COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. AKADRI ALARAPE

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

I. INTRODUCTION

1. The Hearing Tribunal held a hearing on sanction relating to Dr. Akadri Alarape on October 25, 2019. The Hearing Tribunal was comprised of Dr. Robin Cox of Calgary as Chair, Dr. Don Yee of Edmonton and Mr. James Lees of Edmonton (public member). Mr. Matthew Woodley acted as independent legal counsel for the Hearing Tribunal.

2. In attendance at the hearing were Mr. Craig Boyer, legal counsel for the Complaints Director, Dr. Alarape, investigated member, Mr. James Heelan and Ms. Renee Gagnon, legal counsel for Dr. Alarape.

3. The Hearing Tribunal issued a decision dated April 29, 2019 finding Dr. Alarape guilty of unprofessional conduct arising from his conviction on May 18, 2018 for sexually assaulting [redacted], [XX]. In that decision, the Hearing Tribunal also dismissed an objection raised by Dr. Alarape to the admissibility of certain expert evidence to be submitted by the Complaints Director. The Hearing Tribunal convened on October 25, 2019 to hear evidence and submissions in relation to an appropriate sanction arising from the unprofessional conduct noted above.

II. PRELIMINARY MATTERS

4. Counsel for the Complaints Director and for Dr. Alarape had previously confirmed that there were no objections to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing.

III. CHARGE

5. The Notice of Hearing listed the following charge which was the basis for the finding of unprofessional conduct:

    1. on May 18, 2018, you were convicted of an offence under Section 271 of the Criminal Code of Canada relating to events between November 1, 2016 and January 28, 2017 when, on five separate occasions, you did commit sexual assault on [XX], [redacted]

IV. EVIDENCE

6. The following Exhibits were entered into evidence during the hearing:

    Exhibit 1: Notice of Hearing to Dr. Akadri Alarape, dated February 6, 2019

    Exhibit 2: Agreed Statement of Facts, dated February 20, 2019

Exhibit 3: Exhibit Book, comprising:

- Complaint Form from [XX] dated March 3, 2017
- Dr. Michael Caffaro letter to Dr. Alarape dated March 13, 2017
- Undertaking of Dr. Alarape dated March 20, 2017
- Dr. Alarape letter to Katherine Damron dated March 29, 2017
- Dr. Alarape letter to Kristy Ivans dated June 2, 2018
- Criminal Information Form
- Agreed Statement of Facts dated May 18, 2018
- Probation Order dated May 18, 2018

Exhibit 4: Exhibit Book, comprising:

- Report from Dr. S. Hershcovis dated November 16, 2018
- Curriculum Vitae for Dr. S. Hershcovis
- Report from the Comprehensive Occupational Assessment Program dated November 1, 2018
- Character reference letter from Dr. Eraga dated May 28, 2019
- Character reference letter from Dr. Awaken dated June 3, 2019
- Character reference letter from Mr. J. Adedire dated June 6, 2019
- Character reference letter from Pastor A. Ojo dated June 7, 2019
- Character reference letter from Dr. Rengan dated June 18, 2019
- Curriculum Vitae for Dr. B. Leier
- Report from Dr. B. Leier dated October 25, 2019
- Curriculum Vitae for Dr. B. Frizzell
- Letter from [XX] dated October 24, 2019

V. EVIDENCE AND SUBMISSIONS ON SANCTION

a. Evidence Adduced by the Complaints Director

7. Mr. Boyer, counsel for the Complaints Director, called Dr. Sandy Hershcovis to give expert evidence. After reviewing her qualifications, Mr. Boyer asked that Dr. Hershcovis be qualified to give expert evidence on "workplace sexual harassment and society's acceptance or attitude towards that conduct". Dr. Hershcovis's expertise was accepted by legal counsel for Dr. Alarape, and the Hearing Tribunal therefore qualified Dr. Hershcovis to give the expert evidence proposed.

8. Dr. Hershcovis then provided evidence about the changing attitudes in society with respect to sexual harassment in the workplace, including her opinion that society has become more educated on the topic of sexual harassment at work and less tolerant of it. Dr. Hershcovis commented on the #MeToo movement and how that reflects on changing attitudes in society. Dr. Hershcovis commented on her own research into the effect of sexual harassment in the workplace on victims, including with respect to the negative impacts on employee well-being, productivity, performance and job satisfaction. Dr. Hershcovis also addressed the motivation for individuals in the workplace to engage in

sexually harassing behavior, commenting that the motivation appears to be based on control and protecting existing gender-based status.

9. Dr. Hershcovis gave evidence about rape myths in relation to the tradition of placing blame on victims for having encouraged sexual harassment. She indicated that the initial response from Dr. Alarape, which stated that [XX] was the aggressor, was reflective of that myth.

10. In cross-examination, Dr. Hershcovis acknowledged that although she had access to the second letter from Dr. Alarape to the Complaints Director in which he acknowledged his responsibility for his misconduct, she did not refer to it in her report or in her evidence. Dr. Hershcovis also acknowledged that she is not a legal scholar and that she has no training or expertise in sentencing matters before professional regulatory bodies. She acknowledged that sentencing in a professional regulatory matter should include considerations beyond satisfying the attitudes of the public. Dr. Hershcovis agreed that she had not engaged in any psychological testing of Dr. Alarape and that she cannot speak to his individual circumstances or his motivations.

11. In response to a question from the Hearing Tribunal, Dr. Hershcovis gave evidence in relation to the power imbalance that exists in a physician-patient relationship compared with a physician-[redacted] relationship. She stated (page 66, lines 4-21):

> I think that there's a significant power difference between a doctor and a co-worker [redacted]. So it would be similar. There is not the vulnerability, the same vulnerability there as there is with a patient who might be unclothed and whatever, seeing a doctor in a very intimate setting. But there is a strong power difference between a doctor and a co-worker. And the research shows that powerful people are the people most likely to engage in sexual assault and sexual harassment and that they are also the most protected because people within those fields, within those domains are fearful of speaking out against these powerful people because it can impact their careers, it can impact their access to resources and so on. So there is certainly a power difference, and that power difference results in greater silence essentially around sexual harassment and assault in the workplace.

12. Following the conclusion of Dr. Hershcovis's evidence, the Complaints Director closed his case in relation to sanction.

b. Evidence Adduced by Dr. Alarape

13. The Hearing Tribunal then heard evidence from Dr. Beverly Frizzell, a registered psychologist. Mr. Heelan reviewed Dr. Frizzell's qualifications and sought permission from the Hearing Tribunal to qualify Dr. Frizzell to give expert evidence relating to psychology. There was no objection from Mr. Boyer, and the Hearing Tribunal qualified Dr. Frizzell as requested.

14. Dr. Frizzell was part of a multi-disciplinary team at the Comprehensive Occupational Assessment Program ("COAP") that undertook an assessment of Dr. Alarape in 2018. Dr. Frizzell provided evidence about that process and the roles played by the various team members involved in the assessment. Dr. Alarape was assessed over a two-day period by the team members, following which Dr. Frizzell drafted the report. Dr. Frizzell reviewed the findings set out in the report. She testified that there was no evidence of an underlying psychiatric disorder explaining Dr. Alarape's conduct. She reviewed the evidence of personality traits and the impact that those traits have on Dr. Alarape. She stated (page 78-79):

> Well, with any personality trait, there's advantages and vulnerabilities associated with any personality. So the positives of these are the people are generally goal-directed, they will reach goals. They have got the energy to do it. Rules are important. Responsibilities and duty to others are important. The vulnerabilities associated with it tend to be some rigidity, and vulnerability to shame when things don't go well.

15. In relation to the scenarios set out in her report, Dr. Frizzell noted that she determined that Dr. Alarape had a traditional and patriarchal approach to the practice of medicine from both a personality and cultural standpoint. She determined that Dr. Alarape would benefit from additional training relating to communication style with his patients. In terms of identifying factors which contributed to the behavior resulting in the commission of the criminal offence, Dr. Frizzell testified (pages 84-85):

> The first one noted here is that he was working very long hours with no real balance in his life. Working many hours a week, many hours a day, a huge number of patients per day. And this can lead to not only distance in family relationships; it can lead to fatigue, problems with decision making and so forth. The second that we noted was that there was likely an impact of navigating a very different culture with very different standards for dealing appropriately with gender and sexuality. Although Dr. Alarape had been here for a number of years, those cultural factors certainly appeared to be playing a role still. And then I guess general understanding of differences in cultural norms and how those impact what a professional practice looks like here versus other places. The personal factors are psychological factors that we thought made him vulnerable again related more to personality traits, per se, than any kind of clinical or psychiatric problem. There is no history of any psychiatric difficulties. He had no current symptomatology, other than the level of distress you might expect with somebody going through this process. But his desire to help and be seen to be helpful involves a high level of self gratification associated with that. And that can -- that can lead to some risk of boundary violations, not necessarily of the sort that he had -- that led to the complaint, but in general it's a concern.

16. Dr. Frizzell also testified that Dr. Alarape's "psychological profile noted he would have some risk for boundary violations with patients as well" (page 87) but that no physician presents a "zero risk" for boundary violations. Ultimately, when asked whether in her view, Dr. Alarape was fit to practice medicine, she stated (pages 87-89):

> We said that we felt that he was fit to practise with the restrictions that have already been instituted, as well as our recommendations for some ethics training and some long-term mentorship and support. …
>
> They were -- the restrictions that we noted are largely the same as ones that he had instituted prior to coming for the assessment. So ongoing chaperones with any female patient; not operating on his own in a clinic; avoiding private conversations with others; in terms of when he is working with people, making sure that there is a number of people around. … And not having, I guess, conversations that might be irrelevant or inappropriate in that setting. Keeping work relationships professional and finding a professional mentor to provide him with the support that he needs.

17. Dr. Frizell also noted that the ethics training she referred to was undertaken by Dr. Alarape with Dr. Brendan Leier.

18. In cross-examination, Dr. Frizzell acknowledged that the report was limited to Dr. Alarape's interaction with [XX] and that information set out in Exhibit 3 relating to another employee at the clinic also having unwanted attention from Dr. Alarape was not something that was discussed with him. The report was done based only on interviews of Dr. Alarape; the COAP team did not meet with or interview [XX]. Dr. Frizzell also confirmed that while Dr. Alarape was very forthcoming about the circumstances relating to the complaint, he was very protective of his family and refused to provide information about his personal life. In relation to her assessment of risk, Dr. Frizzell stated (page 93):

> I don't think we can speak to assessing the exact level of the risk. What we have said is that we did not think that he was at risk of further sexual violations, but that the boundary violations that he is at some risk of come from that personality style or that need to be liked, which is boundary -- has some risk of boundary violations of any number of types that would not necessarily reflect what happened before.

19. In response to questioning by the Hearing Tribunal in relation to Dr. Frizzell's assessment of the risk of further boundary violations and what, in her view, an acceptable risk is, she gave the following evidence (pages 96-97):

> A Can I just go back to your previous question about acceptable risk. There were a few things that we took into consideration when we were discussing risk in this case. One was that it wasn't a patient, that it was a co-worker. He had been practising for probably about a year and a half when we saw him under these conditions with nothing else having occurred. And so those were some of the reasons that we saw the risk as being less than it would have been when it happened.
> Q So would your approach have been different if it was a patient?
> A Generally that would be seen as a bigger risk.
> Q Okay. Let's look at it from the other way. Is it an equivalent violation?
> A I can't -- I can't speak to whether it's an equivalent violation or not. We were looking at it from the point of view of risk to the patient. Of risk to patients.

> Q Understood, but I think in -- we are also looking at risk to co-workers because that's part of our job.
> A But the question here was boundary violations with risk to patients.

20. Finally, in re-examination by Mr. Heelan, Dr. Frizzell confirmed that, despite the assessment by the COAP team about the nature of the risk, she was comfortable with Dr. Alarape returning to work pursuant to the existing restrictions and having regard to Dr. Alarape's participation in the ethics training with Dr. Leier (page 99).

c. Submissions of the Complaints Director

21. Mr. Boyer presented written and oral submissions to the Hearing Tribunal in support of the Complaints Director's request that Dr. Alarape's practice permit and registration be cancelled pursuant to section 82(1)(h) of the HPA, that he be required to pay the costs of the hearing and a fine. Mr. Boyer summarized the evidence of Dr. Hershcovis, noting that Dr. Alarape's initial response to the complaint was to blame [XX] for the behavior, consistent with Dr. Hershcovis evidence about rape myths.

22. Mr. Boyer made submissions in relation to the *Taher* decision, which resulted in an 18-month suspension based on a joint submission. He noted that Dr. Taher had been out of practice for a period of nearly three years at the time of the decision. He stated that the facts in the Dr. Taher case were different, insofar as Dr. Taher had been convicted of sexual assault against both a patient and a clinical worker. Mr. Boyer provided submissions on why the Complaints Director is seeking cancellation of Dr. Alarape's practice permit and registration when he agreed to an 18-month suspension in Dr. Taher's circumstances. Mr. Boyer pointed to the evidence of Dr. Hershcovis and the changing societal views on sexual assault and harassment in the workplace. Further, he stated that it is clear that the public reaction to Dr. Taher's case was significant and was the impetus for the passage of Bill 21(*An Act to Protect Patients*, SA 2018 c 15) through the Alberta legislature. While Mr. Boyer acknowledged that Bill 21 did not apply directly the facts of this case, the Hearing Tribunal should consider the underlying motivations in such legislative change in considering an appropriate sanction for Dr. Alarape.

23. Mr. Boyer also referred to the decision in *College of Physicians and Surgeons of Ontario v Peirovy*, 2018 ONCA 420. There, the Ontario Court of Appeal reversed a Divisional Court decision which had substituted a sanction of revocation for the initial Discipline Committee's decision to suspend the member. The Ontario Court of Appeal determined that the initial decision-maker was in the best position to determine an appropriate sanction, and that Dr. Hershcovis's evidence was tendered to ensure that the Hearing Tribunal had the best evidence at its disposal in order to make that determination.

24. Mr. Boyer referred the Hearing Tribunal to several cases in his written submissions which determined that the sanction of revocation was warranted. He candidly acknowledged that those cases refer to situations where the victims of the unprofessional conduct were patients, but asks whether a physician in a position of authority over a coworker should be treated differently than a physician in a position of trust in relation to a patient.

25. Mr. Boyer noted that the assessment by the COAP team was not as in-depth as it could have been, and that the assessment did not touch on the fact that there had been another coworker who expressed concerns about attention from Dr. Alarape. Further, that assessment and the evidence before the Hearing Tribunal does not reflect Dr. Alarape taking full responsibility for his unprofessional conduct, in particular his repeated assertions that [XX] was the initial aggressor.

d. Submissions of Dr. Alarape

26. Mr. Heelan presented the Hearing Tribunal with written and oral submissions in relation to sanction. He noted the fact that Dr. Alarape has acknowledged his misconduct and had entered a guilty plea to a *Criminal Code* offence. He noted the serious consequences which followed from that decision, and Dr. Alarape's expression of remorse. Mr. Heelan noted that the evidence of Dr. Hershcovis was general and did not relate specifically to Dr. Alarape. Dr. Hershcovis acknowledged having no expertise in sentencing and was not aware of the conditions that would apply to Dr. Alarape if he were able to continue to practice. She had also not considered any professional disciplinary cases other than the *Taher* decision, including cases where physicians had been permitted to return to practice.

27. Mr. Heelan reviewed the evidence of Dr. Frizzell, which was based on a specific assessment of Dr. Alarape. He noted that Dr. Frizzell specifically determined that it was reasonable and safe for Dr. Alarape to return to practice with conditions, and that other cases demonstrate that the COAP assessment team has refused to provide that opinion for other physicians. He reviewed the letter from Dr. Leier which demonstrated that Dr. Alarape had participated in customized ethics training. He submitted that Dr. Alarape has also put into place the other recommendation from the COAP assessment, including a focus on work-life balance. Mr. Heelan reviewed the reference letters in the materials.

28. In relation to the factors arising in *Jaswal v Newfoundland Medical Board* (1996), 42 Admin LR (2d) 233 ("*Jaswal*"), Mr. Heelan reviewed his written submissions in relation to them.

29. Mr. Heelan noted that Bill 21 is does not apply because the conduct at issue here did not relate to a patient. Further, Bill 21 does not apply retrospectively. Mr. Heelan noted that sexual assault was a serious matter before Bill 21, and the cases provided which predate Bill 21 remain relevant for the Hearing Tribunal to consider in coming to a decision on sanction.

VI. FINDINGS ON SANCTION

30. The Hearing Tribunal reviewed the exhibits and considered the submissions of the parties in relation to sanction. The Hearing Tribunal approaches the consideration of an appropriate sanction mindful of its primary obligation of ensuring the protection of the public through the imposition of sanctions that recognize the importance of deterrence

(general and specific), the need to maintain public confidence in the profession, and the need for rehabilitation where it is possible.

31. In accordance with the submissions of the parties, the Hearing Tribunal has considered these primary factors through the analytical framework set out in *Jaswal*. The Complaints Director submits that the Hearing Tribunal should cancel Dr. Alarape's registration and practice permit, require that he pay the costs of the hearing, and impose a fine in accordance with the fines tables in the HPA. Dr. Alarape submits that a six-month sentence is appropriate, with ongoing practice restrictions.

Nature and Gravity of the Conduct

32. The parties each submit that the conduct at issue here is very serious. The underlying conduct is reprehensible and is to be condemned in the strongest terms. Such behavior is inconsistent with the role of a physician and can never be tolerated. Although the conduct at issue here does not involve the sexual assault of a patient, the Hearing Tribunal finds that there was a power imbalance between Dr. Alarape and [XX] which Dr. Alarape exploited. The Hearing Tribunal accepts the evidence of Dr. Hershcovis which indicates that, while the vulnerability that exists between a physician and patient may not be present, the power imbalance between Dr. Alarape and [XX] is a significant aggravating factor.

33. Further, the admitted conduct involves several separate incidents of unlawful touching for a sexual purpose. This was not a one-time "slip", but rather a series of related events culminating in one criminal conviction.

Age and Experience

34. Dr. Alarape acknowledges that he is not a new or inexperienced physician. However, he refers to the COAP report which noted that his previous practice in Nigeria prior to moving to Australia in 2003 may have created "challenges in understanding how cultural norms intersect with professional practices and boundaries" (Exhibit 4, Tab 3).

35. The Hearing Tribunal disagrees. Dr. Alarape had been practicing medicine in Canada and Australia for 14 years prior to the sexual assault on [XX]. Each and every physician must understand that sexually assaulting an [redacted] is unlawful and entirely inconsistent with cultural norms. Dr. Alarape is an experienced physician and he very clearly should have known that his behavior was inappropriate and unprofessional.

Character and Presence or Absence of Previous Complaints or Convictions

36. The Complaints Director acknowledges that there is no evidence of any prior conviction for unprofessional conduct nor any other complaints. Dr. Alarape points to the character references provided, which indicate generally that the conduct underlying the criminal conviction was out of character for him.

37. The reference letters are from members of Dr. Alarape's church or from co-workers. The Hearing Tribunal considered the reference letters set out in Exhibit 4. Those letters each call on the Hearing Tribunal to reflect the principle of "mercy" in its decision related to sanction. The Hearing Tribunal placed limited weight on the reference letters. Although they attest to Dr. Alarape's general character, it is impossible for the Hearing Tribunal to know what specific information they were provided about Dr. Alarape's present circumstances.

Age and Mental Condition of the Complainant

38. Dr. Alarape submits that there is no evidence to suggest that [XX] was psychologically vulnerable. However, he recognizes that the nature of the relationship was inherently unbalanced.

39. Although the Hearing Tribunal accepts that this factor is not as aggravating as it is in circumstances where a patient or a minor is involved as a complainant, the power imbalance in the relationship (testified to by Dr. Hershcovis) is a factor indicating that Dr. Alarape took advantage of [XX].

Number of Times the Offence Occurred

40. As indicated above, the underlying criminal charge established that Dr. Alarape engaged in the misconduct on five occasions relating to one victim. This is an aggravating factor.

Acknowledgment of Responsibility

41. The parties differ significantly on whether this factor is aggravating or mitigating in relation to Dr. Alarape. The Complaints Director notes that Dr. Alarape's first response to the College complaint was to deny any wrongdoing, and in fact to blame the victim for his own misconduct. It was only after Dr. Alarape plead guilty to the criminal offence that he acknowledged his misconduct relating narrowly to the fact of the criminal offence and conviction. The Complaint Director notes that his first response was consistent with the rape myths described by Dr. Hershcovis in her evidence.

42. In response, Dr. Alarape acknowledged his first response, but points to the fact that he subsequently admitted the misconduct and has taken responsibility for it. He notes that this has resulted in the complainant not being called upon to give evidence in either the criminal prosecution or in the CPSA prosecution.

43. The Hearing Tribunal finds that Dr. Alarape deserves credit for eventually taking responsibility for his misconduct, but that this credit is tempered by the fact he initially either blamed the complainant, or suggested that she was a willing participant in the sexual assault. This fact is reiterated by the summary of Dr. Alarape's version of events provided to the COAP assessment team; there, the language used by Dr. Alarape does not represent an unequivocal recognition of his responsibility for his criminal conduct. He refers to the fact that he "was seduced", although he states that he understands that he was responsible to stop the behavior.

Other Serious Financial or Other Penalties

44. There is no doubt that Dr. Alarape has been subject to serious penalties as a result of his conduct. First, he has been criminally convicted of sexual assault, and was place on probation for 12 months. He has a criminal record and will be subject to travel restrictions. Second, there is some evidence that the complainant filed a human rights complaint, but there is no evidence about the outcome of that process.

45. Other than the costs associated with proceeding with the criminal matter and the current disciplinary hearing, there is no evidence of any specific, serious financial consequence suffered by Dr. Alarape. For example, Dr. Alarape has been permitted to continue to practice medicine (subject to restrictions) during the investigation and prosecution of this matter, unlike some physicians in the cases referred to by the parties. He served no time in custody which would have resulted in a loss of revenue from his practice. There is no evidence of a specific financial consequence suffered by Dr. Alarape as a result of his misconduct.

Impact on the Complainant

46. The impact on the complainant was serious. As a direct result of Dr. Alarape's conduct, the complainant was forced to quit her job which, in her words, she "loved". This is entirely consistent with the evidence of Dr. Hershcovis on the insidious impact of sexual harassment and sexual assault in the workplace. The complainant stated in a letter to the Hearing Tribunal (Exhibit 4, page 69) that she suffered "injury to [her] dignity, feelings and self-respect". She stated that she tried to communicate to Dr. Alarape that his actions were unwanted, but with no effect. She states that after quitting her job, she became severely depressed and anxious, requiring "medical and psychiatric treatments". [XX] states that the events negatively impacted her relationship with her family members. Importantly, she states that when she learned from the College that Dr. Alarape had denied misconduct and labelled her as the aggressor she was "shocked in disbelief". Finally, [XX] states that her desire is for Dr. Alarape to be "reformed and genuinely remorseful" for his misconduct.

47. The serious impact of Dr. Alarape's conduct on the complainant is an aggravating factor.

Aggravating and Mitigating Circumstances

48. Dr. Alarape correctly notes that his admission of unprofessional conduct is a mitigating factor as it resulted in the complainant not being required to come to the hearing to provide evidence. Further, the fact that he has engaged in ethical training with Dr. Leier and his related training in boundary violation issues militates towards more lenient sanctions.

49. The Hearing Tribunal agrees that Dr. Alarape's admission of unprofessional conduct, and the fact that the complainant did not have to give evidence about his misconduct is a mitigating factor. It also recognizes that Dr. Alarape has engaged in additional training to

address the issues identified in the COAP assessment in an effort to mitigate the risks of future boundary violations.

General and Specific Deterrence

50. The Hearing Tribunal finds that the need for both general and specific deterrence militate towards the imposition of a harsh sanction. In relation to specific deterrence, it is vital that Dr. Alarape understand that the medical profession is seriously harmed as a result of this kind of misconduct. An appropriate sanction must communicate the seriousness of Dr. Alarape's misconduct to him in order to ensure that he is deterred from engaging in similar misconduct in the future. While the Hearing Tribunal has recognized Dr. Alarape's acknowledgement of his conduct, it finds that such recognition was late and qualified. A serious sanction is required in order to ensure that Dr. Alarape fully understands the nature and gravity of his offence and the impact on the profession as a whole.

51. Further, while the evidence adduced indicates that Dr. Alarape presents a low risk for future sexual boundary violations, the evidence of Dr. Frizzell indicates that there is moderate risk of future boundary violations in general. While Dr. Frizzell has testified that those risks are manageable with appropriate conditions, the risk warrants a serious sanction in order to clearly communicate the results of future unprofessional conduct of any kind.

52. Regarding general deterrence, the Hearing Tribunal agrees with the Complaints Director that the society's views in relation to sexual assault and sexual harassment in the workplace have evolved, and that a serious sanction is required in order to communicate to the membership the fact that similar conduct will not be tolerated. Physicians are expected to abide by professional and legal standards in relation to their practice, including the treatment of patients, co-workers and employees. Sexual assaults against co-workers or employees remain very serious, even if the specific vulnerability associated with a physician-patient relationship is not present.

53. The seriousness with which the profession treats this kind of misconduct is reflected in the fact that the Complaints Director is seeking cancellation of Dr. Alarape's practice permit and registration in this manner, even in circumstances where there are no previous findings of unprofessional conduct. Further, while the Hearing Tribunal agrees with Dr. Alarape that Bill 21 has no application to the facts here, it is reflective of the general movement in society as described by Dr. Hershcovis towards a recognition of the particularly insidious and harmful impact of sexual assault and sexual harassment in professional settings.

54. The need for both general and specific deterrence is a strong factor in favour of a serious sanction.

Public Confidence in the Integrity of the Profession

55. This factor also militates towards a serious sanction. As a self-governing profession, the College has a responsibility to ensure that serious misconduct by its members will result in serious sanctions. A failure by the Hearing Tribunal to do so risks the public losing confidence in the system of self-regulation.

56. Public confidence in the integrity of the profession has been damaged in the past as a result of professional disciplinary decisions. Specifically, the Complaints Director pointed to the *Taher* case, in which a hearing tribunal agreed with a joint submission on penalty resulting in an 18-month suspension. The facts of that case are egregious, and involved sexual assaults on three individuals, including a patient. However, the public response to that decision resulted in the drafting and passage of Bill 21, which requires the imposition of certain sanctions where a physician engages in "sexual misconduct" or "sexual abuse" as those terms are defined.

57. While the Hearing Tribunal is cognizant of the need to ensure that the sanction imposed has the result of reassuring the public regarding the nature of self-governance, the Hearing Tribunal finds that it must assume that readers of its decision will take the time to inform themselves about the facts of the case as a whole, and how those facts relate to similar cases in the past. That is, the Hearing Tribunal cannot impose a sanction because it expects that the public will be "satisfied" with it. Rather, the Hearing Tribunal must apply the facts of the case to the law as it exists, mindful that its primary objective is the protection of the public, and in light of the need to maintain public confidence in the disciplinary system.

Range of Permitted Conduct

58. Dr. Alarape acknowledges that his conduct fell well outside of the range of permitted conduct. This was not a case where reasonable people could disagree on the fact that the proven conduct was unprofessional. The misconduct was repeated, criminal and was done in a relationship with an inherent power imbalance.

Sanctions in Other Cases

59. The parties provided a significant number of cases in support of their arguments in relation to whether or not cancellation of Dr. Alarape's practice permit and registration was justifiable. The number of cases and the differences in relevant facts warrant a close examination of their applicability to this case.

60. The Complaints Director submitted the *Taher* case. There, Dr. Taher was subject to an 18-month suspension, 15 months of which was an active suspension, and three of which was held in abeyance pending compliance with other orders. The time that Dr. Taher has spent out of practice was applied to the suspension, resulting in the suspension having been fully served prior to the issuance of the decision. Dr. Taher was also subject to conditions on his practice permit and was responsible for the payment of the costs of the investigation and hearing. The Hearing Tribunal notes that the underlying criminal

offences in Dr. Taher's case involved sexual assault against a patient and two employees in the medical clinic. That is, Dr. Taher's case involved three victims, one of who was a patient. In that case, Dr. Taher was also incarcerated intermittently for a period of 30 days. The hearing tribunal in that case accepted the joint submission, noting specifically the fact that Dr. Taher had suffered a significant penalty arising from his actions as a result of his not having practiced for more than two years, his incarceration and existing media attention.

61. While the Hearing Tribunal accepts that the decision in the *Taher* case resulted in public condemnation of the seriousness of the sanction, the decision was based on a joint submission from the parties. The conduct set out in *Taher* is clearly more serious having regard to the fact that there were three victims, one of whom was a patient. Although the Hearing Tribunal notes that the existing consequences for Dr. Alarape are less severe than those which had been experienced by Dr. Taher, that is largely due to the more serious nature of the offences committed.

62. The Complaints Director also referred the Hearing Tribunal to the *Peirovy* decision, cited above. There, the physician's misconduct related to the sexual abuse of four female patients and other inappropriate conduct. The hearing was contested. The sanction imposed by the Discipline Committee was a 6-month suspension, practice restrictions and costs. That decision was appealed to and overturned by the Ontario Divisional Court. The Divisional Court held that the penalty imposed was unreasonable and imposed a sanction of cancellation. The decision of the Divisional Court was further appealed to the Ontario Court of Appeal, which reinstated the original Discipline Committee's decision.

63. The Ontario Court of Appeal noted that the sanction imposed by the Discipline Committee in that case was in line with previous decisions, and that a 6-month suspension had in fact been imposed in a case with more egregious facts. In reviewing the Discipline Committee's consideration of revocation, the Court of Appeal states:

> [63] The Discipline Committee explained that protection of the public is generally taken as the paramount principle of sentencing. It is then that the Discipline Committee stated:
>
> > Although the two principles are not identical, and there will be cases where the egregious nature of the misconduct itself will demand revocation even where the risk of re-offence is low, a well-informed public would be expected to maintain confidence in a self-regulating process which results in the public being protected from abusive physicians.
>
> [64] In this passage, the Discipline Committee was quite properly pointing out that revocation is sometimes "demanded" by egregious conduct alone. As it indicated in other parts of its reasons, however, it is tasked with arriving at a fair and just penalty that addresses all of the sentencing principles. Those principles include the paramount consideration of protection of the public, as well as maintenance of public confidence in the reputation and integrity of the profession, effective self-governance, general deterrence, specific deterrence, and

> the potential for the member's rehabilitation. Proportionality is also an important consideration.

64. Further, the Court of Appeal rejected the Divisional Court's approach to the treatment of previous similar cases by the Discipline Committee. The Divisional Court, in effect, determined that the previous cases were incorrectly decided, or that changes in societal values required that penalties in cases dealing with sexual abuse required a change in approach. The Court of Appeal rejected this, stating (in part):

> [84] The court's conclusion was also made in the absence of a proper and sufficient record showing that the Discipline Committee was not properly carrying out its mandate and that its approach was failing or manifestly out of step with contemporary social values. As already explained, specialized tribunals like the Discipline Committee have been given the mandate to design appropriate penalties for professional misconduct. They have been consistently recognized as being in the best position to assess the level of threat posed to the public by certain forms of behaviour: *Mussani v. C.P.S.O.* (2004), 2004 CanLII 48653 (ON CA), 74 O.R. (3d) 1 (C.A.), at para. 113; *Ryan*, at para. 33.
>
> [85] As for whether the time had come for change, the Discipline Committee noted that the College had prepared Revised Draft Sexual Abuse Principles in 2015 which proposed more severe penalties. The Discipline Committee was aware of and would therefore have taken account of the increasing concern for sexual abuse by physicians. This concern is not new. Since at least 1991, when a taskforce on the sexual abuse of patients submitted its report, it has been recognized that sexual abuse tarnishes public trust in the entire profession. The legislative response to that taskforce report came in 1993 with the introduction of a zero tolerance/mandatory revocation scheme for specified sexual acts between health professionals and their patients.

65. The Court of Appeal also pointed to the fact that consistency in sentencing is "as important in professional bodies as in the criminal courts" (para 80).

66. The Complaints Director also provided a summary of the decisions in the *Nqumayo*, *Levin* and *Rohani* cases. In *Nqumayo*, a 2011 decision, an investigating committee of the CPSA ordered the cancellation of the member's license. The summary indicates that Dr. Nqumayo was criminally convicted of sexually assaulting four patients. He was also required to pay the costs of the investigation and hearing.

67. In *Levin*, a 2015 decision, a hearing tribunal ordered the cancellation of Dr. Levin's registration and practice permit following a criminal conviction in relation to the sexual assault of three patients. He was also required to pay the full costs of the investigation and hearing.

68. In *Rohani*, a 2013 decision from the College of Physicians and Surgeons of British Columbia, Dr. Rohani's registration was cancelled following a conviction of sexual assault against a 16-year-old patient. The summary indicates that the Board determined that his conduct was "so egregious, and the abdication and abuse of his responsibilities as

a physician was so disgraceful, that the most severe penalty … was required". Dr. Rohani was also required to pay a portion of the costs of the hearing.

69. The Complaints Director referred the Hearing Tribunal to the decision of the College of Physicians and Surgeons of Saskatchewan regarding Dr. Poon. There, Dr. Poon was charged with six counts of sexual assault against patients, and he was convicted of two counts. Dr. Poon was sentenced to two years less a day as a result of his convictions. The CPSS sought revocation of Dr. Poon's license, which was not opposed by legal counsel for Dr. Poon. In agreeing with the proposed suspension, the Council stated (in part):

> [26] It is difficult to imagine a more serious example of professional misconduct than the sexual assault of a patient by his or her physician. Not only is such an action a serious and unwelcome personal and physical invasion, it also is a stark betrayal of trust that irreparably ruptures the patient/physician relationship.

70. Finally, following the close of the hearing, the Complaints Director provided the Hearing Tribunal with an additional case which had been recently decided. In [redacted], the member had been convicted of three counts of sexual assault against a minor. The Hearing Tribunal cancelled Dr. [redacted]'s registration, and ordered that he be fined and pay the costs of the hearing. The Complaints Director submitted that these facts were similar to those in this case, and that the [redacted] decision stands as a precedent supporting revocation. Dr. Alarape points out that the nature of the relationship between Dr. [redacted] and his underage victim distinguishes that case from his own. [redacted]

71. Dr. Alarape provided the Hearing Tribunal with several cases. In *Maritz*, an 18-month suspension and costs (reduced from 100 percent to 60 percent on appeal) was imposed against a physician resulting from four findings of unprofessional conduct, including sexual misconduct and violating practice restrictions in relation to prescriptions. The Complaints Director in that case had sought cancellation of the physician's practice permit. Council dismissed the Complaints Director's appeal in relation to the imposition of the suspension. A further appeal to the Court of Appeal was apparently not pursued by the Complaints Director.

72. In *Ontario (College of Physicians and Surgeons of Ontario) v Abdulmohsin*, 2018 ONCPSD 4, a physician was found guilty of unprofessional conduct in relation to inappropriate billing, and the unwanted touching of two colleagues in an "intimate and intrusive manner". There was no underlying criminal conviction. The tribunal accepted a joint submission on penalty representing a three-month suspension, practice conditions, a reprimand and partial costs.

73. In *Ontario (College of Physicians and Surgeons of Ontario) v Abawi*, 2014 ONCPSD 10, a physician was found guilty of unprofessional conduct for making unwanted and inappropriate sexual advances against a colleague, including attempting to hug and kiss her and confining her for a period of time without her consent. The physician blamed the nurse for the incident. There was no underlying criminal conviction. The tribunal accepted a joint submission and imposed a four-month suspension, practice conditions,

educational courses, a reprimand and partial costs. The tribunal there stated (at page 5): "The Committee reviewed similar cases involving physicians who engaged in unprofessional and inappropriate sexual behavior in the workplace and determined that the suspension of four months is in line with previous cases."

74. In *Ontario (College of Physicians and Surgeons of Ontario) v Mourcos*, 2018 ONCPSD 11, a physician was found guilty of unprofessional conduct in relation to inappropriate and unwanted sexual touching of his receptionist, including undoing her bra and touching her breast during a massage. While the matter was reported to the police, it does not appear that there was an underlying criminal conviction. The tribunal there accepted a joint submission of a six-month suspension, practice conditions, a reprimand and costs. In justifying the penalty imposed, the tribunal stated:

> The Committee notes that the proposed penalty takes into account present day societal concerns with respect to this type of professional misconduct. All employees are entitled to work in an environment that is free from harassment. Dr. Mourcos' professional misconduct was indeed very serious and demonstrated a significant lack of judgement. He exploited his position of power over a new young vulnerable employee. Today, there is an increasing sense in society that the public will no longer turn a blind eye and tolerate this sort of exploitation in the workplace.
>
> There is always a power imbalance between physicians and their employees. It is the physician's responsibility to respect and maintain the boundaries and lead by example. Further, misconduct in the workplace is disruptive and has the potential to affect patient care. Indeed, as noted in the Agreed Statement of Facts, Ms A did not return to work after the incident. Sexual harassment can affect everyone in the workplace, the healthcare system and ultimately the profession as a whole.
>
> A six-month suspension of Dr. Mourcos' certificate of registration sends a very strong message to the profession that boundary violations of this nature are completely unacceptable and will not be tolerated.

75. In *Chakravartay* (2019), a hearing tribunal found the member guilty of unprofessional conduct in relation to the inappropriate touching of a student he had been instructing. He was suspended for a period of six months, was required to take certain courses, was subject to practice restrictions and was required to pay 75 percent of the costs of the investigation and hearing. The hearing tribunal in that case specifically referred to the "significant power imbalance in a physician-learner relationship". The case summary states: "A six-month suspension of a physician's practice permit is a significant sanction and in this case, emphasizes that attempting to sexualize a physician-learner relationship is an abuse of power and a violation of trust."

76. In *Ontario (College of Physicians and Surgeons of Ontario) v Mukherjee*, 2019 ONCPSD 16, a physician engaged in an extra-marital affair with a colleague, and prescribed medication for her and her children. When the relationship was breaking down, the physician threatened to terminate the colleague's employment and exploit her financial dependency on him. He intentionally crashed his car into his colleague's car, broke the

door to her house, and sent threatening text messages to her. The physician was convicted of mischief and uttering threats to cause death or bodily harm. The tribunal accepted a joint submission on penalty, which comprised a reprimand, a six-month suspension, courses and costs. There, the tribunal specifically noted the power imbalance between the physician and his colleague and his attempts to exploit that imbalance.

77. In *Graff* (2018), a physician was convicted for attempts to lure underage females online. The physician withdrew from practice. He was incarcerated as a result of his criminal convictions and admitted unprofessional conduct to a hearing tribunal. A joint submission was accepted whereby the physician was required to serve an 18-month suspension (15 of which had already been served), was subject to practice restrictions, and was liable for the payment of costs. The summary notes that the physician had been withdrawn from practice for a period of three years.

78. In *Ontario (College of Physicians and Surgeons of Ontario) v Minnes*, 2015 ONCPSD 3, a physician's certificate of registration was revoked. The physician had engaged in unwanted and inappropriate touching of female nursing staff and had engaged in "overt and intrusive sexual behavior" with a minor. The tribunal noted that the misconduct in relation to colleagues occurred over a number of years with a number of different staff members. He was informed many times that his behavior was inappropriate. After considering similar decisions, the tribunal concluded as follows (at 6-7):

> Repeated boundary violations with staff in the workplace cannot be tolerated or condoned. To his credit, Dr. Minnes has accepted responsibility for his misbehaviour in this regard. He has attended therapy with Dr. K and has made progress in understanding his behaviour and its impact on others. The principle of general deterrence with respect to the membership as a whole, however, warrants a significant response from the Discipline Committee. All physicians must understand that this sort of behaviour is unacceptable.
>
> The Committee finds that the hospital incidents findings, standing alone, warrant a penalty consisting of a public reprimand, suspension of Dr. Minnes' certificate of registration for three months, and a requirement for remediation with respect to boundary issues, including pursuing therapy. This penalty for the hospital findings, in the view of the Committee, would protect the public, maintain public confidence in the integrity and reputation of the profession, adequately address both general and specific deterrence, and provide for Dr. Minnes' ongoing rehabilitation. This penalty is consistent with previous decisions of the Discipline Committee in similar cases.

79. The tribunal in *Minnes* went on to consider the incident in relation to the sexual assault of the minor, and concluded that those facts warranted revocation of the physician's certificate of registration.

80. In *Ontario (College of Physicians and Surgeons of Ontario) v Izzeldin*, 2018 ONCPSD 68, a physician engaged in unwanted sexual touching of Ms. A, an employee and patient. This included unwanted hugging and the touching of her bare breast. The behavior continued over the course of several months. He was also found guilty of inappropriate

behavior and sexual abuse towards several patients, two of whom were minors. The tribunal accepted a joint submission revoking the physician's certificate of registration, imposing a reprimand, requiring the payment of a fine and partial costs.

81. In *Ontario (College of Physicians and Surgeons of Ontario) v Hyson*, 2019 ONCPSD 10, a physician was criminally convicted of an offence in relation to obtaining the sexual services of a prostitute. The physician had been communicating with what he thought was an underage girl when in fact it was with a police officer. The physician also breached an undertaking given to the College. A joint submission for the revocation of the physician's certificate of registration was accepted. The tribunal specifically referenced the vulnerability of the minor.

82. In *Ontario (College of Physicians and Surgeons of Ontario) v Shenava*, 2019 ONCPSD 38, a physician was found guilty of professional misconduct arising from convictions for three counts of assault against three patients. The tribunal accepted a joint submission which revoked the physician's certificate of registration, imposed a reprimand and required partial payment of costs. The tribunal noted the violation of trust resulting from the boundary violations and the fact that the power imbalance between the physician and his patients was "knowingly violated". The patients were described as "young women, vulnerable because of their psychological issues" (page 7). Further, an expert was retained who provided an opinion that the physician's suffered from significant deficits in his ability to safely practice.

Conclusion on Sanction

83. Having carefully considered the cases provided by the parties, the Hearing Tribunal finds that previous decisions do not generally support a sanction of revocation of Dr. Alarape's registration and practice permit in the facts of this case. While the cases clearly demonstrate the fact that findings of unprofessional conduct arising from sexual assault must be treated seriously and must be condemned in the strongest terms, cancellation appears to be reserved for cases in which either multiple victims were identified (*Nquamayo*, *Shenava*, *Poon*, *Levin*), or whether the course of conduct was particularly egregious given a specific relationship involving a breach of trust relating to a minor (*Izzeldin*, *Hyson*, *Minnes*, [redacted], *Rohani*) or a vulnerable population (*Shenava*).

84. While the Hearing Tribunal is cognizant of the fact that the comparison of facts in such cases is an imperfect science, the facts of this case appear most analogous to the facts in *Minnes* as it relates to the workplace professional misconduct appear, and *Abawi* and *Mourcos*. Each of those cases involved unwanted sexual touching of co-workers or subordinate employees. Further, the misconduct here was not a one-time event. While the power imbalance involved in the facts in *Charkravarty* is similar to the power imbalance inherent in the relationship between Dr. Alarape and [XX], the misconduct in that case involved a one-time event. The other fact which distinguishes those cases from the facts here is that there was no underlying criminal conviction.

85. As in *Peirovy*, the Hearing Tribunal accepts the expert evidence from Dr. Frizzell and the COAP assessment which indicated that Dr. Alarape was a low risk for committing a similar offence in the future, and that with appropriate measures in place, his risk of a subsequent boundary violation is not serious enough to prohibit him from practicing. This is an important element for the Hearing Tribunal in considering whether or not revocation is required in the interest of the protection of the public. The expert evidence submitted by Dr. Alarape indicates that risks to public safety can be adequately addressed through appropriate conditions on Dr. Alarape's practice. Based on the evidence before the Hearing Tribunal, it appears that the conditions that have been in place for the past two years have not resulted in any further or additional concerns regarding Dr. Alarape's practice. The Hearing Tribunal therefore finds that the protection of the public does not require cancellation of Dr. Alarape's registration and practice permit.

86. Further, the Hearing Tribunal concludes that the maintenance of the public's confidence in the medical profession and its ability to self-govern would not be unduly compromised by a refusal on the part of the Hearing Tribunal to order cancellation. Dr. Alarape has been subjected to serious consequences in the criminal proceedings, and a lengthy period of suspension with other appropriate conditions will communicate that the medical profession imposes serious sanctions for serious misconduct.

87. While similar cases point away from the cancellation of Dr. Alarape's registration and practice permit, the factors considered above militate towards a lengthy period of suspension. The proven offence was very serious, and it represented intentional conduct over a period of time. Dr. Alarape had been practicing for many years and very clearly should have known better; his conduct is not explainable (even in part) by inexperience. While Dr. Alarape acknowledged his misconduct, his first reaction was to deny his role in the events underlying the criminal conviction, and his acceptance of responsibility appeared to be qualified based on the COAP report. The Hearing Tribunal also accepts that there is a strong need for both specific and general deterrence. The Hearing Tribunal accepts that there is a particular vulnerability that exists in relation to a physician and his or her patient, and that a violation of the trust relationship through a sexual assault of a patient goes to the heart of the College's role in relation to the protection of the public. While that particular vulnerability may not exist in relationships with all colleagues, the Hearing Tribunal concludes that the nature of the relationship between Dr. Alarape and [XX] includes an appreciable power imbalance and vulnerability. [XX] [redacted], and the coercive effect arising from such economic vulnerability makes the conduct more blameworthy than it would be in an environment where the abuser [redacted] a co-worker.

88. A lengthy period of suspension will communicate not only to Dr. Alarape but also to members of the profession that sexual assaults committed against [redacted] will have serious consequences, and that the distinction between such misconduct and physician-patient abuse is one of degree, not of kind. A lengthy period of suspension also reflects the evidence provided by Dr. Hershcovis of a changing perception in society in relation to the treatment of sexual assault and sexual harassment in the workplace.

89. For all of those reasons, the Hearing Tribunal has concluded that Dr. Alarape shall serve a suspension for a period of 15 months.

90. In relation to conditions which must attach to Dr. Alarape's certificate in order to ensure the protection of the public, the Hearing Tribunal requested additional submissions from each of the Complaints Director and Dr. Alarape with respect to such conditions given the Hearing Tribunal's conclusion on cancellation. In response to that invitation, Mr. Boyer submitted that if the Hearing Tribunal is not prepared to order cancellation of Dr. Alarape's practice permit and registration, it should order a lengthy period of suspension (18 months), and impose the following conditions: (a) a requirement for an independent neuropsychological assessment; (b) an order that Dr. Alarape's practice permit being subject to any recommendations arising from such assessment; (c) a requirement that Dr. Alarape be subject to a chaperone requirement including advising all clinical staff about the requirement, signage, chaperone presence for patients visits, a requirement to create logs, and unannounced inspections; (d) a requirement that patients be advised of the chaperone requirements including both booked and walk-in appointments.

91. In response, Mr. Heelan submitted that a second neuropsychological assessment is unnecessary given the COAP assessment. He agreed that Dr. Alarape should have a chaperone present for visits with all female patients. He also agrees that all clinic staff members should be made aware of that requirement, and that the chaperone requirement should be monitored by the Complaints Director. However, he disagreed that signage should be posted in the clinic, or that all patients ought to be notified. He notes that Dr. Alarape's misconduct had nothing to do with interactions with patients. He also stated that Dr. Alarape should be restricted to working in a clinical setting which employs at least one other regulated health professional.

92. The Hearing Tribunal has concluded that it will not direct an independent neuropsychological assessment in these circumstances. It does so based on the existing COAP report, which was produced by highly-respected professionals based on an established and defensible process. That report specifically considered the risks of reoffending and concluded that the risk of a similar offence was low, and that the risk of a future boundary violation was mitigated through ethics training. While the Hearing Tribunal was troubled by the apparent limitation in the report in relation to Dr. Alarape's participation in the process, it concludes that the conclusions in the report itself are valid and ought to guide the Hearing Tribunal's decision-making. For those reasons, the Hearing Tribunal declines to order an independent neuropsychological assessment.

93. However, the Hearing Tribunal does find that the chaperone requirements are required in the public interest and in the interests of the protection of the public. Dr. Alarape must have a chaperone present for all female patient visits (both booked and walk-in) and all clinic staff must be advised of the chaperone requirement. Dr. Alarape must post a sign in each clinic room and in the waiting room in a form and content acceptable to the Complaints Director. Further, Dr. Alarape must require that all staff advise each patient at the time of booking or walk-in that he is subject to a chaperone requirement. Dr. Alarape must ensure that a log is kept demonstrating that these steps are being observed, and must

submit the log to the Complaints Director on a monthly basis. The Complaints Director may also conduct unannounced inspection visits. That condition shall continue until determined otherwise by the Complaints Director.

94. The Hearing Tribunal orders that Dr. Alarape's practice permit must restricted to working in a clinical setting which employs at least one other regulated health professional. However, the Hearing Tribunal is not satisfied that this requirement standing alone is sufficient to mitigate future risks. Therefore, the substance of section 2 of the undertaking given by Dr. Alarape on March 20, 2017, shall continue to apply: he shall not work with a solo female staff member or to be alone with a solo female staff member in an enclosed space. That condition shall continue until determined otherwise by the Complaints Director.

95. Finally, the Hearing Tribunal remains concerned with ensuring that continued monitoring of Dr. Alarape is in place for a period of time following his reinstatement. The Hearing Tribunal believes that this is necessary in order to ensure that Dr. Alarape has ongoing support to mitigate the risks of future boundary violations. Therefore, the Hearing Tribunal will order that Dr. Alarape enroll, at his own cost, into a continuing care agreement with the College, for a period of at least five years.

96. In relation to costs, the Hearing Tribunal is satisfied that Dr. Alarape should be responsible for 100 percent of the costs of the investigation and hearing. The gravity of the offence and the need for specific deterrence here means that Dr. Alarape must bear the financial responsibility for his actions. Those costs must be paid within 60 days of the date of this written decision, unless other payment arrangements are made to the satisfaction of the Complaints Director. Given the serious financial consequence of this sanction, the Hearing Tribunal concludes that a further financial penalty in the form of a fine is not required in the public interest.

VII. Orders

97. The Hearing Tribunal therefore imposes the following orders pursuant to section 82 of the HPA.

a. Dr. Alarape's practice permit and registration is suspended for a period of 15 months, effective on a date to be determined by the Complaints Director, provided that such suspension shall commence no later than two months following the date of this decision;

b. Upon reinstatement, Dr. Alarape's practice permit shall be subject to the following conditions until otherwise determined by the Complaints Director:

i. Dr. Alarape shall have a chaperone present for all female patient appointments;

ii. Dr. Alarape shall advise all staff members employed at his clinic (or any subsequent workplace) about the chaperone requirement;

iii. Dr. Alarape shall post a notice in each examining room and in the clinic waiting area announcing the chaperone requirement in a form and content approved by the Complaints Director;

iv. Dr. Alarape shall ensure that all staff members advise female patients at the time of booking (for booked appointments) or at the time of registration (for walk in appointments) about the chaperone requirement;

v. Dr. Alarape shall ensure that a log of compliance with sections (i), (ii) and (iii) is created and maintained, and is submitted to the Complaints Director on a monthly basis;

vi. The Complaints Director is authorized to conduct unannounced inspection to ensure compliance with sections (i)-(v);

c. Dr. Alarape shall enter into a continuing care agreement with the College for a period of five years, in form and content acceptable to the Complaints Director;

d. Dr. Alarape's practice permit must require that he work in a clinical setting which employs at least one other regulated health professional;

e. Dr. Alarape shall not work with a solo female staff member or to be alone with a solo female staff member in an enclosed space, and such order shall remain in effect until otherwise determined by the Complaints Director;

f. Dr. Alarape shall pay 100 percent of the costs of the investigation and hearing with 60 days of the date of this decision, or as otherwise determined by the Complaints Director; and

g. The Hearing Tribunal reserves jurisdiction to resolve disputes about the nature of these orders.

Signed on behalf of the Hearing Tribunal by the Chair

RGCox

Dated: December 13, 2019

Dr. Robin Cox