COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

("THE COLLEGE")

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. BRIANNE HUDSON

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

INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Brianne Hudson on February 14, 15 and 16, and April 13, 2022. The members of the Hearing Tribunal were:

   Ms. Naz Mellick, public member and Chairperson;
   Dr. Randall Sargent;
   Dr. Brinda Balachandra; and
   Mr. James Lees, public member.

2. Mr. Gregory Sim of Field Law acted as independent legal counsel for the Hearing Tribunal.

3. Mr. Craig Boyer appeared as legal counsel for the Complaints Director, Dr. Dawn Hartfield, who was also in attendance. Ms. Taryn Burnett and Ms. Shayla Stein appeared as legal counsel for Dr. Brianne Hudson. Dr. Hudson also attended the hearing.

PRELIMINARY MATTERS

4. There were no objections to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing from either party.

5. Ms. Burnett explained that she would be applying to close a portion of the hearing to the public at the appropriate time.

OPENING STATEMENTS

6. Mr. Boyer introduced the agreed book of exhibits and an admission agreement signed by Dr. Hudson. Mr. Boyer explained that Dr. Hudson admitted a sexual relationship with [redacted] but the allegation that this relationship amounted to sexual abuse within the meaning of the *Health Professions Act*, RSA 2000, c. H-7 ("*Health Professions Act*") would be contested, along with the second allegation. Mr. Boyer explained that the Complaints Director at the time in question, Dr. Michael Caffaro, would testify as would [redacted]'s parents who made the complaint to the College.[1]

7. Ms. Burnett deferred her opening remarks until the commencement of Dr. Hudson's case.

ALLEGATIONS

8. The Notice of Hearing contained the following allegations of unprofessional conduct against Dr. Hudson:

[1] [redacted]'s name has been replaced with '[redacted]' throughout this document.

i. Between August 2019 and December 2019 you did have a sexual relationship with your patient, [redacted], amounting to sexual abuse as defined under the *Health Professions Act*;

ii. You did submit your 2020 Renewal Information Form with the false information that you had not had a sexual boundary violation [with a] patient that had not been reported to the College of Physicians and Surgeons of Alberta;

All of which is contrary to the College of Physicians and Surgeons of Alberta Standards of Practice which constitutes unprofessional conduct under the *Health Professions Act*, RSA 2000, c. H-7.

EVIDENCE of the COMPLAINTS DIRECTOR

Dr. Michael Caffaro

9. Mr. Boyer first called Dr. Michael Caffaro. Dr. Caffaro was the Complaints Director prior to January 21, 2021 and dealt with the complaints against Dr. Hudson.

10. Dr. Caffaro testified that he first received a complaint from Allen Gukert, the Director of the Peace River Correctional Centre ("PRCC") dated February 8, 2019. Mr. Gukert complained that Dr. Hudson was confrontational and argumentative with him when PRCC was attempting to arrange to transfer [redacted] from the Grande Prairie Queen Elizabeth II Hospital to a healthcare facility closer to the PRCC. [redacted] was incarcerated and the Court had remanded [redacted] to the custody of the PRCC until his next court date. Mr. Gukert alleged that Dr. Hudson denied [redacted]'s transfer without a medical reason; questioned the need for PRCC staff to monitor [redacted] while in hospital; provided him with a bag of food from McDonald's; attempted to allow [redacted] to use her personal cell phone; and paid a $500 cash deposit for [redacted] to be released from custody representing a violation of her professional boundaries.

11. The complaint from Mr. Gukert was investigated. Dr. Hudson provided a response to the complaint dated May 16, 2019. Dr. Hudson's response explained her involvement in [redacted]'s care and her decisions to bring McDonald's to the hospital for [redacted]; to attempt to locate a lawyer for [redacted]; and to become his advocate after she ceased providing him with medical care. She said the last day that she treated [redacted] as a patient was December 28, 2018 when she wrote an order for him to receive Gravol.

12. Dr. Hudson's response explained how she agreed to use [redacted]'s bank card to transfer $2,000 from his bank account to a law firm to represent [redacted] in upcoming court proceedings, and then to facilitate communications between [redacted] and his lawyer. Dr. Hudson said she did not recall allowing [redacted] to use her personal cell phone, but she acknowledged it was possible that she did. Dr. Hudson also acknowledged that she paid [redacted]'s $500 bail on January 9, 2019. She then explained that she located a wheelchair-

accessible housing option for [redacted] and took him out of the hospital to view it, co-signed his lease and paid his damage deposit and first month's rent on January 25, 2019.

13. Dr. Hudson's response then explained that on February 7, 2019 [redacted] was discharged from hospital and they began a close personal relationship including hugging and kissing on the cheek. In her May 16, 2019 response to the Gukert complaint she wrote that she and [redacted] were friends and they had not engaged in any sexual contact.

14. Mr. Gukert's complaint was resolved through a Memorandum of Understanding with Dr. Hudson dated August 7, 2019. Dr. Hudson accepted a referral to the Physician Health Monitoring Program and attended the Alliance Assessment Centre in Houston in July 2019. She also agreed to take a course on professionalism and ethics. Dr. Hudson received confirmation from Dr. Caffaro that the complaint file had been closed on September 17, 2019.

15. Dr. Caffaro agreed on cross-examination that Dr. Hudson had attended the Alliance Assessment Centre from July 30 to August 1, 2019. Following her attendance there he had no reason not to allow her to practice medicine.

16. Dr. Caffaro subsequently learned that Dr. Hudson and her legal counsel wished to meet with him. Dr. Caffaro met with Dr. Hudson and Ms. Burnett on January 24, 2020. Dr. Hudson disclosed that following her attendance at the Alliance Assessment Centre in July 2019 she had engaged in an increasingly personal and emotionally intimate relationship with [redacted]. Dr. Hudson disclosed that her relationship with [redacted] had become sexual on two occasions in August and November of 2019 and they had an ongoing personal relationship.

17. Dr. Caffaro treated this disclosure from Dr. Hudson as a new complaint. He asked Dr. Hudson to withdraw from medical practice on an interim basis and she agreed to withdraw as of February 13, 2020. Dr. Hudson also agreed to attend a further assessment at the Alliance Assessment Centre in Houston. Dr. Hudson responded to the new complaint on February 14, 2020.

18. Dr. Caffaro agreed that the Alliance Assessment Centre report from February 2020 concluded that Dr. Hudson could return to the safe practice of medicine in a controlled setting.

19. Dr. Caffaro then testified that the College received another complaint about Dr. Hudson from [redacted]'s parents, [redacted] and [redacted], dated February 24, 2020. It alleged that Dr. Hudson had over-stepped her ethical boundaries in her interactions with [redacted]. Dr. Hudson responded to this further complaint on April 17, 2020.

20. Dr. Caffaro then testified that Bill 21, *An Act to Protect Patients* was passed in 2018, but the provisions addressing sexual abuse and sexual misconduct took effect as of April 1,

2019. Dr. Caffaro explained that the College took steps to notify its registrants about the Bill 21 changes beginning in the fall of 2018. The College's website was updated and all of the College's registrants were notified about the meaning of the changes when Bill 21 received Royal Assent. The College's new Standard of Practice concerning sexual abuse and sexual misconduct was the subject of a *Messenger* newsletter to registrants in March 2019 and it was emailed to all registrants in April 2019. Registrants were also all required to complete a continuing professional development module on the Bill 21 changes by the end of December 2019 in order to renew their registration and practice permits for 2020. Dr. Caffaro agreed on cross-examination that this module first became available to registrants in August 2019.

[redacted]

21. Mr. Boyer next called [redacted], who is [redacted]'s father. [redacted] explained that he and his wife [redacted] complained to the College because Dr. Hudson was attempting to block them from knowing what was happening with [redacted]. Dr. Hudson had also confronted [redacted] and his wife when they were trying to help [redacted] move to his new apartment.

22. [redacted] said he was first aware of [redacted]'s relationship with Dr. Hudson in or around May of 2019. [redacted] understood that Dr. Hudson and [redacted] were dating, but he only saw Dr. Hudson kiss [redacted] lightly. He initially believed that Dr. Hudson would be good for [redacted], but he later began to see her controlling him.

23. [redacted] exchanged text messages with Dr. Hudson beginning on December 14, 2019. He said he was confused about Dr. Hudson's role in [redacted]'s life and whether she was his physician because she was dealing with his prescriptions. Dr. Hudson texted [redacted] and told him "I just called the pharmacy and they said he's been off [suboxone] since November" and "That's not good". [redacted] believed there was a doctor-patient relationship between late 2019 and early 2020. Dr. Hudson also provided [redacted] with medical advice about the care that [redacted] would need at the hospital.

24. The last time [redacted] was aware of [redacted] having contact with Dr. Hudson was in the spring of 2020, when she got him into a facility in Calgary and travelled there with him.

[redacted]

25. Mr. Boyer next called [redacted], who is [redacted]'s step-mother. [redacted] confirmed that she authored the complaint to the College on behalf of [redacted] and herself. [redacted] said that in May 2019 [redacted] told them he had a girlfriend, but it was a secret because she was his physician, and she would lose her job if anyone found out. [redacted] said that she understood Dr. Hudson was [redacted]'s girlfriend and his physician at that point in time.

26. [redacted] said she heard nothing about [redacted] and Dr. Hudson's relationship over the rest of 2019, then described meeting Dr. Hudson on January 31, 2020, when she went with [redacted] and their

other son to Grande Prairie to help [redacted] move. [redacted] said meeting Dr. Hudson was awkward because of a previous text exchange.

27. Mr. Boyer then closed the Complaints Director's case.

Dr. HUDSON'S OPENING STATEMENT

28. Ms. Burnett began Dr. Hudson's case with an opening statement. Ms. Burnett explained that the issue in this case would be the application of the *Health Professions Act* and the relevant standards of practice to the facts. The Hearing Tribunal would need to consider the evidence of when Dr. Hudson last treated [redacted] on December 28, 2018 and how their relationship started in January of 2019 and progressed from there. Ms. Burnett said they would also call evidence to address the Renewal Information Form. Ms. Burnett said she would first call Dr. Hudson. She would then call Dr. Peter Graham from Acumin, Mr. Nate Lakusta who is Dr. Hudson's former spouse, Dr. Brad Martin who is Dr. Hudson's practice mentor, Dr. Darryl Bartie her practice monitor and Matt Petrie, her treating psychologist.

SECTION 78 APPLICATION

29. Ms. Burnett then made an application under section 78 of the HPA to close part of the hearing to the public.

30. Section 78 allows the Hearing Tribunal to order that a hearing or part of a hearing be closed to the public. Section 78 lists several possible grounds for this, including probable prejudice to a civil action or the prosecution of an offence; to protect the safety of the person who applies or of the public; because not disclosing a person's confidential personal health, property or financial information outweighs the desirability of having the hearing open to the public; because the presence of the public or the complainant could compromise the ability of a witness to testify; or other reasons satisfactory to the Hearing Tribunal.

31. Ms. Burnett submitted that in this case the Hearing Tribunal would receive reports that contain very personal information. They would detail information about Dr. Hudson's upbringing, her health and her family. There is a risk that disclosing this information to the public could cause significant harm. These reports would be described during Dr. Graham's evidence. Ms. Burnett said that closing the portion of the hearing during which Dr. Graham would testify and not disclosing this information to the public through an open hearing or through the availability of the transcripts of Dr. Graham's testimony or when those reports were discussed would outweigh the desirability of having the hearing open to the public.

32. On behalf of the Complaints Director Mr. Boyer did not oppose the application to close the part of the hearing during which Dr. Graham would testify. Mr. Boyer submitted there would be no objection to closing any other portion of the hearing when the Alliance and

Acumin reports are discussed, provided the closing and re-opening of the hearing is clearly defined for the record.

33. After hearing from the parties, the Hearing Tribunal allowed the application to close the portion of the hearing during which Dr. Graham would testify and any other portion of the hearing when the Acumin and Alliance reports are discussed. The Hearing Tribunal understands that Dr. Graham's testimony and the Acumin and Alliance reports will describe very personal details about Dr. Hudson, but also about third parties including members of her family. Preserving the confidentiality of this information about third parties does outweigh the desirability of holding the whole hearing in public. Closing only the portion of the hearing during which this very personal information will be discussed balances the need for confidentiality with the need for open and transparent discipline proceedings.

EVIDENCE of DR. HUDSON

Dr. Brianne Hudson

34. Dr. Hudson graduated from medical school in 2011 and subsequently undertook a family medicine residency in Grande Prairie. By the time of the hearing she had been in family medical practice in Grande Prairie for 9 years.

35. Dr. Hudson has a broad scope of practice. She maintains a general family medicine practice, works part-time in the emergency department, serves as a hospitalist rounding on hospital in-patients and in long-term care and she maintains a special interest in HIV-medicine. After returning to practice in 2020 she worked with a chaperone and could only see outpatients. She did maintain her practice of seeing HIV patients in Grande Prairie and the surrounding areas. She also described an interest in complex pain and transgender medicine patients.

36. Dr. Hudson said she first met [redacted] in 2011 shortly after she began her residency. [redacted] was admitted to the hospital and she rounded on him and assessed him. Dr. Hudson described how [redacted] had made a positive impression on her.

37. Dr. Hudson said she next saw [redacted] in 2016 when he began to visit the hospital frequently due to an opioid addiction. [redacted] was paraplegic following a workplace accident and he suffered from problematic wounds that would become infected. Dr. Hudson would see him in the emergency department and when she was on call as a hospitalist for her physician group, which was about every 6 or 7 weeks.

38. Dr. Hudson then described that following the birth of her youngest child she suffered postpartum anxiety. In November of 2018 her common law partner was returning to work and her youngest child was starting daycare. Dr. Hudson was also working 6 or 7 days each week at this time. She said this was stressful for her and made her anxious so she

began to take medication. Dr. Hudson described that her emotional needs were not being met while she was trying to meet the needs of her patients and her family.

39. On December 20, 2018 [redacted] was in hospital for osteomyelitis and wound care. [redacted]'s physician went on holiday and Dr. Hudson took over his care as an in-patient. She rounded on him and learned at that time that [redacted] was incarcerated with corrections officers guarding him at all times.

40. Dr. Hudson said [redacted] described his medical treatment while in detention and it made her very upset. She said he described not having the necessary cushion to sit on to accommodate his wound vacuum and dressings and he had not been provided with proper care for his ostomy. She said he had also been required to walk and climb into a vehicle on his own and that he fell and his wound dressings ripped off. She also said he described being made to drag himself across the floor of his cell to reach the food that was provided to him.

41. Dr. Hudson said that [redacted] told her he had a court date on January 2, 2019 and that he was facing 2 to 5 years of incarceration. She said she became concerned about [redacted]'s life if he was sentenced to incarceration. On December 21, 2018 Dr. Hudson suggested to [redacted] that he needed legal counsel. He did not have a cell phone of his own since he was incarcerated. Dr. Hudson asked the corrections officers if [redacted] could use her phone, but they said no and that they had a phone for [redacted] to use.

42. Dr. Hudson then said that she received a telephone call asking for her approval to transfer [redacted] to the hospital in Peace River. Dr. Hudson said that unlike Grande Prairie there is a correctional facility in Peace River. She believed the purpose of this request was so that the correctional officers could be closer to their families for the holidays. Dr. Hudson refused the request. She said she had never before been asked to transfer a patient for that kind of reason. Grande Prairie was [redacted]'s home. He had specific and complicated medical needs including a "PICC" line that they had the ability to address in Grande Prairie. Dr. Hudson refused two further telephone requests to transfer [redacted], including a request from Mr. Allan Gukert.

43. Dr. Hudson then began to feel that she was in a moral dilemma. [redacted] had an upcoming court date and required legal assistance. He had money in his bank account, but he didn't have a lawyer. She began to contact lawyers to find someone to assist [redacted]. She also offered to continue to see [redacted] as his advocate after his regular physician returned from holidays and took over his medical care. Dr. Hudson said that the last medical thing she did for [redacted] was to write a prescription for gravol for him on December 28, 2018. After that she became his advocate. Dr. Hudson contacted lawyers to assist [redacted], engaged and paid a lawyer and acted as a liaison between [redacted] and his lawyer.

44. [redacted]'s lawyer arranged his cash bail which Dr. Hudson also paid until she could pay herself back from [redacted]'s bank account. [redacted] had given Dr. Hudson access to his bank account.

45. [redacted] was released from incarceration on January 10, 2019. Dr. Hudson said she went to visit [redacted] that afternoon and he gave her a gift. Dr. Hudson said that was a turning point for her and she began to having feelings for [redacted]. She then offered to help [redacted] find a permanent place to live instead of the shelter where he had been residing.

46. Dr. Hudson described meeting with the Chief of Family Medicine, Dr. Byebwa in approximately mid-January 2019. She said that Dr. Byebwa raised a concern about her relationship with [redacted]. He said that some nurses had expressed concerns about Dr. Hudson's relationship with [redacted], and with paying his bail. Dr. Hudson said she had stopped treating [redacted] or looking at his medical records in December of 2018. She said Dr. Byebwa was satisfied with this explanation and told her it was ok to support [redacted] to move out of the homeless shelter where he had been living.

47. Dr. Hudson then took [redacted] to look for apartments. When [redacted] learned that he couldn't rent an apartment without a co-signor, Dr. Hudson discussed with him whether she should co-sign his lease. She said [redacted] was doubtful that she should do this and looking back he had a lot of insight that she did not have at the time. Eventually [redacted] accepted her help with a lease. Dr. Hudson took [redacted] to his new apartment around the end of January 2019 and they hugged for the first time. She helped him pack his things and move out of the homeless shelter.

48. Dr. Hudson said that her relationship with [redacted] was developing very quickly at this time. She had developed strong feelings for him. On February 11, 2019 she decided to tell [redacted] how she felt. She told him that he was the new love of her life and they hugged. Shortly thereafter around mid-February 2019 Dr. Hudson told her common law partner that she was in love with [redacted] and saw no future with him. By March of 2019 Dr. Hudson and [redacted] were hugging, kissing, lying in bed together and touching in a sensual way.

49. Dr. Hudson said she learned of Mr. Gukert's complaint in April of 2019. She responded to the complaint in her letter to the College dated May 16, 2019. Her response set out a detailed chronology of the development of her interactions with [redacted] and the development of their personal relationship. Dr. Hudson wrote in part that "presently, [redacted] and I are friends. At no time have we engaged in sex of any kind (including penile-vaginal, oral, anal, or masturbation)." Dr. Hudson did acknowledge that her relationship with [redacted] to that point in time had included hugging and kissing on the cheek. She ended the letter by acknowledging that her conduct had crossed boundaries. She said that she had never developed this type of relationship with any other patient and she would "not allow this to happen again in the future."

50. In August of 2019 Dr. Hudson entered into a Memorandum of Understanding with the College. She accepted a referral to the College's Physician Health Monitoring Program and agreed to cooperate with the Assistant Registrar for the program, Dr. Beach. Dr. Hudson also agreed to complete a course on professionalism and ethics. Dr. Hudson said

the College also required her to go for a neuropsychiatric evaluation at the Alliance Centre in Houston, Texas from July 30 to August 1, 2019.

51. Dr. Hudson said the Alliance Centre assessment report wasn't available until about two months later, but her understanding was that Dr. Hobday of the Alliance Centre had spoken to Dr. Caffaro and told him that she was fit to practice with conditions. Dr. Hudson said she understood that she was permitted to have an ongoing relationship with [redacted]. She said she had asked Dr. Hobday when it would be permissible for her to have a sexual relationship with [redacted] but Dr. Hobday told her she couldn't answer that and deferred to the College.

52. Dr. Hudson was asked about Dr. Hobday's report in cross-examination. She said the report did not say that a relationship with [redacted] was prohibited, so she took this to mean that a relationship would be permitted.

53. Dr. Hudson said that when she returned from Houston, the College required her to attend a boundaries course and she had to maintain a practice mentor, Dr. Brad Martin, but she was permitted to continue practicing.

54. Dr. Hudson's relationship with [redacted] was ongoing after her return from Houston. It was at this time, in August of 2019, that their relationship became sexual for the first time. They had several sexual encounters in mid to late August 2019. Dr. Hudson then attended a boundaries course offered through the College of Physicians and Surgeons of British Columbia on November 1 and 2, 2019. She said she found the course confusing and received no clear guidance. She said she understood from the course that at some stage a sexual relationship with [redacted] would be appropriate.

55. Dr. Hudson said that it was after she returned from the boundaries course in British Columbia that she began to feel guilty about her relationship with [redacted]. She said they had sexual intercourse on one further occasion and she decided to report herself to the College. She said she initiated discussions with the College in late November of 2019 and by mid-December a meeting had been scheduled with Dr. Beach for January 23, 2020. In cross-examination Dr. Hudson acknowledged that her reference to sexual intercourse meant conduct described in the definition of "sexual abuse" in the *Health Professions Act*.

56. Dr. Hudson said she submitted the College's Renewal Information Form in support of her annual renewal application on December 22, 2019. She answered "No" to the question "are you presently, or have you ever, engaged in a sexual or inappropriate personal relationship with a patient that has not been previously reported to CPSA?" Dr. Hudson said she answered "No" because she said the College was already aware of her relationship with [redacted] and a meeting had already been scheduled with Dr. Beach for her to report herself.

57. Dr. Hudson met with Dr. Beach on January 23, 2020 and he advised her to report to Dr. Caffaro. A meeting with Dr. Caffaro was arranged for the following day and Dr. Hudson reported herself to him as well. Following her meeting with Dr. Caffaro, Dr. Hudson gave a written undertaking to the College to withdraw from practice effective February 13, 2020. She also undertook to undergo a further assessment at the Alliance Centre in Houston.

58. Dr. Hudson attended the further assessment in Houston from February 25 to 26, 2020. Following her return she was permitted to return to practice, but with conditions. These conditions were set out in an agreement between the College and Dr. Hudson dated July 3, 2020 and remained in place as of the date of the hearing. The conditions included having a chaperone present for all patient interactions including telephone appointments other than the communication of urgent information, having another physician or regulated health professional present in any clinical setting, having a practice monitor, Dr. Darryl Bartie and a practice mentor, Dr. Brad Martin, to attend counselling and to participate in a boundaries aftercare program.

59. Dr. Hudson said that in August of 2019 when her sexual relationship with [redacted] began, she did not understand that the definition of a "patient" in the College's standards of practice had changed. She said she considered [redacted] to be her former patient and she believed their relationship was permitted. Dr. Hudson said the College's training for physicians about the Bill 21 changes to the *Health Professions Act* first became available in August of 2019, but she completed the training in March of 2020.

60. Dr. Hudson said that she last saw [redacted] in February of 2021 and has had no contact with him at all since April of 2021. She has no plans to reconnect with him.

61. Dr. Hudson commented on her exchange of text messages with [redacted]'s father, [redacted]. Dr. Hudson confirmed that she contacted [redacted]'s pharmacy about his prescription because she was concerned about him. She said she was not involved in prescribing his suboxone. In response to a question from the Hearing Tribunal, Dr. Hudson said that the pharmacy knew her as Dr. Hudson. She was calling as [redacted]'s partner and not as his physician, but she did not clearly identify her role when she called. She acknowledged that she received more information from the pharmacy that she would have been able to obtain had she not been a physician.

62. Dr. Hudson also commented on her interactions with [redacted] and [redacted] in January of 2020 when [redacted] was moving to a new apartment and his family came from out of town to help. She felt she acted inappropriately with them, crossed boundaries, and said things that she should not have said. She said she took responsibility for her actions that day.

63. Dr. Hudson described the steps she has taken since this matter came to light. She voluntarily underwent a 4-day forensic fitness for duty evaluation with Dr. Peter Graham of Acumen Assessments in Kansas in October of 2021. Dr. Hudson said that Dr. Graham and his team confronted her in a way that she had not previously experienced. She said

Dr. Graham's team helped her to understand that her previous therapeutic relationship with [redacted] caused a power imbalance and it would never have been appropriate to have a relationship with him. Dr. Hudson said that before going to Kansas she had been of the view that a sexual relationship could have been appropriate after some time had passed.

64. Dr. Hudson said she had a follow up telephone call with Dr. Graham in November of 2021 and he had recommended that she see Matt Petrie in Leduc for counselling. Dr. Hudson said she had been seeing Mr. Petrie since late November.

65. Dr. Hudson also described attending a 2-hour holistic boundaries course with a spiritual healer in May 2020. She said this course was pivotal in shifting her view of boundaries. She now understands crossing boundaries to be harmful on a "soul level".

66. Dr. Hudson concluded her direct testimony by telling the Hearing Tribunal that she is a person who wants to do what is right. She said she was torn by the complex scenario with [redacted] in December of 2018. She felt it would be unconscionable not to assist him, but she acknowledged that doing so was a slippery slope and led to boundary violations. Dr. Hudson said she now has very good awareness of her professional boundaries; she thinks about them multiple times each day. She also said that her core beliefs have changed. She said she can now give herself permission to maintain boundaries with patients who need help beyond the scope of her profession. She now has a support network to talk with about boundaries and prevent future issues. As an example, Dr. Hudson described an interaction with a patient who was experiencing career issues and she had wanted to write a reference letter on her behalf. Dr. Hudson said she discussed this with the chaperone who identified it as a boundary issue. Dr. Hudson then spoke with her practice monitor about it and they agreed she should not write the letter.

67. Dr. Hudson said she wanted to continue with her rehabilitation and to continue to practice medicine in Grande Prairie. She said she could guarantee that she would not enter an inappropriate personal or sexual relationship in the future. She apologized to the Hearing Tribunal, the College and to the medical profession for her conduct. She also apologized to [redacted], to [redacted] and [redacted] and their family.

68. In response to a question from the Hearing Tribunal about the impacts of her conduct on [redacted], Dr. Hudson said that her boundary crossings got [redacted] involved in a stressful situation. She said that [redacted] felt bad about his role and that he felt emotional distress.

69. In cross-examination Dr. Hudson acknowledged that after she wrote her May 16, 2019 letter to the College responding to Mr. Gukert's complaint, she engaged in a sexual relationship with [redacted] in August and November of 2019, including sexual intercourse. She also acknowledged that her sexual encounters with [redacted] fell within the activities described in the definition of "sexual abuse" in the *Health Professions Act*. She said that at the time she relied on her own understanding of the College's standards of practice that [redacted] was a former patient and she did not think that their relationship could be sexual abuse. She did

not take any steps to verify that her relationship with [redacted] was permissible first. She also acknowledged that she receives the College's *Messenger* newsletter and she presumed she received the College's notifications about Bill 21 in 2018 and 2019, but she did not remember. She said she receives the *Messenger* but she does not read it every month.

70. Dr. Hudson also acknowledged that the first time she told anyone at CPSA about her sexual relationship with [redacted] was on January 23, 2020, when she met with Dr. Beach.

Mr. Nate Lakusta

71. Mr. Lakusta was Dr. Hudson's common law partner for roughly 7 years before she became involved with [redacted]. Mr. Lakusta said he first became aware of [redacted] in late 2018, or early 2019 when he learned that Dr. Hudson had been helping [redacted] at the hospital and with his bail. Mr. Lakusta had recently returned to work and Dr. Hudson was in therapy. Their relationship was not on good terms and he found his partner's degree of involvement with [redacted] to be strange.

72. Dr. Hudson told Mr. Lakusta on Valentine's Day 2019 that she had feelings for [redacted]. Mr. Lakusta said this was awkward for him and Dr. Hudson seemed off. They went on a previously planned family trip to Mexico in February before separating in April of 2019.

73. Mr. Lakusta described changes in Dr. Hudson that he saw since she returned from Acumen Assessments in Kansas. He said she was now able to see other people's perspectives, step back and evaluate situations better, and she was now more considerate of his time and his perspective on co-parenting their children. He said the therapy had helped to make her a better person.

Dr. Peter Graham

74. Dr. Peter Graham is the founder of Acumen Assessments and a licensed psychologist in Kansas. His practice focuses on forensic fitness for duty assessments for physicians, which he described as 95% of what they do.

75. Dr. Graham was in contact with Dr. Hudson for several months and received collateral information including the two previous assessments by the Alliance Centre in Houston before she attended in Kansas for an assessment with his team in the fall of 2021. He described the evaluation process used with Dr. Hudson, including the polygraph examination they used to rule out any boundary violations with other patients. Dr. Graham confirmed that Dr. Hudson passed the polygraph evaluation.

76. Dr. Graham's report extensively reviewed Dr. Hudson's background and the reasons that she voluntarily attended at Acumen Assessments. Her factual disclosures recorded in Dr. Graham's report included that while she was treating [redacted] in hospital, she would purposefully see him last so she could spend more time chatting and visiting with him.

[redacted]

77. [redacted]

78. [redacted]

79. [redacted]

80. Dr. Graham's report went on to summarize his evaluation findings. [redacted]

[redacted]

81. [redacted]

82. [redacted] Dr. Graham stated that Dr. Hudson would be fit for duty as a licensed physician only if she continues with her current process of accountability to the College and with a more fulsome commitment to therapeutic and educational rehabilitation. He then provided specific recommendations, including that Dr. Hudson see Matt Petrie for psychotherapy. He suggested ongoing monitoring for about 5 years would be typical. Dr. Graham acknowledged in his report that Dr. Hudson's violations of "Bill 21" would need to be examined in a formal hearing process and the College would remain the finder of fact regarding her ability to remain licensed.

Dr. Darryl Bartie

83. Dr. Bartie is a colleague of Dr. Hudson's in Grande Prairie and has served as her practice monitor over the last 1½ years. They are both part of the same primary care network, but they are not in the same practice or call group. Dr. Bartie said that Dr. Hudson approached him and asked him to serve in the role and he agreed.

84. Initially Dr. Bartie and Dr. Hudson met weekly to review cases where Dr. Hudson had questions about how she should proceed. They would identify and discuss the navigation

of any potential boundary issues. Then the College reduced the required frequency of their meetings to every two weeks, sometimes by phone. Dr. Bartie said he submits a report to the College every two to three months. He has no concerns about any inappropriate relationships with patients or former patients, or about her fitness to practice.

85. Dr. Bartie said that since Dr. Hudson returned from the Acument Assessment in Kansas she has seemingly learned a lot about herself and about boundaries. She now realizes that she could never again have a relationship with [redacted].

Matt Petrie

86. Mr. Petrie is a registered psychologist practicing in Leduc, Alberta and specializing in trauma-informed care for first responders and military clients. He acknowledged that Dr. Hudson was the first physician he had seen for sexual boundary violation issues and he reported little previous experience with sexual boundary issues. He began to see Dr. Hudson when she was referred to him for her boundary violations. Mr. Petrie used cognitive behavioural therapy and insight oriented behavioural therapy in the 11 sessions he had with Dr. Hudson up to the date of the hearing.

87. Mr. Petrie testified that Dr. Hudson now recognizes the importance of maintaining professional boundaries and that she had demonstrated growth with her ability to think critically about how her thoughts and emotions affect her behaviour. He said she also now recognizes the power differential in her relationship with [redacted] and that she can never move forward with that relationship. Mr. Petrie described that Dr. Hudson is now "hypervigilant" to the way she is with patients and conscious of the need for work-life balance and saying "no" to requests that would previously have been difficult for her to turn down.

88. Mr. Petrie said that in his opinion Dr. Hudson is a conscientious person with a lot of potential to grow and understand herself and her interactions with patients. She has gained a lot of insight and she understands the importance of setting boundaries in her personal and professional life, so the likelihood of this happening again is low. Mr. Petrie said he plans to continue providing therapy for Dr. Hudson.

89. Ms. Burnett and Ms. Stein then closed Dr. Hudson's case.

SUBMISSIONS

Submissions of the Complaints Director

90. On behalf of the Complaints Director, Mr. Boyer submitted that Dr. Hudson's Admission Agreement included an admission that she had a sexual relationship with [redacted] between August and November, 2019. While Dr. Hudson disputed that her conduct was sexual abuse as defined by the *Health Professions Act*, and that she provided false information

on her 2020 Renewal Information Form, it would be for the Hearing Tribunal to determine the facts and apply the applicable standards of professional conduct.

91. Mr. Boyer submitted that the *Health Professions Act* was amended by Bill 21, *An Act to Protect Patients* which received Royal Assent on November 19, 2018. The provisions germane to this case came into effect on April 1, 2019.

92. Effective April 1, 2019 the *Health Professions Act* was amended to incorporate a definition of "patient" for the purposes of a complaint of sexual abuse. A "patient" is defined to mean a patient as defined by the Standard of Practice established by the Council of the College. The term "sexual abuse" was defined to include specific types of sexual contact between a physician and a patient. Section 82(1.1) was added to the *Health Professions Act* to mandate the cancellation of a physicians' registration and practice permit in the event of a finding of unprofessional conduct based in whole or in part on sexual abuse.

93. The Council of the College developed a new Standard of Practice entitled Boundary Violations: Sexual which also took effect on April 1, 2019 (the "new Standard of Practice"). This new Standard of Practice defines a "patient" for the purposes of a complaint of unprofessional conduct in relation to sexual abuse or sexual misconduct to include a person who has been treated by the physician within one year after the person ceased to be the physician's patient. The new Standard of Practice also states that sexual contact may be inappropriate after one year in several scenarios, including where the patient is vulnerable.

94. Mr. Boyer anticipated Dr. Hudson would argue that her boundary violation with [redacted] began in 2018, so that her conduct should be assessed according to *Health Professions Act* prior to the Bill 21 amendments came into effect. Mr. Boyer said this argument would not survive legal scrutiny.

95. Mr. Boyer explained that the Gukert complaint, CPSA file 190158.1.1, arose from Dr. Hudson's decision to transition from [redacted]'s physician and become his advocate instead. The Gukert complaint was dated February 8, 2019. That complaint was resolved on August 7, 2019 through a Memorandum of Understanding between Dr. Hudson and the Complaints Director. That Memorandum provided that Dr. Hudson accepted a referral to the Physician Health Monitoring Program and agreed to complete a course on professionalism and ethics.

96. Mr. Boyer then explained that the complaint which is the subject of the charges in the Notice of Hearing before the Hearing Tribunal was CPSA file 200091.1.1. This complaint was initiated by the then Complaints Director Dr. Caffaro pursuant to section 56 of the *Health Professions Act*, after Dr. Hudson self-reported her conduct to Dr. Caffaro on January 24, 2020. This complaint was based on Dr. Hudson's conduct after the *Health Professions Act* amendments came into effect on April 1, 2019.

97. In relation to the first charge, that between August and December 2019 Dr. Hudson had a sexual relationship with [redacted] amounting to sexual abuse, Mr. Boyer explained that section 82(1.1) of the *Health Professions Act* is very similar to the "zero tolerance" provisions applicable to regulated health professionals in Ontario. Mr. Boyer referred the Hearing Tribunal to *Mussani v. College of Physicians and Surgeons of Ontario*, (2004) 74 O.R. (3d) 156 where the mandatory cancellation provisions of Ontario's *Regulated Health Professions Act* took effect part way through Dr. Mussani's sexual relationship with his patient. The Ontario Court of Appeal acknowledged that the effect of the mandatory cancellation provisions could be "harsh, extreme, and even arguably unjust", but the Court rejected Dr. Mussani's assertions that the mandatory cancellations provisions breached his *Charter* rights.

98. Mr. Boyer also referred us to *Rosenberg v. College of Physicians and Surgeons of Ontario* (2006), 275 D.L.R. (4th) 275 where the mandatory cancellation provisions took effect well-after Dr. Rosenberg began a sexual relationship and cohabitating with his patient. The Ontario College of Physicians and Surgeons' Discipline Committee rejected Dr. Rosenberg's argument that his conduct should be governed by the version of the legislation as it stood prior to the amendments providing for mandatory cancellation. The Ontario Court of Appeal upheld the Discipline Committee's decision. The Court of Appeal held that the moment the law changed, Dr. Rosenberg was required to comply with it. His conduct after the amendments came into effect was subject to those amendments. He was found to have engaged in sexual abuse after the amendments came into effect and his registration was cancelled.

99. Mr. Boyer also referred us to *Leering v. College of Chiropractors of Ontario* (2010), 98 O.R. (3d) 561 and *Tanase v. College of Dental Hygienists of Ontario*, 2021 ONCA 482, for which leave to appeal to the Supreme Court of Canada was denied. In *Leering* the Ontario Court of Appeal held that sexual abuse as defined by the Ontario legislation required only the concurrence of a sexual relationship and a patient relationship. It did not matter which of those conditions occurred first. Once those conditions existed at the same time there was no need for further inquiry. There were also overlapping sexual and patient relationships in the *Tanase* case. The Ontario Court of Appeal rejected Mr. Tanase's argument that his circumstances were exceptional because he had married his patient. The Court held that the sexual abuse and mandatory cancellation provisions were a "bright-line rule prohibiting sexual relationships". The Court said it was open to the Ontario legislature to make such a rule, it did not violate the *Charter*, and it must be respected by the Court.

100. Mr. Boyer then submitted that Dr. Hudson was mistaken in her apparent belief that she could continue to have a relationship with [redacted] and that the relationship could be sexual. Dr. Hudson's subjective beliefs following her attendance with Dr. Hobday's team and at the Alliance Centre are not a legal excuse or justification that can avoid the application of the *Health Professions Act* as it read in August of 2019 and beyond. Dr. Hudson did not ensure that she was aware of the Bill 21 amendments to the *Health Professions Act* and

the College's new Standard of Practice. She disregarded the College's communications about the development and implementation of the amendments and the new Standard of Practice. She took no steps to find out if she could continue to have a relationship with [redacted]. She made no inquiries of the College before she began the sexual relationship. Dr. Hudson's failure to learn about the amendments and the new Standard of Practice are no excuse: *R. v. Pontes*, [1995] 3 S.C.R. 44, *College of Veterinarians of Ontario v. Greenberg-Blechman*, 2010 ONCJ 358.

101. The health records provided by Dr. Hudson to the College and the Alberta Health billing information for [redacted] demonstrate that Dr. Hudson was treating [redacted] as a patient over a two-year period between the fall of 2016 and December of 2018. Less than one year later, Dr. Hudson began an admitted sexual relationship with [redacted] in August of 2019, thereby committing "sexual abuse" as defined in the *Health Professions Act*. [redacted]'s evidence suggested that Dr. Hudson and [redacted] were in a relationship even earlier, in May of 2019, but the evidence of the nature of their relationship and whether it was sexual in nature at that time was unclear. Mr. Boyer submitted that the evidence also demonstrated that Dr. Hudson continued as [redacted]'s physician beyond December of 2018, by gathering information about [redacted]'s suboxone prescription from a pharmacy in December of 2019.

102. Mr. Boyer submitted that the first charge was proven on a balance of probabilities and that Dr. Hudson's conduct amounts to unprofessional conduct.

103. In relation to the second charge, Mr. Boyer submitted that it was disingenuous for Dr. Hudson to claim that she had answered the question about sexual or inappropriate personal relationships in the Renewal Information Form honestly. Dr. Hudson had failed to be candid and forthright in answering the question.

104. In responding to Dr. Hudson's submissions, Mr. Boyer said that it was not uncontroverted that Dr. Hudson's physician-patient relationship with [redacted] ended in December 2018. [redacted] was paraplegic with complex health needs. He was taking suboxone and had difficult personal and financial circumstances. He was in a vulnerable state. Dr. Hudson purported to end her physician-patient relationship with [redacted] and become his advocate instead, but a physician's relationship and power imbalance with a patient does not turn off like a light-switch. Her care of [redacted] was not episodic in nature. She had cared for him in 2016, 2017, and on multiple dates in 2018. There was no evidence that Dr. Hudson took any steps to try to formally terminate her physician-patient relationship, such as letter to him for example. Even if she had, it would be unrealistic to suggest that [redacted] would have no expectation of seeing her again.

105. Mr. Boyer also responded to Dr. Hudson's argument that the Complaints Director was seeking a retrospective application of the law. Dr. Hudson's impugned conduct occurred after April 1, 2019 when the *Health Professions Act* amendments and the new Standard of Practice came into effect. While Dr. Hudson may have last provided treatment to [redacted] on December 28, 2018, the new Standard of Practice defines a "patient" as an individual in a

physician-patient relationship with the physician, or within one year from the date the individual ceases to be the physician's patient. The Complaints Director was not asking the Hearing Tribunal to impose new consequences for Dr. Hudson's conduct prior to April 1, 2019. The law only prohibited Dr. Hudson from engaging in future sexual encounters with individuals who were her patients, or who had ceased to be her patients within the preceding year.

Submissions of Dr. Hudson

106. On behalf of Dr. Hudson, Ms. Burnett and Ms. Stein submitted that the relevant events span two periods of legislation and two standards of practice relating to sexual contact between physicians and patients. Prior to April 1, 2019, physicians were subject to the previous version of the *Health Professions Act* which did not define a "patient" or address when a sexual relationship may occur between a physician and a patient. They were also subject to the former Standard of Practice entitled Sexual Boundary Violations (the "former Standard of Practice"). The former Standard of Practice distinguished "current" from "former" patients and prohibited physicians from engaging in sexual contact with former patients for a period of time following the last physician-patient encounter.

107. Ms. Burnett and Ms. Stein submitted that Dr. Hudson admitted her sexual relationship with [redacted] between August and November 2019, but she did not admit that this constituted sexual abuse of a patient under the amended *Health Professions Act* and the new Standard of Practice. The Complaints Director was asking the Hearing Tribunal to apply the amended *Health Professions Act* and the new Standard of Practice to Dr. Hudson's relationship with [redacted] even though their physician-patient relationship ended in December of 2018, before the amendments or the new Standard of Practice came into effect, and even though [redacted] had become a former patient under the former Standard of Practice in effect at the time. The Hearing Tribunal cannot make a finding of sexual abuse if physician engages in sexual relations with someone who was not a patient at the time the sexual relations took place. This would amount to allowing the amended legislation and standard to reach backwards in time to 'renew' a physician-patient relationship that had already terminated. In other words, it would amount to a 'retrospective' application of the law.

108. Ms. Burnett and Ms. Stein then described principles of transitional law. They submitted that a 'retroactive' application of law changes the legal consequences of past events, as if the law had been different than it was at the time that those events occurred. A law has 'retrospective' effect if it changes the future and ongoing legal consequences of past events.

109. There is a presumption against the retroactive or retrospective application of laws because these applications undermine the need for laws to be certain, predictable and stable, although the strength of the presumption varies with the disadvantage caused by their application. A retroactive or retrospective application of the law is presumptively

unfair because it changes the rules for those who have planned their affairs under the former law: *Merck Frost Canada & Co. v. Apotex Inc*, 2011 FCA 329. There is also a presumption against legislation conferring the power on a subordinate authority like the College to make retrospective rules: Sullivan on the Construction of Statutes, 6th ed.; *Wiest v. Middelkamp*, 2003 BCCA 437.

110. The presumption against the retrospective application of law can be rebutted where the legislation contains clear language stating that the legislature intended it to apply retrospectively, or where the goal of the legislation is public protection: *Brosseau v. Alberta (Securities Commission)*, [1989] 1 SCR 301. Ms. Burnett and Ms. Stein referred to two cases illustrating the effects of clear language. In *Page Estate v. Sachs*, [1993] OJ No. 269, the presumption against retrospective application of legislation applied, but the Court found the legislation to contain express language stipulating its retrospective effect. On the other hand, in *Wiest v. Middlekamp*, *supra*, the BC Court of Appeal found no language to rebut the presumption against retroactive application. The Court therefore declined to apply the new legislation to the facts.

111. In *Ontario (College of Physicians and Surgeons of Ontario) v. Kunynetz*, 2019 ONSC 4300, the Ontario Superior Court considered whether Ontario's equivalent to Bill 21 applied retrospectively to facts arising before the amendments came into force. The Court concluded that the amendments did not have retrospective effect. The legislation was directed at public protection, but there was nothing in the legislation to suggest the legislature had weighed the benefits of retrospectivity against its potential for unfairness. Ms. Burnett and Ms. Stein also cited *Thow v. British Columbia (Securities Commission)*, 2009 BCCA 46 where the Court declined to uphold a tougher sanction imposed pursuant to amendments to the BC *Securities Act* enacted after the appellant's impugned conduct. We note that in both of these cases the Courts refused to uphold the imposition of new legal consequences for events that occurred in the past, prior to the enactment of the new laws.

112. Ms. Burnett and Ms. Stein submitted that Dr. Hudson's physician-patient relationship with [redacted] started and ended under the pre-amendment *Health Professions Act* and the former Standard of Practice, prior to April 1, 2019. Applying the amended *Health Professions Act* and the new Standard of Practice to Dr. Hudson's former physician-patient relationship with [redacted] would be a retrospective application of law. It would change the future and ongoing nature of her relationship with [redacted] from that of a former patient to a "patient". This would result in a severe professional consequence for Dr. Hudson since sexual contact with a patient amounting to sexual abuse results in mandatory cancellation of her registration with the College.

113. The presumption against the retroactive and retrospective applications of law applies in this case and should be strong given the unfair and severe consequences that the retrospective application of the amended *Health Professions Act* and the new Standard of Practice would have on Dr. Hudson. Ms. Burnett and Ms. Stein emphasized that when the

Health Professions Act amendments and the new Standard of Practice came into effect on April 1, 2019, many physicians may not have reviewed them and may have believed that only sexual contact with a current patient was prohibited. They noted that the new Standard was not available to the profession until March 2019, only days before it came into effect, and the College's training module on the amendments and the new Standard of Practice was not released until August 2019. They referred to Dr. Hudson's testimony that she only became aware of the contents of the new Standard of Practice in November 2019.

114. Ms. Burnett and Ms. Stein submitted that the presumption against retrospectivity has not been rebutted. Nothing in the amended *Health Professions Act* or the new Standard of Practice suggest that the changes were intended to apply retrospectively to capture former physician-patient relationships terminated prior to April 1, 2019. There is an 'Advisory Note' in the new Standard of Practice that complaints received after April 1, 2019 will be adjudicated based on the *Health Professions Act* regardless of when the alleged incident occurred, but the College has consistently agreed that complaints involving sexual relationships with patients whose facts arose before April 1, 2019 are not to be adjudicated under Bill 21, referring to *Taylor, Re*, 2021 CarswellAlta 33561, *Alarape (Re)*, 2020 CanLII 10423 (AB CPSDC); *Sayeed (Re)*, 2022 CanLII 2813 (AB CPSDC); and *Imtiaz (Re)*, 2020 CanLII 65430 (AB CPSDC). We note that in each of those cases the impugned sexual contact or relationship pre-dated April 1, 2019. In the *Alarape (Re)* case the conduct also involved a co-worker and not a patient of the physician. Ms. Burnett and Ms. Stein nevertheless submitted that the intent of the Advisory Note is unclear and insufficient to rebut the strong presumption against retrospectivity.

115. Ms. Burnett and Ms. Stein submitted that the amended *Health Professions Act* and the new Standard of Practice are intended to protect the public, but the public safety exemption does not apply to rebut the presumption against retrospectivity in this case. There is no indication that the Alberta legislature or the College's Council considered the benefits, consequences, or potential unfairness of applying the new legislation or Standard to pre-existing circumstances. They also submitted that the legislature's true intent as evidenced by Alberta Hansard was to target and protect patients against physicians found guilty of sexual offences as defined in the *Criminal Code of Canada*. Dr. Hudson's conduct should be contrasted since she engaged in a consensual sexual relationship with [redacted], whom she had treated eight months prior. Her conduct was not criminal in nature, nor is she a predator or at risk of additional sexual boundary violations with other patients. Ms. Burnett and Ms. Stein referred to the evidence of Dr. Graham, Mr. Petrie, and Dr. Bartie, all of whom provided evidence that Dr. Hudson was able to continue practicing medicine.

116. Ms. Burnett and Ms. Stein then responded to Mr. Boyer's submissions on the merits of the charges. In relation to charge 1 they submitted that a finding of sexual abuse would require a concurrent physician-patient and sexual relationship. This would require the retrospective application of the law, which would be wholly unfair and inconsistent with the

legislative intent and the case law discussed above. They submitted that the pre-April 1, 2019 *Health Professions Act* and the former Standard of Practice should be applied to the evidence, so there was no concurrent physician-patient relationship and sexual relationship. [redacted] was a former patient under the former Standard of Practice and he remained so.

117. Ms. Burnett and Ms. Stein then distinguished the cases referenced by the Complaints Director. In the *Mussani* and *Rosenberg* cases the physicians had engaged in sexual relationships with patients who they were concurrently treating. The concurrent relationships existed both before and after the change in the legislation, so there were no concerns about retrospectivity.

118. Similarly, in the *Leering* and *Tanase* cases the regulated health professionals both engaged in concurrent treatment and sexual relationships with patients, but the concurrent relationships occurred only after the change to the legislation, and not before. There were again no concerns about retrospectivity. Dr. Hudson's case was different in that her medical treatment of [redacted] occurred entirely before the legislation changed and the sexual relationship occurred only after. The treatment and sexual relationships were never concurrent.

119. Ms. Burnett and Ms. Stein then referred to *Ontario (College of Physicians and Surgeons of Ontario) v. Redhead*, 2013 ONCPSD 18 for its analysis of whether a physician-patient relationship existed. In that case the Discipline Committee considered factors such as (a) whether the physician had a patient file for the patient; (b) whether there were billing records; (c) the nature and number of treatments provided; (d) whether any psychotherapy was provided; (e) whether the complainant consented to treatment and signed a consent form; (f) whether there was any documentary evidence of the physician referring to the complainant as a patient; (g) whether the physician wrote any consultation letters; (h) whether there were any letters reporting back to the physician about the patient; (i) whether the complainant was seeing other physicians when the sexual relationship began; (j) whether the physician referred the complainant to other professionals; and (k) whether the physician prescribed medication to the complainant.

120. Ms. Burnett and Ms. Stein submitted that the uncontroverted evidence was that Dr. Hudson last provided medical care to [redacted] on December 28, 2018 in her capacity as a hospitalist at the QEII Hospital in Grande Prairie. None of the *Redhead* factors were applicable after December of 2018.

121. The only suggestion that Dr. Hudson was [redacted]'s physician after December of 2018 came from [redacted]'s hearsay testimony. [redacted] testified that [redacted] said he was in a relationship with his doctor in May, 2019. [redacted] could only say that she believed [redacted] was referencing Dr. Hudson, but she had no further discussion with [redacted] about it.

122. While [redacted] testified that he exchanged text messages with Dr. Hudson about [redacted]'s suboxone prescription, he could not say whether Dr. Hudson was treating [redacted] and the text messages do not establish a physician-patient relationship. Dr. Hudson only called and spoke with the pharmacy in her capacity as [redacted]'s partner. If the pharmacist provided her with more information than she might otherwise have received that was not due to anything that Dr. Hudson did. She did not introduce herself to the pharmacist as Dr. Hudson or as [redacted]'s physician. The pharmacist could have been called to testify but wasn't. Dr. Hudson's texts with [redacted] about [redacted]'s condition do not demonstrate a physician-patient relationship either. She merely provided suggestions about what [redacted] may need should [redacted] take him to the hospital.

123. Ms. Burnett and Ms. Stein then submitted that Dr. Hudson admits to unprofessional conduct for engaging in a sexual relationship with her former patient contrary to the former Standard of Practice. She maintained that she did not commit sexual abuse under the amended *Health Professions Act* and the new Standard of Practice.

124. In relation to charge 2, Ms. Burnett and Ms. Stein submitted that Dr. Hudson understood the College was seeking to identify unknown boundary violations with patients that were either "sexual or inappropriate". They said that Dr. Hudson answered "no" to this question because her inappropriate relationship with [redacted] was already known to the College. Dr. Hudson had acknowledged the relationship and her boundary violations in her May 16, 2019 response to the Gukert complaint. She had acknowledged offering financial support to [redacted], assisting him with legal counsel and posting his bail. She also disclosed the development of their close personal relationship which included hugging and kissing on the cheek, but she said they had not engaged in sexual activity.

125. Dr. Hudson's response to the Gukert complaint led to her referral to Dr. Beach of the College's Physician Health Monitoring Program and to Dr. Hobday of the Alliance Centre. Dr. Hobday's report was sent to Dr. Beach at the College in October 2019 so Dr. Hudson understood the College was aware of her inappropriate relationship with [redacted], including her desire for the relationship to continue.

126. Ms. Burnett and Ms. Stein submitted that Dr. Hudson interpreted the word "or" in the question as intending to capture a relationship that was one or the other; either sexual or inappropriate. They submitted that any ambiguity or doubt arising from the language on the Renewal Information Form and specifically in the interpretation of the word "or" should be resolved against the College which drafted the question. Dr. Hudson did not intend to answer falsely. She did not attempt to conceal her relationship with [redacted]. She had completed a boundaries course in November 2019 and then decided to self-report her sexual contact with [redacted] to the College prior to submitting the Renewal Information Form. The College was contacted, and a meeting was scheduled with Dr. Beach for January 23, 2020. A further meeting was held with Dr. Caffaro the following day.

127. In response to a question from the Hearing Tribunal, Ms. Burnett acknowledged there was no evidence of any discussion with [redacted] or notice to him that Dr. Hudson would no longer be his physician after December 28, 2018.

ANALYSIS

128. The Hearing Tribunal's role is to weigh the evidence, make findings of fact, identify the applicable standard of practice, and to apply that standard of practice to the facts. The Complaints Director has the burden of proving the charges against Dr. Hudson on a balance of probabilities standard, that is, whether it is more likely than not that the alleged unprofessional conduct occurred.

Charge 1

129. Charge 1 alleged that between August 2019 and December 2019 Dr. Hudson did have a sexual relationship with her patient, [redacted], amounting to sexual abuse as defined under the *Health Professions Act*.

130. After a careful review and consideration of the evidence, the law and the parties' submissions, the Hearing Tribunal found charge 1 to be proven and that Dr. Hudson's conduct was unprofessional conduct.

Legislation and Standards

131. Prior to April 1, 2019, the College's former Standard of Practice prohibited physicians from initiating any form of sexual advance toward a previous patient where there was a risk of a "power imbalance" from the previous physician-patient relationship. It also stated that in the absence of risk of a continuing power imbalance, a physician must not have any sexual or intimate involvement with a former patient for a period of time after the last physician-patient encounter depending on the nature and extent of the physician-patient relationship.

132. On November 19, 2018, the legislature enacted Bill 21*, An Act to Protect Patients*. The provisions of Bill 21 relevant to this hearing came into force on April 1, 2019 and amended the *Health Professions Act* by adding provisions pertaining to sexual contact between regulated health professionals and their patients, including definitions of "sexual abuse" and "patient". Sexual abuse is defined in the *Health Professions Act* under section 1(1)(nn.1) as the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature and includes any of the following conduct:

    i. sexual intercourse between a regulated member and a patient of that regulated member;
    ii. genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;

iii. masturbation of a regulated member by, or in the presence of, a patient of that regulated member;
iv. masturbation of a regulated member's patient by that regulated member;
v. encouraging a regulated member's patient to masturbate in the presence of that regulated member;
vi. touching of a sexual nature of a patient's genitals, anus, breasts or buttocks by a regulated member.

133. The *Health Professions Act* defines a "patient", for the purposes of a complaint of unprofessional conduct in relation to sexual abuse to mean a patient as set out in the Standards of Practice of the Council of a College.

134. Section 133.1(1)(a) of the *Health Professions Act* required the Council of a College to develop Standards of Practice defining who is considered a patient. The Standards of Practice required Ministerial approval by section 133.1(4) and (5). The Council of the College developed the new Standard of Practice and issued it as of April 1, 2019.

135. The new Standard of Practice provides that an individual is a regulated member's "patient" in two circumstances:

1. When a regulated member-patient relationship has been formed and not ended.
2. For a period of one year from the date the individual ceased to be the regulated member's patient. ("the one-year rule")

136. The new Standard of Practice then states that an individual becomes a patient when a regulated member-patient relationship is formed. It states that this type of relationship is formed when there is a reasonable expectation that care will extend beyond a single encounter and the regulated member has engaged in one or more of the following activities:

1. Gathered clinical information to assess a person;
2. Provided a diagnosis;
3. Provided medical advice or treatment;
4. Provided counseling to a patient;
5. Created a patient file for the patient;
6. Billed for medical service provided to the patient;
7. Prescribed a drug for which a prescription is needed to the patient.

137. The new Standard of Practice states that if a regulated member has any doubts as to whether or when a regulated member-patient relationship has ended they may wish to seek advice from the CMPA or the CPSA.

138. The new Standard of Practice explains that physicians may not rely on their belief that a patient is "consenting" to a sexual relationship. The new Standard of Practice states that all types of sexual relationships with patients are prohibited even if the physician believes that the patient is consenting. It states that the patient's alleged "consent" is not a valid defense because of the inherent power imbalance that typically exists in the physician-patient relationship.

Dr. Hudson

139. According to her testimony, Dr. Hudson first met [redacted] in 2011 during rounds at the QEII Hospital. She had further encounters with [redacted] in which she treated him at the hospital between 2016 and 2018. Dr. Hudson testified that in 2016 "[redacted] had fallen into opioid addiction and he started to frequent the hospital regularly". She said "he was in and out of hospital with infections repeatedly".[2]

140. [redacted] was an inpatient at the hospital between December 20, 2018 and December 28, 2018. He was also incarcerated so he was attended by guards from the Peace River Correctional Centre. Dr. Hudson was the physician responsible for [redacted]'s medical care over this period of time.

141. On February 18, 2019 the director of the Peace River Correctional Centre, Mr. Allen Gukert submitted a complaint alleging that Dr. Hudson had failed to maintain professional boundaries with [redacted] during [redacted]'s hospital stay in December 2018. This complaint, which was identified as CPSA complaint file no. 190158.1.1 was resolved through an informal resolution with the cooperation of the complainant pursuant to section 55(2)(a.1) of the *Health Professions Act*. The informal resolution was documented in a Memorandum of Understanding dated August 7, 2019.

142. The process leading to this hearing began on January 24, 2020, when Dr. Hudson and Ms. Burnett attended a meeting with the then Complaints Director, Dr. Caffaro. It was in that meeting that Dr. Hudson self-reported to Dr. Caffaro that her relationship with [redacted] had become sexual in nature between August and November of 2019. Dr. Caffaro commenced a new complaint file identified as no. 200091.1.1 pursuant to section 56 of the *Health Professions Act*. Dr. Caffaro also subsequently received a complaint regarding Dr. Hudson's conduct towards [redacted] from [redacted] and [redacted].

143. As a result of the new section 56 complaint Dr. Hudson withdrew from active medical practice on February 13, 2020. She attended the Alliance Assessment Center in Houston, Texas for an assessment of her fitness to practice between July 30 and August 1, 2019 and then returned to practice with restrictions according to her agreement with the CPSA dated July 3, 2020, which remains in place at the time of the hearing.

[2] Hearing Transcript, pg. 74-76.

Formation of a Physician-Patient Relationship

144. In determining whether a physician-patient relationship was established between Dr. Hudson and [redacted], the Hearing Tribunal has considered the factors in the new Standard of Practice listed above and the factors from *Ontario (College of Physicians and Surgeons of Ontario v. Redhead*, supra. By any measure Dr. Hudson was in a physician-patient relationship with [redacted] by December 28, 2018, which is when she said she last provided treatment to [redacted].

145. The Hearing Tribunal reviewed the AHS billing information pertaining to Dr. Hudson's care of [redacted]. These records confirm that between December 30, 2016 and December 29, 2018 Dr. Hudson billed AHS for medical services provided to [redacted] thirty-one times over twenty-two days, with thirteen entries referencing care provided between December 20 and December 29, 2018.

146. Dr. Hudson testified that she provided treatment intermittently to [redacted] from 2016 onward and was then involved with [redacted]'s treatment more extensively in late December, 2018.[3] Dr. Hudson took over [redacted]'s care on December 20, 2018 in her role as a hospitalist while another physician was away. The hospital records also demonstrate that between December 20-29, 2018:

- Dr. Hudson diagnosed [redacted]'s sacral ulcers, blood abnormalities and nutritional deficiencies;
- Dr. Hudson prescribed Gravol and ordered IV iron and adjusted the dosing of [redacted]'s antibiotics;
- Dr. Hudson ordered consults for recreational therapy and diet and nutrition for [redacted];
- Dr. Hudson physically examined [redacted] and diagrammed his wounds, ordered imaging, ordered blood work, and referred [redacted] to a social worker; and
- Dr. Hudson provided medical advice or treatment related to [redacted]'s peripherally inserted central catheter ("PICC") line insertion, intravenous iron, oversight of intravenous antibiotics, dietary modifications, dressing changes, and wound vacuum oversight.

147. During this period Dr. Hudson resisted requests from Mr. Gukert and others to transfer [redacted] back to Peace River Correctional Centre. Dr. Hudson testified that she was of the opinion that [redacted]'s complex medical needs were better addressed in Grand Prairie at the QEII Hospital.[4] Dr. Hudson explained her decision to refuse to transfer [redacted] for medical reasons in her letter of May 16, 2019 responding to Mr. Gukert's complaint.

148. On December 26, 2018 Dr. Hudson wrote and signed a letter addressed "To Whom It May Concern" about [redacted]'s medical condition and care requirements. She wrote, in part, that

[3] Hearing Transcript, pg. 74-76.

[4] Hearing Transcript, pg. 82-83.

[redacted] is a paraplegic man with severe chronic ulcers. She also wrote that [redacted] was opioid dependent and will experience severe withdrawal symptoms if he does not receive methadone every day. She listed items that [redacted] would require while incarcerated due to his complex health problems, including an air bed, wheelchair with an appropriate cushion, daily methadone, a wound vacuum, a catheter and daily ostomy supplies.

149. On December 27, 2018 Dr. Hudson spoke with [redacted]'s cell block supervisor and a Sergeant from the Sherriff's Department regarding [redacted]'s court dates. Dr. Hudson made notes indicating that she spoke with the Sergeant about [redacted]'s complex health history and the need for measures to be put in place prior to his next court date.

150. This evidence demonstrates that by December 28 or 29, 2018, Dr. Hudson had seen [redacted] on multiple successive occasions, gathered clinical information about him, diagnosed him, provided him with medical advice and treatment, prescribed medications for him, contributed to his hospital records, referred him to other health professionals, made phone calls and wrote a letter on his behalf in which she referred to herself as a physician and provided her opinion about his treatment and requirements, and billed Alberta Health for her professional services to [redacted].

151. Dr. Hudson's care of [redacted] extended well-beyond a single encounter. She clearly understood the seriousness of [redacted]'s illnesses and health conditions and was invested in his care. She expected to see him frequently in the hospital as part of her call group. In her May 16, 2019 letter to the College responding to Mr. Gukert's complaint, she wrote that since 2016 or 2017, [redacted] was repeatedly admitted to hospital for his ulcers and for recurrent infections and she saw him on multiple occasions as part of the call group.

152. Dr. Hudson stated that, when she took over [redacted]'s care in December 2018, he was contending with significant social and health issues in addition to his paraplegia and opioid dependence. He was anemic and poorly nourished which inhibited his wound healing; he had a PICC line; he was an amputee with serious infections of the bone and blood. Because he had wounds and ulcers that would not heal, he required specialized care to change his dressings. He could not maintain basic standards of cleanliness and his wound care was not being maintained. He was homeless and incarcerated and had an imminent court date respecting very serious charges but had not yet retained legal representation.

153. Dr. Hudson should have recognized that [redacted]'s circumstances meant that he was in a highly vulnerable state in December of 2018. She should also have recognized throughout 2019 that many of those same circumstances continued. [redacted]'s vulnerable state and Dr. Hudson's position of authority meant that there was a significant risk of a power imbalance between them in December 2018 and continuing through 2019.

154. The Hearing Tribunal does not accept that Dr. Hudson's care of [redacted] can be reduced to "a single instance of episodic care to [redacted] by way of prescribing him Gravol" on

December 28, 2018.[5] This was only one of a series of physician-patient interactions between Dr. Hudson and [redacted]. The record clearly shows that a physician-patient relationship formed between Dr. Hudson and [redacted] based on the medical care that Dr. Hudson provided to [redacted] between at least December 20, 2018 and December 28, 2018. According to the one-year rule in the new Standard of Practice, [redacted] was a patient of Dr. Hudson's for a period of one year from December 28, 2018. Whether applying the new Standard of Practice and the one-year rule to define [redacted] as a patient in 2019 is contrary to the presumption against the retrospective application of legislation is discussed below.

Sexual Relationship

155. Dr. Hudson's relationship with [redacted] became personal in nature in 2019 and she developed feelings for him. There was no dispute that Dr. Hudson's relationship with [redacted] became sexual between August and November 2019. Dr. Hudson acknowledged this in her Admission Agreement with the Complaints Director. She also confirmed during her direct and cross-examinations that her relationship with [redacted] was sexual in nature between August and November of 2019 and included sexual intercourse. Dr. Hudson further confirmed that the sexual conduct she engaged in with [redacted] during that period of time included conduct described in the definition of "sexual abuse" in the *Health Professions Act*.

Determining which Standard of Practice Applies

156. Charge 1 requires the Hearing Tribunal to determine whether between August and December of 2019 Dr. Hudson engaged in a sexual relationship with her patient, amounting to sexual abuse as defined by the *Health Professions Act*.

157. The definition of "sexual abuse" in the *Health Professions Act* applies only to conduct between a regulated member of the College and a "patient". The *Health Professions Act* provides that a "patient" means a patient as defined by the College's standards of practice. The College defined the term "patient" in its new Standard of Practice which came into effect on April 1, 2019. If [redacted] was not a "patient" of Dr. Hudson's as defined by the new Standard of Practice during the sexual relationship between August and December of 2019, then Dr. Hudson would not have engaged in sexual abuse.

158. The Hearing Tribunal considered whether applying the new Standard of Practice to the physician-patient relationship between Dr. Hudson and [redacted] described above would constitute a retrospective application of the new Standard of Practice contrary to the presumption against the retrospective application of legislation. The Tribunal concluded that it would not.

[5] Written submissions of Dr. Hudson, pg. 16.

159. Ms. Burnett and Ms. Stein referred us to *CNG Producing Co. v. Alberta (Provincial Treasurer)*, 2002 ABCA 20 at paragraph 22, where the Alberta Court of Appeal set out the following definitions of "retroactive" and "retrospective" legislation from the Supreme Court of Canada's decision in *Benner v. Canada (Secretary of State)*, [1997] 1 S.C.R. 358, citing E.A. Driedger in "Statutes: Retroactive Retrospective Reflections" (1978), 56 Can. Bar. Rev. 264, at 268-269:

> A retroactive statute is one that operates as of a time prior to its enactment. A retrospective statute is one that operates for the future only. It is prospective, but it imposes new results in respect of a past event. A retroactive statute *operates backwards*. A retrospective statute *operates forwards*, but it looks backwards in that it attaches new consequences *for the future* to an event that took place before the statute was enacted. A retroactive statute changes the law from what it was; a retrospective statute changes the law from what it otherwise would be with respect to a prior event. [emphasis in original]

160. In *CNG Producing Co.*, the Court of Appeal also described the "general rule" regarding retrospective legislation at paragraph 27, citing the Supreme Court of Canada in *Gustavson Drilling (9164) Ltd. v. Minister of National Revenue* (1975), [1977] 1 S.C.R. 271 at 279. The Supreme Court held:

> The general rule is that statutes are not to be construed as having retrospective [retroactive] operation unless such a construction is expressly or by necessary implication required by the language of the Act. An amending enactment may provide that it shall be deemed to have come into force on a date prior to its enactment or it may provide that it is to be operative with respect to transactions occurring prior to its enactment. In those instances the statute operates retrospectively [retroactively].

161. Ms. Burnett and Ms. Stein also referred us to *Tran v. Canada (Public Safety and Emergency Preparedness)*, 2017 SCC 50. In *Tran* at paragraph 43, the Supreme Court confirmed that the presumption against retrospectivity provides that statutes are not to be construed as having retrospective operation unless such a construction is expressly or by necessary implication required by the language of the legislation. The Court explained that the purpose of the presumption is to protect acquired rights and to prevent a change in the law from "look[ing] to the past and attach[ing] new prejudicial consequences to a completed transaction".

162. Ms. Burnett and Ms. Stein also relied on Sullivan on the Construction of Statutes, 6th Ed. at Chapter, 25. There the author summarized Driedger's 1978 article referenced above, including as follows:

    i. A statute is not retrospective by reason only that it adversely affects an antecedently acquired right.

ii. A statute is not retrospective unless the description of the prior event is the fact situation that brings about the operation of the statute.
iii. The presumption does not apply unless the consequences attaching to the prior event are prejudicial ones, namely a new penalty, disability or duty.
iv. The presumption does not apply if the new prejudicial consequences are intended as protection for the public rather than as punishment for a prior event.

163. Driedger's 1978 article was also cited approvingly in *Thow v. British Columbia (Securities Commission)*, 2009 BCCA 46. There the BC Court of Appeal quoted Driedger's explanation that the presumption against retrospectivity does not apply to all statutes:

> [T]here are three kinds of statutes that can properly be said to be retrospective, but only one that attracts the presumption. First, there are the statutes that attach benevolent consequences to a prior event; they do not attract the presumption. Secondly, there are those that attach prejudicial consequences to a prior event; they attract the presumption. Thirdly there are those that impose a penalty on a person who is described by reference to a prior event, but the penalty is not a consequence of the event; these do not attract the presumption.

164. The Court in *Thow* explained at paragraph 24 that the common theme in cases about Driedger's third category of statutes was that the statutes did not impose prejudicial consequences for past conduct, but to protect society against future misconduct.

165. In Sullivan, the author distinguished between retrospective and immediate applications of law and defined an immediate application as follows:

> In this text, an immediate application is understood to be one in which new legislation is applied to all facts that come within its scope, including facts that began before its coming into force. When legislation is applied immediately, it may have the effect of interfering with vested rights.

166. There is no presumption against the immediate application of new legislation.

167. The College's new Standard of Practice does not operate retroactively or retrospectively to impose prejudicial consequences on Dr. Hudson for a past event. There was no "prior event" or "completed transaction" involving [redacted] prior to April 1, 2019 to which any prejudicial consequences for Dr. Hudson attached.

168. The College's new Standard of Practice defines a physician's "patient" based on the existing facts, including those facts that began before April 1, 2019, to include an individual who was in a physician-patient relationship with that physician within the past year. Since charge 1 concerns the timeframe between August and December of 2019,

the one-year timeframe in the definition of a patient included a period of time prior to April 1, 2019 when the new Standard of Practice came into effect.

169. The new Standard of Practice does not attach any prejudicial consequences to its definition of [redacted] as a patient of Dr. Hudson. According to the new Standard of Practice [redacted] was a patient of Dr. Hudson's in December of 2018 and for one year thereafter, including between August and December of 2019, but no prejudicial consequences followed from that definition for Dr. Hudson. The fact that the new Standard of Practice defines [redacted] as a patient of Dr. Hudson for one year from December of 2018 does not lead to the finding of sexual abuse and an order for mandatory cancellation.

170. The new Standard of Practice only attached prejudicial consequences to Dr. Hudson's decision to engage in a sexual relationship with [redacted] after April 1, 2019, at a time when he met the definition of a patient in the new Standard of Practice. Dr. Hudson's conduct occurred at a time when she knew or ought to have known that the new Standard of Practice and its definitions of "patient" and "sexual abuse" were in effect and the consequences it prescribed. The new Standard of Practice provides that if after April 1, 2019 a physician engages in conduct of a sexual nature with a patient, such as sexual intercourse, then the physician has engaged in sexual abuse.

171. The Alberta Court of Appeal in *CNG Producing Co*. explained at paragraph 32 that the presumption against retrospectivity is based on the reluctance of the courts to accept interference with vested rights, but that all types of legislation, both retroactive and prospective, interfere with rights and expectations which may have existed prior to their enactment. The Court of Appeal cited the Supreme Court of Canada in *Gustavson Drilling* for the proposition that "most statutes in some way or other interfere with or encroach upon antecedent rights", but "[n]o one has a vested right to continuance of the law as it stood in the past." The Supreme Court held "[t]he mere right existing in members of the community or any class of them at the date of the repeal of the statute to take advantage of the repealed statute is not a right accrued." The Federal Court of Appeal's decision in *Apotex Inc. v. Merck & Co*., 2011 FCA 329 at paragraph 39 says the same thing.

172. The Court of Appeal in *CNG Producing Co*. went on to cite *National Life Assurance Co. of Canada v. Peace River (Town)* (1998), 64 Alta L.R. (3d) 360 (Alta C.A.) at paragraph 19 for the proposition that a "vested or accrued right is a claim or interest that cannot be defeated without causing grave injustice; it is something that should be protected because to take it away would be arbitrary or unfair."

173. Dr. Hudson did not have a vested right to the continuation of the former Standard of Practice. She had no vested right to consider [redacted] a "previous patient" or a "former patient" when the new Standard of Practice came into effect on April 1, 2019 and to engage in a sexual relationship with him after April 1, 2019 without triggering its definition of sexual abuse and the resulting consequences.

174. As explained above, the former Standard of Practice prohibited physicians from initiating any form of sexual advance toward a previous patient where there was a risk of a power imbalance between them. There was clearly a power imbalance between Dr. Hudson and [redacted] in December of 2018 and throughout 2019. The former Standard of Practice also prohibited sexual relationships for a period of time depending on the nature and extent of the physician-patient relationship. The Hearing Tribunal found that a sexual relationship would have been inappropriate at any point after December 28, 2018 and throughout 2019 due to the nature and extent of Dr. Hudson's physician-patient relationship with [redacted]. Dr. Hudson therefore had no right to engage in a sexual relationship with [redacted] before the new Standard of Practice came into effect on April 1, 2019.

175. The Hearing Tribunal also found the Federal Court of Appeal's decision in *Apotex Inc. v. Merck & Co*., supra at paragraphs 46 to 50 to be instructive. In considering whether a set of regulations applied retrospectively, the Federal Court held that the new regulations "did not work a revolution" in the existing law. The new regulations provided a "clearer indication" of circumstances in which damages could be awarded. The Court held that declaratory or clarifying legislation which corrects defects in earlier, less certain legislation does not implicate the concerns associated with retrospective or retroactive legislation. The Hearing Tribunal considered the new Standard of Practice in this case to clarify the previous meaning of a physician's "patient".

176. The new Standard of Practice had immediate effect. It created a new definition of a "patient" which applied to facts that began before April 1, 2019 and clearly and unambiguously stated that physicians who engage in sexual relationships with individuals meeting that definition after April 1, 2019 would be committing sexual abuse. There is nothing arbitrary or unfair about this. It does not constitute a retroactive or retrospective application of law.

<u>The Presumption Against Retrospectivity is Rebutted</u>

177. Even if it was a retrospective application to apply the new Standard of Practice to find that [redacted] was a "patient" of Dr. Hudson's based on their physician-patient relationship prior to April 1, 2019, then the Hearing Tribunal finds that the presumption against retrospectivity has been rebutted.

178. In *Tran* at paragraph 50, the Supreme Court of Canada explained that the presumption may be rebutted where the legislature has used plain language indicating that it considered the potential for unfairness and intended retrospective operation; where retrospective operation is required by necessary implication from the language used; or where the legislative intent for the prejudicial consequence at issue is designed to protect the public rather than to punish a prior event. This "public protection" exception is only triggered where the design of the penalty signals that the legislature has weighed

the benefits of retrospectivity against its potential for unfairness, i.e. where there is a clear nexus between the protective measure and the public risks caused by the conduct to which it attaches.

Necessary Implication

179. Even if Dr. Hudson had a right to treat [redacted] as a "prior patient" before April 1, 2019, the amended *Health Professions Act* and the new Standard of Practice demonstrate an intention to affect that right: *Waterloo (City) v. 379621 Ontario Ltd.*, 2014 ONCA 231 at paragraphs 4-5.

180. The *Health Professions Act* defines a "patient" for the purposes of a complaint of unprofessional conduct in relation to sexual abuse or sexual misconduct as a patient as set out in the Standards of Practice of a Council of a College. Section 133.1(1) of the *Health Professions Act* required the Council of the College to develop a standard of practicing defining who is considered a patient and when a sexual relationship may occur between a regulated member and a patient. The College's Standard of Practice required Ministerial approval under section 133.1(4) and (5).

181. These provisions of the *Health Professions Act* are clear and unambiguous. They authorized the Council of the College to adopt the new Standard of Practice defining a "patient" for the purposes of its regulated members. From a common-sense perspective it makes sense for each College's Council to define a "patient" for its regulated members because the context, nature, limits of care, and variety of services that regulated healthcare professionals provide to patients will differ across health disciplines. The regulated healthcare provider-patient relationship will also differ in terms of time and depth based on the needs of patients. Each College's Council is properly situated to craft the most relevant definition of "patient" suitable to its practice parameters.

182. In this case the Council of the College adopted the new Standard of Practice including the one-year rule after review and approval by the Minister. The new Standard and the one-year rule are intelligible and sufficiently precise. They reflect the considerations in section 133.1(2) of the *Health Professions Act*. The one-year rule accounts for the risk of a continuing power imbalance between a physician and their patient and the passage of time since the physician last provided professional services to the patient.

183. The Council's power to make the new Standard of Practice includes the power to make the one-year rule apply retrospectively to physician-patient relationships that were formed prior to April 1, 2019. The Hearing Tribunal concluded that this power exists by necessary implication. The Council has the powers given to it expressly by the *Health Professions Act*, but also by implication the powers that are reasonably necessary to carry out the College's purposes. The College's primary purposes are to protect and serve the public interest and regulate the practice of medicine by its regulated members: *Health Professions Act*, s. 3(1)(a) and (b). The College also has the power in section

133.1(1)(a) of the *Health Professions Act* to make the new Standard of Practice defining a "patient" for the purposes of a complaint of unprofessional conduct based on sexual abuse or sexual misconduct.

184. In order to define a "patient" for the purposes of complaints of unprofessional conduct based on sexual abuse or sexual misconduct by a physician, it was necessary to define when an individual becomes a patient of the physician. The requirement to make the new Standard of Practice defining a "patient" in section 133.1(1)(a) was mandatory as of April 1, 2019. It must therefore have been intended to apply to relationships between physicians and individuals who were already patients of those physicians on April 1, 2019. By necessity this meant that the new Standard of Practice's definition of "patient" had to apply to physician-patient relationships that had formed prior to April 1, 2019.

185. The need for the new Standard of Practice and the one-year rule to apply to physician-patient relationships formed prior to April 1, 2019, and therefore the necessarily implied power of the Council to make and apply them retrospectively can be demonstrated by an application of Dr. Hudson's argument. If we accept Dr. Hudson's argument, then a physician who last provided professional services to a patient on March 31, 2019 would be free to consider that individual a "former patient" and embark on a sexual relationship with them on or after April 1, 2019 without risk of an allegation of sexual abuse despite the new Standard of Practice. Other than the uncertain consequences of breaching the former Standard of Practice, it would allow the physician to engage in sexual contact or initiate sexual relationships after April 1, 2019 with anyone to whom they had last provided professional services on or before March 31, 2019.

186. Dr. Hudson's interpretation would leave patients vulnerable to physicians who abuse the continuing power imbalance inherent in their relationships with former patients, subvert the College's capacity to regulate its members and undermine public confidence in the proper regulation of the medical profession.

187. The Hearing Tribunal did not accept Dr. Hudson's submission that by applying the new Standard of Practice to her physician-patient relationship with [redacted] prior to April 1, 2019 the Complaints Director had "reached back" in time to "renew" a physician-patient relationship. The new Standard of Practice did not "renew" Dr. Hudson's physician-patient relationship with [redacted] after it had ended.

188. The former Standard of Practice did not define an end-date for physician-patient relationships after which sexual relationships would be permitted. The former Standard of Practice prohibited a physician from any form of sexual advance towards a previous patient where there was an ongoing risk of a power imbalance, which was clearly the case with Dr. Hudson and [redacted] throughout 2019. It also provided that in the absence of risk of a continuing power imbalance, a physician must not have any sexual or intimate involvement with a former patient for a period of time after the last physician-patient encounter depending on the nature and extent of the physician-patient relationship.

189. The new Standard of Practice redefines and clarifies what a physician-patient relationship means and when it exists. The new Standard of Practice provides that a physician-patient relationship forms when the physician has engaged in one or more enumerated activities and there is a reasonable expectation that the care will extend beyond a single encounter.

190. As above, we have concluded that Dr. Hudson was in a physician-patient relationship with [redacted] at least by December 28, 2018 whether by applying the *Redhead* factors or by applying the definition of a "patient" and the criteria in the new Standard of Practice. That physician-patient relationship already existed on April 1, 2019 when the new Standard of Practice came into effect and it continued to exist through August to November of 2019 when Dr. Hudson's relationship with [redacted] became sexual.

Primary Intention of the Legislature

191. In *Tran*, supra at paragraph 50 the Supreme Court of Canada explained that the presumption against retrospectivity may also be rebutted where the legislative intent supports doing so, and the design of the "penalty" signals that the legislature has weighed the benefits of retrospectivity against its potential for unfairness. The Court said this would be the case where there is a clear nexus between the protective measure and the risks to the public associated with the prior conduct to which it attaches.

192. The Alberta legislature may be taken to have considered the potential for unfairness in amending the *Health Professions Act* and requiring Colleges to adopt new Standards of Practice defining a "patient" that could include physician-patient relationships formed prior to April 1, 2019 and then mandating cancellation for physicians who engage in "sexual abuse" of a patient after April 1, 2019. This may be inferred because the purpose of the legislation overrides any concern about unfairness.

193. If defining [redacted] as a patient of Dr. Hudson after April 1, 2019 based on the care she provided to him before April 1, 2019 could be characterized as a prejudicial consequence, given that it is a pre-condition for a finding of sexual abuse and mandatory cancellation, then there is a clear nexus between the retrospective definition of [redacted] as a "patient", the finding of sexual abuse and the consequence of mandatory permanent cancellation. Mandatory permanent cancellation is clearly intended as a public protection measure, consistent with the College's primary purpose in section 3(1)(a) of the *Health Professions Act*, because it prevents any further risk of reoccurrence.

194. The legislative intent for Bill 21, the sole purpose of which was to amend the *Health Professions Act,* is also evident from Bill 21's title, "*An Act to Protect Patients*". Its intent was also the subject of discussion in the legislature. For example, the following excerpt

of a letter from the Association of Alberta Sexual Assault Services was read into the record as recorded in Alberta Hansard:[6]

> Health professionals occupy a unique position of power and control over their patients, and the abuse of this power and the betrayal of that trust can have devastating lifetime effects. As survivor advocates, we are in full support of a lifetime ban. We have no doubt that the after effects of this type of sexual victimization impact survivors throughout their entire life.

195. Ms. Burnett and Ms. Stein submitted that the legislature's true intent as evidenced by Alberta Hansard was to target and protect patients against physicians found guilty of sexual offences as defined in the *Criminal Code of Canada*. They argued that Dr. Hudson's conduct should be distinguished since she engaged in a consensual sexual relationship with [redacted], whom she had treated eight months prior. Her conduct was not criminal in nature, nor is she a predator or at risk of additional sexual boundary violations with other patients.

196. The Hearing Tribunal did not agree that the Legislature only intended the definition of "sexual abuse" to refer to sexual offences as defined in the *Criminal Code*. While there are references to "sexual assault" in the Hansard excerpts provided to us, a review of the whole excerpt does not suggest an intention to limit the *Health Professions Act* amendments to criminal conduct. A *Criminal Code* conviction is not a prerequisite for a finding of sexual abuse, nor is conduct that would amount to sexual assault or any other offence under the *Criminal Code*. The *Health Professions Act* defines "sexual abuse" without reference to the *Criminal Code*. There is nothing vague or ambiguous about the definition that would require resort to Alberta Hansard to interpret.

197. "Sexual abuse" of a "patient" as defined in the *Health Professions Act* and the College's new Standard of Practice is a breach of that Standard of Practice and a type of unprofessional conduct. Patients are in inherently vulnerable positions with respect to their physicians. Physicians who commit sexual abuse take advantage of this vulnerability and reveal their inability or unwillingness to uphold the trust that patients place in them, when weighed against their own interests and motives. The Alberta legislature chose to legislate permanent cancellation of physicians' registrations if they commit sexual abuse in order to eliminate the risk of recidivism and to protect the public and the integrity of the profession. Should these physicians remain in practice after a finding of sexual abuse it would seriously undermine the sense of safety patients must be assured of when seeking health care. It would also undermine public confidence in the integrity of the profession and the College's ability to protect the public.

198. The Hearing Tribunal also notes that the new Standard of Practice required Ministerial approval. The Minister must be taken to have reviewed and approved the new Standard

[6] Alberta Hansard, November 8, 2018, p. 1903.

of Practice including the one-year rule knowing that the one-year rule would necessarily apply to the time period prior to April 1, 2019, when the new Standard of Practice would come into force.

199. For all of the above reasons the Hearing Tribunal finds that the new Standard of Practice applies to Dr. Hudson's relationship with [redacted] prior to April 1, 2019 and defines [redacted] as a "patient" of Dr. Hudson for one year from December 28 or 29, 2018. [redacted] was therefore a patient of Dr. Hudson's between August and November of 2019 when they engaged in sexual contact including sexual intercourse. This does not represent an improper retrospective application of the new Standard of Practice. Even if it did, the Hearing Tribunal concluded that the presumption against retrospectivity has been effectively rebutted.

Conclusion on Charge 1

200. [redacted] was a patient of Dr. Hudson's between August and November of 2019 according to the new Standard of Practice when their relationship became sexual in nature and they engaged in proscribed sexual activities. Dr. Hudson's conduct met the definition of "sexual abuse" in section 1(1)(nn.1) of the *Health Professions Act*.

201. The new Standard of Practice and its definition of a "patient" are intelligible and precise, so [redacted]'s status as a "patient" at the time Dr. Hudson engaged in a sexual relationship with him was not difficult to ascertain. She could have done so by referring to and reading the new Standard of Practice that was in effect for some four months prior to commencing the sexual relationship. Dr. Hudson confirmed she did not always check her emails or read publications from the College, which are normal channels of communication between regulated members and their professional regulatory body.

202. Dr. Hudson's ignorance of the amended *Health Professions Act* and the new Standard of Practice cannot serve as an excuse for conduct that occurred four months after the new Standard of Practice took effect. It is difficult to imagine what further measures the College could have taken to alert Dr. Hudson to the new Standard of Practice, especially in light of her concomitant duty to stay informed of changes to the laws and standards which govern her profession: *Mussani*, supra. The moment the *Health Professions Act* changed and the new Standard of Practice came into effect Dr. Hudson was required to comply: *Rosenberg*, supra.

203. Or, given her clear knowledge of [redacted]'s multifaceted vulnerabilities and the regulatory issues that already existed as a result of Mr. Gukert's complaint, Dr. Hudson could have sought advice from the College before proceeding with a sexual relationship. The Hearing Tribunal found it surprising that Dr. Hudson proceeded with the sexual relationship without inquiring, despite the fact that her existing personal relationship with [redacted] had already drawn notice and review by the College. The Hearing Tribunal was also concerned by Dr. Hudson's evidence that when she left the Alliance Centre at the

beginning of August, 2019 she asked Dr. Hobday when a sexual relationship with [redacted] would be appropriate. She said that Dr. Hobday told her to contact the College. Dr. Hudson was on notice to speak with the College before embarking on a sexual relationship with [redacted]. She elected not to do so.

204. The Hearing Tribunal concluded that Dr. Hudson's behaviour represented a gross failure of professional judgment and responsibility and a breach of the new Standard of Practice. She allowed what Dr. Graham described as a type of lovesick misconduct to overrun her professional judgment and responsibilities. She took advantage of an extremely vulnerable, disabled, opioid-dependent individual who was her patient. The Hearing Tribunal cannot accept that Dr. Hudson should be regarded as an exception to the rules that other physicians must abide by.

205. Ms. Burnett and Ms. Stein called several other witnesses on Dr. Hudson's behalf, but none of this evidence refuted what Dr. Hudson herself confirmed, that she had a sexual relationship with [redacted] between August and November of 2019 during a time when he met the definition of a "patient" in the new Standard of Practice. The Tribunal was also concerned by Dr. Graham's evidence. Dr. Graham's evidence was that Dr. Hudson said she had avoided fully informing herself of her obligations under Bill 21, but she nevertheless understood that her sexual relationship with [redacted] had "crossed a line".

206. Engaging in the sexual abuse of a patient is extremely serious unprofessional conduct. As described in the Association of Alberta Sexual Assault Services' letter read in the legislature during debate on Bill 21, a health professional who abuses their position of power and control to do this can have devastating lifetime effects.

207. While the effects of a finding of sexual abuse may be harsh, the Hearing Tribunal considers those effects to be proportionate. As described above, physicians hold privileged positions of power and influence over patients. Patients are inherently vulnerable to their physicians. Physicians who commit sexual abuse take advantage of that vulnerability and demonstrate their inability or unwillingness to uphold the trust that patients and the public place in them. Permanent cancellation eliminates the risk of recidivism and thereby protects the public from further unprofessional conduct. It also demonstrates to the public that sexual abuse of patients is not tolerated with 'second chances' for physicians who ought to have known better. Should these physicians remain in practice after a finding of sexual abuse it would seriously undermine the sense of safety patients must be assured of when seeking health care. It would also undermine public confidence in the proper regulation of the medical profession by the College and the integrity of the profession itself.

208. The Hearing Tribunal also noted that Dr. Hudson referred to her sexual relationship with [redacted] as "consensual", but Dr. Hudson was in a clear position of power and influence over [redacted] in December of 2018 and throughout 2019. In Dr. Hudson's April 17, 2020 letter to the College in response to the complaint by [redacted]. and [redacted], she acknowledged that she

created a situation in which [redacted] was dependent upon her in their relationship, at least initially.

209. The new Standard of Practice makes clear that physicians may not rely on a patient's alleged "consent" to a sexual relationship due to the power imbalance between them. The presence of a physician-patient relationship vitiates any expression of consent and results in the prescribed sexual contact between physician and patient constituting sexual abuse.

210. A finding of unprofessional conduct on the basis of sexual abuse necessitates the immediate suspension of Dr. Hudson's practice permit pursuant to section 81.1(1) of the *Health Professions Act*.

Charge 2

211. Charge 2 alleged that Dr. Hudson submitted her 2020 Renewal Information Form with the false information that she had not had a sexual boundary violation [with a] patient that had not been reported to the College.

212. The Hearing Tribunal carefully considered the evidence, the law and the parties' submissions and found charge 2 proven and that Dr. Hudson's conduct was unprofessional conduct.

213. The Renewal Information Form was in evidence through the agreement of the parties. Dr. Hudson completed her Renewal Information Form on December 22, 2019. In response to the question "[a]re you presently, or have you ever, engaged in a sexual or inappropriate personal relationship with a patient that has not been previously reported to CPSA?" she answered "No".

214. On behalf of Dr. Hudson, Ms. Burnett and Ms. Stein submitted that Dr. Hudson interpreted the word "or" so that the question was asking if she had ever engaged in one or the other of a sexual relationship with a patient or an inappropriate personal relationship with a patient that had not previously been reported to the College. In other words, Dr. Hudson interpreted the question such that she could answer "no" because her inappropriate personal relationship with [redacted] had already been reported to the College. The word "or" meant that she could disregard that her sexual relationship with [redacted] had not previously been reported to the College and answer only with respect to the inappropriate personal relationship. We do not accept this interpretation.

215. The question is not ambiguous. The word "or" in the question is plainly a disjunctive conjunctive between two types of relationships a physician may have engaged in with a patient that have not been previously reported to the College. Properly interpreted, the question asks whether the physician has ever engaged in a sexual relationship with a patient that has not previously been reported to the College, or an inappropriate personal

relationship with a patient that has not previously been reported to the College. The question is asking about both types of relationships. Dr. Hudson would have to have answered "yes" because as of December 22, 2019 when she submitted the Renewal Information Form she had never before reported her sexual relationship with [redacted] to the College.

216. Dr. Hudson testified that she initiated discussions with the College in late November 2019 and a meeting date with Dr. Beach was set for January 23, 2020, but there was no advance notice to the College of what the meeting would be about. Scheduling a meeting with the intention of disclosing a sexual relationship to the College is not the same as actually disclosing it. Meetings can be cancelled or rescheduled. Dr. Hudson may have changed her mind about disclosing the relationship between November and January. There was no disclosure of the sexual relationship to the College until January 23 or 24, 2020 and the Renewal Information Form submitted on December 22, 2019 contained false information. We also note that at the time Dr. Hudson submitted the Renewal Information Form [redacted] still met the definition of a "patient" in the new Standard of Practice.

217. The Hearing Tribunal therefore found charge 2 to be factually proven and that Dr. Hudson's conduct amounted to unprofessional conduct as defined by the *Health Professions Act*. The Renewal Information Form is the tool by which the College maintains up to date information about its physician registrants and includes monitoring for patient safety issues such as sexual abuse. It is essential that the College be able to trust physicians to answer completely and honestly in order for the College to carry out its public protection mandate. Dr. Hudson's conduct undermined the College's ability to regulate the medical profession in the public interest. The Hearing Tribunal concluded that her conduct harms the integrity of the medical profession contrary to section 1(1)(pp)(xii) of the *Health Professions Act*.

218. While this is sufficient to determine charge 2, the Hearing Tribunal was also concerned by Dr. Graham's description of the history that Dr. Hudson reported to him. In his Acumen Assessment report, Dr. Graham recorded that Dr. Hudson told him about her sexual relationship with [redacted]. She told Dr. Graham that after the sexual relationship began in August, 2019 she knew that she had crossed the line and she would have to answer "yes" to a question on her license renewal. Dr. Graham said Dr. Hudson also told him that she had a limited knowledge of Bill 21 and she was avoiding fully informing herself.

CONCLUSION

219. The Hearing Tribunal finds charges 1 and 2 proven and to constitute unprofessional conduct.

220. The Hearing Tribunal will receive submissions on sanctions. The parties may make submissions on sanction in writing, or if either party wishes to call additional evidence or to make oral arguments on sanctions they may request an oral hearing by writing to the

Hearings Tribunal care of the Hearings Director. The Hearing Tribunal will consider such requests and advise the parties of its decision.

221. In light of the Hearing Tribunal's decision on charge 1, Dr. Hudson's permit to practice is immediately suspended pursuant to section 81.1(1) of the *Health Professions Act* pending the determination of sanctions.

Signed on behalf of the Hearing Tribunal by its Chair:

Ms. Naz Mellick

Dated this 9th day of January, 2023.