyone can make a mistake and Hearing Tribunals should discipline physicians without negatively impacting the communities that rely upon them. The public may be more offended by the lack of available healthcare resources, than by a physician who breached a patient boundary to have a consensual, although inappropriate relationship while suffering from an illness. Ms. Prather referred to the evidence of Dr. Khumree's patients who testified that they need him, and a long suspension would not help.

[119] Ms. Prather submitted that the following sanctions should be imposed:

1. A five-month suspension, but with credit given for the time Dr. Khumree spent out of practice while he was attending residential treatment, so this should be considered fully served;
2. $50,000 fine payable to the College as a contribution to the patient relations program fund;
3. 50% or less of the College's investigation and hearing costs.

[120] Ms. Prather added that there should be no condition for a chaperone to accompany Dr. Khumree for sensitive examinations of female patients. A chaperone condition is not rationally connected to Dr. Khumree's unprofessional conduct. It would also be at odds with Dr. Wright's conclusion that Dr. Khumree is fit to practice. Ms. Prather said that the Physician Health Monitoring Program could maintain the condition, but it should not be imposed by the Hearing Tribunal on Dr. Khumree's practice permit even if it is possible to do so. There is similarly no need for full boundary violation monitoring as Dr. Wright did not recommend it and it makes no sense to require it.

V. ORDERS

[121] The Hearing Tribunal has carefully considered Dr. Khumree's admissions and the findings of unprofessional conduct, the evidence in the record and the submissions on behalf of the Complaints Director and Dr. Khumree. The Hearing Tribunal makes the following orders:

1. Dr. Khumree's practice permit shall be suspended for a period of six months, with three months of suspension commencing on a date acceptable to the Complaints Director, with the balance to be held in abeyance provided Dr. Khumree complies with the Tribunal's other orders;

2. Dr. Khumree's practice permit will be subject to the following conditions based on the COAP Assessment Report and Dr. Wright's February 21, 2021 letter:

    a. For time periods to be determined by the College's Physician Health Monitoring Program and Dr. Khumree's therapist:

        i. Dr. Khumree must attend regular therapy sessions to address his avoidant personality style and interpersonal relationships with a therapist approved by the Complaints Director and with periodic reports from the therapist to the College on a schedule approved by the Complaints Director;

        ii. Dr. Khumree must remain subject to an Alumni Agreement with the College's Physician Health Monitoring Program providing for periodic bodily fluid and breathalyzer testing so that the College can be alerted to any further substance use;

iii. Dr. Khumree must attend regular meetings with a physician mentor approved by the Complaints Director;

b. Within 1 year of this decision, Dr. Khumree must successfully complete education approved by the Complaints Director and at Dr. Khumree's cost on:

i. The interactions of race, culture and medical practice and trauma-informed care;

ii. The impact of personality types on effective interpersonal communications;

3. Dr. Khumree will pay a fine of $5,000 which may be paid in installments acceptable to the Complaints Director commencing on a date acceptable to the Complaints Director;

4. Dr. Khumree will pay 50% of the investigation and hearing costs in this matter which may be paid in installments acceptable to the Complaints Director commencing on a date acceptable to the Complaints Director.

[122] The Hearing Tribunal will retain jurisdiction to address any issues with the implementation of these orders.

Reasons for Orders

[123] Dr. Khumree's proven unprofessional conduct was inexcusable and extremely serious. The Hearing Tribunal considered that it warrants serious sanctions.

[124] Dr. Khumree breached the College's Standard of Practice on Sexual Boundary Violations and engaged in a sexual relationship with a patient who he was treating for depression and mental health concerns, including with prescription medications. This was not an isolated incident. It was a relationship that spanned a considerable period of time. Dr. Khumree clearly knew that his conduct was wrong, yet he allowed it to continue. There was a significant risk that patient ███ could have developed a dependency on Dr. Khumree due to the nature of their personal relationship. There was also a significant risk that Dr. Khumree's clinical judgment could have been compromised and that patient ███ could have suffered harm.

[125] Dr. Khumree also treated himself with prescription medications, including narcotic and sedative medications. This too was an ongoing pattern of behaviour. Dr. Khumree's conduct was unnecessary and contrary to the CMA Code of Ethics.

[126] Further, Dr. Khumree was dishonest with the College. He failed to disclose that he had engaged in a sexual relationship with a patient and that he had been charged with impaired driving. He breached the College's Standard of Practice: Self-Reporting to the College. Dr. Khumree admitted that he answered falsely because he was afraid of the consequences. This falls short of the expectations for a regulated member of the College.

Providing false information undermines the College's ability to carry out its public protection mandate and it harms the integrity of the medical profession in the eyes of the public.

[127] The Hearing Tribunal considered the impacts of Dr. Khumree's proven unprofessional conduct on patient Dr. Khumree was in a position of power over He also clearly recognized from his own medical training that sexual relationships with patients are wrong. Dr. Khumree had an obligation to maintain a therapeutic boundary between him and and to refrain from a sexual relationship with her. Dr. Khumree failed in this and placed his own interests ahead of his patient's interests.

[128] The victim impact statement said that has lost her trust in doctors to place her health ahead of their own personal interests. It said Dr. Khumree had never apologized to or accepted responsibility for the damage and pain he caused her. It said that Dr. Khumree had never had to face the consequences of his behaviour. The Hearing Tribunal has taken victim impact statement into account, but notes Ms. Ivans' evidence that she prepared the statement based on her discussions with Ms. Ivans typed the victim impact statement and reviewed and signed it, but without making any substantive alterations. did not compose or deliver the victim impact statement herself or testify at the hearing. Dr. Khumree had no opportunity to cross-examine her and the victim impact statement was not under oath or affirmation. The Tribunal has also noted Dr. Khumree's evidence that he was advised not to contact so he could not apologize to her.

[129] The Hearing Tribunal also considered several mitigating factors. Dr. Khumree was a young, relatively inexperienced physician and new to Canada when he met and subsequently began to treat and then became personally involved with with ensuing issues. Dr. Khumree's lack of any past discipline history is also a mitigating factor, but the Tribunal recognizes that an unblemished history means little for a physician with relatively little experience. Dr. Khumree did admit that his alleged conduct occurred and was unprofessional. This avoided the need for a contested hearing on the merits of the allegations and should be treated as a mitigating factor.

[130] The Hearing Tribunal has also considered that Dr. Khumree's unprofessional conduct occurred several years ago and he has made efforts to rehabilitate himself since then. Dr. Khumree has also already undertaken a boundaries course through the College of Physicians and Surgeons of British Columbia on November 2 and 3, 2018. He supplied a reference letter from Dr. Ferai Senzani attesting to his good character since they began working together in October 2015.

[131] There was also the evidence that Dr. Khumree was experiencing difficult personal circumstances and that he has an avoidant personality disorder with compulsive traits that contributed to his substance use and unprofessional conduct. The Hearing Tribunal considered that Dr Khumree's depression and substance use disorder were mitigating factors and that a rehabilitative approach to sanctions was necessary to accommodate Dr. Khumree. A purely punitive approach to sanctions would be inappropriate, but even

when accommodation is warranted it does not entitle the physician to a complete exemption from the discipline process: *Wright v. CARNA*, 2012 ABCA 267 at para. 69.

[134] In this case the Hearing Tribunal has considered the need for sanctions that will balance Dr. Khumree's need for accommodation and treatment, but also deter future unprofessional conduct. Our sanctions orders are therefore guided by the COAP report produced by Dr. Wright's team and the parties' submissions. We note that Dr. Wright testified that Dr. Khumree's risk of engaging in unprofessional conduct was not a significant risk, or her team would not have assessed him as fit to practice.

[135] It is critically important to deter not just Dr. Khumree, but the whole medical profession from breaching Standards of Practice, the CMA Code of Ethics and from engaging in unprofessional conduct that harms the integrity of the profession. Physicians must not see practice standards, ethical codes and rules as malleable when life inevitably presents challenging situations. Physicians must see those standards and codes as minimum standards to protect the public. They are warnings to stop and if necessary seek guidance for those challenging situations.

[136] The Hearing Tribunal believes the sanctions ordered above are necessary to reinforce the critical importance of its Standards of Practice, the CMA Code of Ethics and the avoidance of unprofessional conduct. The sanctions are necessary to deter Dr. Khumree and the medical profession at large from breaching boundaries with patients, from self-prescribing and from dishonesty with the College.

[137] The sanctions ordered above are also necessary to maintain public confidence in the integrity of the medical profession. The Hearing Tribunal considered but rejected Dr. Khumree's suggestion that he receive a suspension with credit for the time he spent in residential treatment away from his practice. The treatment Dr. Khumree attended in British Columbia was for his substance use disorder. Dr. Khumree's time away from work was not a sanction arising from the allegations for which he should receive credit. The Hearing Tribunal considered that the public would not appreciate the equation of residential treatment with a suspension to be imposed by the Hearing Tribunal.

[138] A suspension of six months, with three months to be served and an additional three months in abeyance pending compliance with the other sanctions is long enough to deter Dr. Khumree from similar unprofessional conduct in the future while remaining proportionate to Dr. Khumree's proven unprofessional conduct in this case. The Hearing Tribunal considered whether to suspend Dr. Khumree for longer, but decided it was not warranted in this case. It is unnecessary to impose a longer suspension to deter other physicians from similar sexual boundary violations since the *Health Professions Act* has been revised since Dr. Khumree's conduct occurred. If it were not for Dr. Khumree's depression and substance use disorder and the impacts on his behaviour at the time, the Hearing Tribunal would likely have imposed a significantly longer suspension, such as the 12 months proposed by the Complaints Director.

[139] The Hearing Tribunal considered the evidence of Dr. Khumree and his patients about the impact that a suspension would have on them. Ultimately the Tribunal rejected Dr. Khumree's submission that a suspension would do more harm than good. A three-month period of suspension to commence on a date acceptable to the Complaints Director will not unduly interfere with Dr. Khumree's care of his patients. Provided Dr. Khumree remains compliant with the other sanctions there will be no need for him to serve the balance of the six-month suspension. Further, the Alberta Court of Appeal rejected similar arguments in *Visconti v. CPSA*, 2012 ABCA 46 at para. 13. The Court held that it is unacceptable to suggest that physicians who practice in areas of high demand should be held to a lower standard of accountability. The Hearing Tribunal was also concerned at Dr. Khumree's suggestion that a suspension of his practice permit could be destabilizing for him. It caused the Hearing Tribunal to question whether Dr. Khumree has good control over his condition.

[140] The Hearing Tribunal strongly believes that conditions on Dr. Khumree's practice permit guided by the COAP report and Dr. Wright's supplemental letter are necessary in this case. Mental health issues and substance use disorders can relapse so ongoing treatment and care is important. The Hearing Tribunal expects that the conditions described above will ensure that Dr. Khumree obtains the necessary therapy to continue his recovery while protecting the public's interest in the safe and effective practice of medicine. These conditions will also ensure that the College is alerted if issues arise in the future requiring intervention. The education will assist Dr. Khumree to cope with challenging interpersonal situations that the COAP report identified as potentially problematic for him.

[141] A $5,000 fine represents a modest and appropriate contribution to the College's patient relations program fund. The Hearing Tribunal considered Dr. Khumree's proposal to make a much larger $50,000 contribution plus 50% of the investigation and hearing costs. The Tribunal decided to reject Dr. Khumree's proposal as it made no provision for the suspension of his practice permit going forward. The Tribunal believes a suspension is necessary in this case and that it is important to avoid any appearance that serious allegations such as sexual boundary violations could be resolved entirely through financial sanctions. The Tribunal also considered that a six-month suspension with three months in abeyance would not impose an excessive financial burden on Dr. Khumree. The Tribunal noted that he had proposed to pay a $50,000 fine in addition to 50% of the costs.

[142] The Hearing Tribunal was not advised of the amount of the investigation and estimated hearing costs, but we determined that Dr. Khumree should be required to pay 50% of those costs. The charges were serious and the hearing was necessary, but Dr. Khumree admitted all three charges and this avoided a contested hearing and spared witnesses from having to testify at the merits stage. Dr. Khumree should receive some credit for this. At the sanctions stage none of the witnesses or evidence called by the parties was irrelevant or unhelpful to the Tribunal. There was no unnecessary expenditure of hearing time. The Hearing Tribunal also noted that Dr. Khumree had suggested he should be responsible for 50%. While the Complaints Director had proposed that Dr. Khumree pay

75% of the costs, the Tribunal was concerned about the potential impact of a larger costs order on Dr. Khumree. 50% was determined to represent an appropriate balance in the circumstances of this case.

[143] The Hearing Tribunal also considered each of the previous cases cited by Mr. Boyer for the Complaints Director and by Ms. Prather for Dr. Khumree. The cases demonstrate that sexual boundary violations and related conduct by physicians have generally resulted in long suspensions ranging from 12 to 18 months. The cases also demonstrate that where mental illness or disability contributes to a physician's unprofessional conduct the Hearing Tribunal must consider that illness or disability in its analysis.

[144] In the case of *CPSA and Dr. Maritz*, the Council Review Panel heard an appeal from sanctions imposed on Dr. Maritz following findings that he engaged in inappropriate sexual relationships with two patients. Dr. Maritz was also found to have failed to disclose his sexual relationship with a patient to the College in a timely manner and to have breached an undertaking with the College. The Council Review Panel upheld an 18-month suspension. It also commented that due to the inherent power imbalance between a physician and patient, it is not possible for a physician and patient to enter a truly consensual relationship. Accordingly, such relationships are inappropriate and prohibited.

[145] In the case of *CPSA and Dr. Garbutt*, the physician admitted and was found to have had an inappropriate sexual relationship with his patient and that he had failed to report his sexual boundary violation to the College in his annual renewal information form. The Hearing Tribunal accepted a joint submission on sanctions for Dr. Garbutt to permanently withdraw from practice and pay a $5,000 fine. The Tribunal commented that had Dr. Garbutt not withdrawn from practice, it would have considered imposing a lengthy suspension. The Tribunal commented that where a physician misuses the power inherent in their relationship with a patient for personal gratification, the patient frequently suffers lasting damage, the public loses the ability to trust those entrusted with their most personal forms of care and the integrity of the profession is harmed.

[146] In the case of *CPSA and Dr. Laseleta*, the physician admitted and was found to have failed to maintain an appropriate boundary with his patient, to have failed to properly terminate the doctor-patient relationship before pursuing a personal relationship which ultimately became a sexual relationship. The Hearing Tribunal accepted a joint submission on sanctions for a 12-month suspension and requiring a multi-disciplinary assessment for fitness to practice prior to any reinstatement. In this case Dr. Laseleta had voluntarily withdrawn from his practice when the complaint was made so the Tribunal accepted the joint proposal that he receive credit for this with the result that the suspension was fully served.

[147] In the case of *CPSA and Dr. Lycka*, the physician admitted to having a sexual relationship with his patient and to failing to create and maintain clinical records for treatment he provided. The physician did not admit that his conduct was unprofessional, but the Hearing Tribunal concluded that it was. The Tribunal accepted a joint submission

on sanctions for Dr. Lycka to serve a 12-month suspension and to enter into an after-care agreement of at least 5 years or until he retires. Dr. Lycka was also required to complete a boundaries course. Dr. Lycka had withdrawn from practice for health reasons as of the date of the hearing so the sanctions were contingent on a determination that he was fit to return.

[148] In *CPSA and Dr. Rydz*, the physician was found to have engaged in an inappropriate sexual relationship with his patient. The Council of the College ordered pursuant to the *Medical Profession Act* that Dr. Rydz be suspended for a period of 18 months, of which he would serve 16 months with the balance of 2 months held in abeyance pending the completion of the other terms and conditions ordered. The Council noted that Dr. Rydz had already been suspended for 16 months so the suspension was considered served. Conditions were also imposed requiring a boundaries course, a continuing care agreement for 5 years, and that Dr. Rydz would practice only in a setting acceptable to the College with a practice monitor acceptable to the College.

[149] In *CPSO and Dr. Schwarz*, the physician was found to have engaged in the sexual abuse of a female patient by touching her inappropriately, and by engaging in unprofessional conduct regarding three nurses by inappropriately touching them and commenting in a sexual manner without consent. The Discipline Committee ordered revocation of the physician's registration, a reprimand and reimbursement of the cost of patient therapy.

[150] In *CPSA and Dr. Smeida*, the physician was found guilty of unprofessional conduct for pursuing and engaging in an intimate relationship with one patient and inviting a second patient to engage in a personal relationship with him. The Hearing Tribunal reprimanded and suspended the physician for a minimum of one year and imposed conditions on his return to practice, including a boundaries course, a multidisciplinary assessment, a chaperone requirement and a continuing care agreement for at least 5 years.

[151] In *Re McKennitt*, 2018 CarswellAlta 2545, a CPSA discipline decision, the physician admitted and was found guilty of charges including violating practice conditions made pursuant to a continuing care agreement by self-prescribing, prescribing for a patient in a personal relationship with him, and deceiving or attempting to deceive the College in its investigation. The Hearing Tribunal accepted a joint submission providing for the physician to receive a 24-month suspension with credit for time he had been suspended on an interim basis and conditions on his practice permit. In doing so the Hearing Tribunal held that the conditions to be imposed on the physician's practice addressed the ongoing risk arising from his medical issues. The sanctions therefore appropriately included elements designed to assist the physician with treatment under necessary and stringent conditions.

[152] In *CPSA and Dr. Dicken*, the physician was found guilty of failing to maintain an appropriate professional relationship with the mother of his infant patient over a period of five months. He was ordered to serve a 9-month suspension, complete a boundaries course, attend a multi-disciplinary assessment prior to reinstatement and enter into a continuing care agreement. There was no evidence that the physician had any underlying

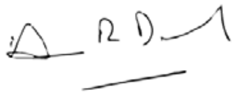
psychological or neuropsychological pathology that contributed to his unprofessional conduct, but the Hearing Tribunal was not satisfied this had been sufficiently investigated. It directed the multi-disciplinary assessment to investigate this question.

[153] In the case of *Dr. Velestuk and the CPSS*, the physician admitted and was found guilty of charges including billing for services that were not rendered, failing to meet record keeping standards, and providing false samples for drug testing. The physician's admitted addiction to multiple substances was a key mitigating factor in the Council's analysis. The Council held that misconduct occurring as a result of active addiction must be considered differently than had the conduct occurred in the absence of addiction. The Council accepted a joint submission for a reprimand, a 7-month suspension to be served retroactively given the time already suspended, a further suspension pending the physician giving an appropriate undertaking for future compliance, a $15,000 fine, and an ethics course in professionalism.

[154] Ms. Prather also referred to *Singh and the Law Society of British Columbia*, 2013 LSBC 17. In that case the lawyer admitted to unprofessional conduct including breaches of accounting rules, failures to rectify trust shortages, and borrowing funds from a client and then misleading that client. The evidence demonstrated that the lawyer's behaviour was the result of a disability, being his uncontrolled addiction to alcohol. While the parties both submitted that the lawyer's conduct would normally warrant a significant suspension, they argued that the sanctions to be imposed should take his disability into account. The Discipline Panel accepted a joint submission for the lawyer to pay a $10,000 fine and be subject to conditions on his practice, including medical monitoring.

[155] The Complaints Director had proposed that Dr. Khumree should continue to be subject to an order to have a chaperone accompany him for any sensitive examinations of female patients. Dr. Khumree's proven unprofessional conduct was unrelated to any sensitive examination of a female patient. There has been no suggestion of any issues with Dr. Khumree's care of patients other than ███ The Hearing Tribunal therefore declined to make this order.

Signed on behalf of the Hearing Tribunal by its Chair:



Dr. Alasdair Drummond

Dated this 2nd day of March, 2022.