COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING THE CONDUCT
OF DR. IAN GEBHARDT

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

June 27, 2023

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INTRODUCTION

[1] The Hearing Tribunal of the College of Physicians & Surgeons of Alberta (the "**CPSA**") held a hearing, virtually through Zoom, into the conduct of Dr. Ian Gebhardt on October 18, 19, 20 and 21, 2022.

[2] The members of the Hearing Tribunal were:

Dr. Randall Sargent, Chair;
Dr. Neelam Mahil, physician member;
Mr. Douglas Dawson, public member; and
Ms. Juane Priest, public member.

[3] Ms. Julie Gagnon acted as independent legal counsel for the Hearing Tribunal.

[4] In attendance at the hearing were:

Mr. Craig Boyer and Ms. Monica Tran, legal counsel for the Complaints Director;
Dr. Dawn Hartfield, Complaints Director;
Mr. Alan Rudakoff, KC and Ms. Ashley Reid, legal counsel for Dr. Ian Gebhardt;
Dr. Ian Gebhardt, (the "**Investigated Member**");
Ms. Jennifer White, Hearing Facilitator.

PRELIMINARY MATTERS

[5] Neither party objected to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing. The hearing was conducted virtually. There were no jurisdictional issues raised.

[6] Pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**"), the hearing was initially open to the public. The hearing was closed for the evidence of the Patient, for the reasons outlined further in this decision.

[7] In his opening statement, Mr. Boyer noted that the Patient would proceed to give evidence in the presence of his mother so she could help him with managing the videoconference.

[8] In his opening statement, Mr. Rudakoff noted that Dr. Gebhardt vehemently denied the allegations against him. Mr. Rudakoff brought an application to prevent the Patient from giving testimony. Mr. Rudakoff noted that the Patient is so lacking in capacity and credibility that he should not be called as a witness. Mr. Rudakoff indicated that the application should be brought at this time, as it may affect the timing of calling witnesses.

[9] In response, Mr. Boyer noted that the Complaints Director was taking the position that the Patient was a competent witness, but that in any event, the application was premature as the Hearing Tribunal did not have any evidence from any witnesses that would describe their experience with the Patient.

[10] The Hearing Tribunal considered the submissions of the parties and determined that it would defer the application and hear further submissions on the application at the time the Complaints Director sought to call the Patient as a witness. The Hearing Tribunal determined that it would benefit from additional information prior to making its determination on the competence of the Patient to give evidence.

CHARGE

[11] The Allegation in the Notice of Hearing is:

1. That on or about June 6, 2017, you did act inappropriately with your patient, particulars of which include one or more of the following;

    a. place your patient's hand on your penis,

    b. have your patient stroke your penis,

    c. place your mouth on your patient's penis,

    d. ask your patient to place his mouth on your penis,

    e. have your patient place his mouth on your penis.

[12] The Investigated Member denied the allegations.

EVIDENCE

[13] The following Exhibits were entered into evidence during the hearing:

Exhibit 1 - Agreed Exhibit Book

- Tab 1 Notice of Hearing dated May 27, 2022
- Tab 2 Section 56 Memo of Complaint by Dr. MC dated August 17, 2017
- Tab 3 Undertaking to Withdraw from Dr. Ian Gebhardt dated August 17, 2017
- Tab 4 Letter from J. Peacock dated September 27, 2017 with copy of chart for the Patient
- Tab 5 Transcript from criminal trial re testimony of the Patient and Crown confirming charges being stayed on December 6, 2018
- Tab 6 Memorandum by Dr. MC dated January 8, 2019

Tab 7 Letter of response from Dr. Gebhardt dated January 25, 2019

Tab 8 Undertaking to use a chaperone from Dr. Gebhardt dated January 29, 2019

Tab 9 Letter of response from Dr. Gebhardt with EMR audit log

Tab 10 Alberta Health billings for the Patient's visits with Dr. Gebhardt

Tab 11 Extracts from Clients Ongoing Rehabilitation and Equality (C.O.R.E.) records for the Patient

Tab 12 Report from Dr. MN dated November 3, 2020

Tab 13 Report from Dr. MN and Dr. DH dated May 27, 2021

Tab 14 Report from Dr. TD dated October 9, 2022

Tab 15 Dr. MN Curriculum Vitae

Tab 16 Dr. DH Curriculum Vitae

Tab 17 Dr. TD Curriculum Vitae

Tab 18 CPSA Standard of Practiced – Sexual Boundary Violations (effective up to March 31, 2019)

Exhibit 2 - Handwritten Notes of the Patient's Mother

Exhibit 3 - Notes/Records of the Patient's Care Worker

Exhibit 4 - Photograph of examining room

Exhibit 5 - Photographs of examination room

Exhibit 6 - Article entitled *Eyewitnesses with Pervasive Development Disorders*

Exhibit 7 - Article entitled *Lie-Telling Behavior in Children with Autism and its Relation to False-Belief Understanding*

Exhibit 8 - Article entitled *Exploring the Ability to Deceive in Children with Autism Spectrum Disorders*

Witnesses for the Complaints Director

The Patient's Mother
The Patient's Care Worker
Dr. MN
Dr. DH
The Patient

Witnesses for the Investigated Person

Dr. Ian Gebhardt
Dr. TD

The Patient's Mother

Direct Examination

[14] The Patient's mother described her son as having developmental delay from an early age (3 years). Testing was done and the Patient was diagnosed with Pervasive Development Delay - not otherwise stated ("**PDD-nos**") which is a form of autism. [Transcript p 25, L 17-22]

[15] The Patient is very delayed; his cognitive skills are very low. His ability to understand things is very low. He does not really read. He is physically able to do things others do but is lacking in social skills. He is verbal, but there are difficulties in understanding things.

[16] At about age 18 years, the Patient moved from home to his own apartment where he struggled with safety issues, including cooking safely, despite support from workers. The Patient was also challenged by boundary issues and easy trust of other people. The Patient's mother testified about an incident involving a stranger who the Patient allowed into the apartment and then apparently asked the Patient to disrobe in the bathroom. [Transcript p 24, L 12]

[17] Following that event, the Patient was assessed by the Medicine Hat Clients Ongoing Rehabilitation and Equality Association ("**C.O.R.E.**") and was offered a placement in the home of the Patient's Care Worker, along with other clients and the family of the Patient's Care Worker. That live-in experience lasted nine years.

[18] In June 2017, the Patient was residing in the home of his Care Worker but in 2019, the Patient moved from the Care Worker's home to a C.O.R.E. supported home (fourplex) where he currently resides and receives supervision from staff employed by C.O.R.E.

[19] At the time of the hearing, the Patient was not working, but before COVID, he worked at a movie theatre as an usher and cleaner.

[20] The Patient's mother described her son as loving, outgoing, and helpful. She volunteered that he usually follows rules. The Patient's mother stated her son is not known to tell lies or fabricate stories, and that their family encourages truth telling and clarity of information. The Patient's mother observed that around truth telling and complex reporting, her son can become confused. [Transcript p 27, L 3-13]

[21] The Patient's mother gave an example of her son telling her he had a burger and salad for lunch but that she then found out he had a burger and fries. He has high cholesterol. The Patient's mother described these as silly little things and said that for the most part, he is a truthful person.

[22] The Patient’s mother described her son’s upbringing as "sheltered" and that in the past, he showed little interest in sexuality, but now shows interest in more intimate relationships with both genders. [Transcript p 28, L 14-25] The Patient’s mother said appropriate behaviours are encouraged. The Patient’s mother stated that she talks to her son on the phone every night.

[23] The Patient’s mother was asked about Dr. Gebhardt and noted he had been her son’s doctor for at least a couple of years. The Patient no longer sees Dr. Gebhardt. The Patient’s mother was asked about the appointment of June 6, 2017. The Patient’s mother reported her son was "told to keep a secret that was not a good secret" [Transcript p 31, L 17-21] according to the information she received on June 6, 2017 when she spoke with her son, during their nightly phone call. The Patient’s mother stated she understood that Dr. Gebhardt asked her son to put his mouth on Dr. Gebhardt’s penis and that Dr. Gebhardt masturbated her son. [Transcript p 32, L 3-5]

[24] At that time, the Patient’s mother asked her son not to share the information. She was not sure if it was true, because it involved a doctor and “you’re supposed to trust and respect them”. The Patient’s mother said she wanted to keep the information in the "support bubble" while they determined if it was accurate. The “bubble” referred to C.O.R.E. staff including: the Patient’s Care Worker, and the C.O.R.E. Director. [Transcript p 35, L 3-26]

[25] The Patient’s mother stated that her son reported the events to his maternal grandmother when he phoned after speaking to her. The Patient’s mother had also informed the paternal grandmother in case the Patient decided to tell her and asked her to ensure details remained private. [Transcript p 36, L 3-9]

[26] Medicine Hat Police Service was not called immediately as C.O.R.E. waited until a period of about one week to make sure that the story was not made up. The Patient’s mother testified that her son would bring it up and start talking about it and he did not change his story.

[27] The Patient’s mother recalled in her evidence that her son had previously said he did not like Dr. Gebhardt. The Patient’s mother stated she rarely accompanied her son to appointments but recalled one visit where she found Dr. Gebhardt’s bedside manner “weird” and unsettling. [Transcript p 37, L 16-21]

[28] Regarding appointments with Dr. Gebhardt, the Patient’s mother stated C.O.R.E. staff usually accompany the Patient. The Patient’s mother stated that the staff are usually in the clinic room, but for some reason left the clinic room on June 6, 2017.

Cross-Examination

[29] In cross-examination by Ms. Reid, counsel for Dr. Gebhardt, the Patient's mother agreed that the stranger who entered her son's apartment had taken the Patient to the bathroom and inappropriately touched him. The Patient's mother agreed that there may be other instances where her son was a victim of sexual impropriety that she did not know about.

[30] The Patient's mother confirmed a chart note from Dr. Gebhardt for October 25, 2013 [Exhibit 1, Tab 4, p 18] which noted that her son masturbated with fruit in his room. The Patient's mother agreed there were examples of other sexualized activity, including sexualized activity with other males in 2017. The Patient's mother agreed that her son had sexualized behaviours and thoughts prior to the alleged incident.

[31] Ms. Reid suggested to the Patient's mother that her son engaged in untruths, fibs and lies about a host of topics and activities. Ms. Reid pointed to notes from September 2010, [Exhibit 1, Tab 11, p 157] that the Patient was late getting to the bowling alley. The Patient's mother agreed this was an example of an untruth, fib or lie. The Patient's mother denied another note regarding an incident outside the bowling alley as an example of an untruth [Exhibit 1, Tab 11, p 159]. The Patient's mother stated that her son denied any involvement and that it was the other person responsible for the behaviour.

[32] The Patient's mother agreed the following were examples of untruths, lies or fibs: a note dated May 1, 2011, regarding missing fruit and the Patient denying he had a bowl of apples that was later found in his room [Exhibit 1, Tab 11, p 164]; a note, dated March 20, 2012 that the Patient denied he kissed a female individual in the kitchen area [Exhibit 1, Tab 11, p 165]; a note that the Patient had chosen to hide the fact that he received his incentive pay on July 15 and 29 (2013) and spent it before he brought it home [Exhibit 1, Tab 11, p 170]; and a note dated October 5, 2013 that the Patient told the Care Worker the doctor had told him he could use fruit when he played with himself [Exhibit 1, Tab 11, p 205].

[33] The Patient's mother confirmed she was not in Dr. Gebhardt's office on June 6, 2017. The Patient's mother stated that she thought her son was the first to tell her about the June 6, 2017 visit but after being shown a note [Exhibit 1, Tab 11, p 242], the Patient's mother confirmed that the C.O.R.E. staff called her first and then her son called her.

[34] The Patient's mother acknowledged she continued to send her son to Dr. Gebhardt even though her son had said he didn't like Dr. Gebhardt and that she did not have a good feeling from him. The Patient's mother noted doctors are hard to come by.

[35] The Patient's mother was asked about the statement in her notes [Exhibit 2], that her son did not know "if telling truth or lying". The Patient's mother confirmed this and testified that her son was very confused. [Transcript p 42, L 11–14] Ms. Reid reviewed with the Patient's mother the reason to delay the call to police. The Patient's mother stated that as a group, they wanted to make sure this was not a false accusation because her son sometimes gets confused and does not tell the truth. [Transcript p 53, L 7-15]

Re-Examination

[36] The Patient's mother indicated that in her experience, the Patient does not tell fanciful stories that have no connection to reality. The Patient's mother also confirmed that her son has not previously made allegations against another person of being sexually touched when it turned out to be untrue.

Hearing Tribunal Questions

[37] The Patient's mother stated that in her notes of June 6, 2017 [Exhibit 2], she wrote down exactly what her son told her. The reference in the notes to "so confused" is to the Patient being confused. The Patient's mother confirmed that the notation in Exhibit 2 "4:50" was the time her son called her.

[38] The Patient's mother stated that her son's behaviour changed following the June 6, 2017 appointment. She gave examples including that he became more fixated on things, he became more aggressive, and was more tired.

Exhibit 2 (Patient's mother's notes June 2017)

[39] During her evidence, the Patient's mother referred to notes she had prepared following the June 6, 2017 appointment with Dr. Gebhardt. The notes were entered as Exhibit 2.

[40] The notes suggest that the Patient contacted his mother at 4:50 PM on June 6, 2017 to tell her about the clinic appointment. The note reads "he sounded upset." The note states the Patient "didn't know if in trouble but wanted to tell the truth." The Patient's mother wrote "doesnt [sic] know if telling truth or lying – so confused."

[41] The notes indicate that the Patient told his mother that he put on a gown, the doctor took the underwear off, touched the Patient's stomach, asked questions, took penis in hand and went up and down with it, checked penis for lumps, checked "butt hole" wearing gloves and "stuff on it", checked the tip of the penis where he goes pee, put his finger on tip of penis, doctor unzipped his own zipper, doctor put his mouth on the Patient's penis, doctor asked the Patient to put his mouth on doctor's penis.

[42] The Patient's mother wrote the Patient "doesn't know if appropriate or not that doctor put his mouth on [the Patient's] penis"; "Doctor told [the Patient]

to keep it a secret between him and doctor"; and "[The Patient] said it was weird, just very weird."

[43] The Patient's mother wrote "Called June 7 9:30PM – told me he called gradma [sic] and told her what happened." The Patient's mother wrote she "asked him to not tell anyone else no one else needs to know."

[44] The Patient's mother's notes state: June 8 "I called grandma H and she said [the Patient] told her same very things and if I knew. I said what did he tell you. She told me [the Patient] said the doctor said to keep this a secret but he didnt [sic] think he should keep it a secret because if he wanted to play with his penis he knows it should be done in private in his room and he should do it, not anyone else. He didnt [sic] think it was right."

[45] The Patient's mother also wrote on June 8 that she visited another of her son's grandmothers and told her in case the Patient called her. The Patient did call his grandmother and told her he had his doctor appointment and he was thinking of getting a new doctor since he didn't like this one anymore.

Care Worker

Direct Examination

[46] The Patient's Care Worker has been a C.O.R.E. Association staff member for 12 years and has training in early childhood care and care of developmentally delayed adults. She has experience as a foster parent.

[47] The relationship with the Patient began in 2010 as he was her first live-in C.O.R.E. client. She was engaged in his training regarding life skills, finances, preparing meals, and making good choices.

[48] The Care Worker testified a daily log of happenings is kept; summaries at the end of each month, quarter and year are reported to C.O.R.E. There are also specific forms if the individual is taken to a doctor's appointment. [Transcript p 66, L 4-11]

[49] The Care Worker described the Patient's development as equal to that of a six- to eleven-year-old. His speech is very clear so people expect a lot more from him. He can read at a grade 2 or 3 level.

[50] A child psychologist followed the Patient from 2010 to 2015 when care was transferred to Dr. B because the Patient had reached adult age. The Patient expressed some interest in sexuality. The Care Worker testified the Patient was prescribed risperidone, which she understood was partly intended to curb his sexual desires. [Transcript p 67, L 15-20] The Care Worker stated that the Patient was confused as to which gender he preferred.

[51] The Care Worker testified she accompanied the Patient to most of the appointments with Dr. Gebhardt, usually going into the office with him to discuss issues with the doctor [Transcript p 68, L 6-9]. Initially, the Care Worker stayed in the examination room with the Patient and Dr. Gebhardt. However, there were times she left the room. The Care Worker testified that she made a note from one of the first meetings with Dr. Gebhardt that he had stated "this is a safe place, if you need to talk, you can come to me and talk to me anytime. We can talk in private." [Transcript p 68, L 23-27]. The Care Worker testified that there were a number of occasions where the Patient said that he wanted to talk to Dr. Gebhardt in private.

[52] At an appointment on May 30, 2016, the Patient asked if he could talk to Dr. Gebhardt about his friend tickling him and touching his private parts. The Care Worker told the Patient he could talk to Dr. Gebhardt if he wanted to. Dr. Gebhardt reinforced that the area where the bathing suit covers is not for other people to touch. [Transcript p 69, L 24 to p 70, L 1]

[53] The Care Worker testified the Patient saw Dr. Gebhardt on August 8, 2016 for results of an MRI and the Patient wanted to talk to Dr. Gebhardt about his penis. She told Dr. Gebhardt that the Patient was concerned that his penis was sore. The Patient had very strong body odour afterward and had a shower at home even though it was afternoon. Dr. Gebhardt was alone with the Patient for five to ten minutes and the Care Worker was told all was normal and that he just had a little semen backup in the tube, which was normal. [Transcript p 70, L 15–25]

[54] With respect to the June 6, 2017 appointment, the Care Worker explained the reason for the visit included the issue of weight loss of over 30 pounds and fitness to return to work at the movie theatre. The Care Worker and another C.O.R.E. worker were in the room with the Patient and Dr. Gebhardt. Dr. Gebhardt asked the Patient to get into a gown and so the Care Worker and her colleague left the room. The colleague had brought the Patient to the appointment and the Care Worker had come in her own vehicle. The Care Worker went with her colleague to the colleague's car, to transfer the Patient's bag as he was going home with the Care Worker. The Care Worker estimated it took ten minutes [Transcript p 82, L 17-18] before she re-entered the clinic waiting room to meet the Patient. He came out with a requisition for some blood work.

[55] The Care Worker testified the first thing the Patient said at the car was that he didn't know if he should tell the Care Worker or tell his mom. The Care Worker asked the Patient what he wanted to tell. The Patient said that Dr. Gebhardt put his mouth on the Patient's penis and then the Patient put his mouth on Dr. Gebhardt's penis. [Transcript p 82, L 21-25] The Care Worker said she listened and did not say too much so she wouldn't influence what the Patient said. The Patient told the Care Worker that the doctor had his gloves on and was pressing on his stomach. The Care Worker commented that the doctor had to do the examination, so that's quite normal. Then the

Patient said that he put his hand in the Patient's butt crack. The Care Worker said they do have to check you out. [Transcript p 83, L 2-7]

[56] They went home and the Care Worker telephoned her supervisor at C.O.R.E. right away and reported what the Patient had said to her. The supervisor informed her superiors, who were going to talk to the Patient in the morning [Transcript p 83, L 8-14]. The Patient went into his room and called his mother, which is usual for him [Transcript p 83, L 15-17]. The Care Worker said he told his mother the same thing and his mother asked him a "bunch of questions." [Transcript p 83, L 18-19]

[57] The Care Worker testified that the next day (June 7, 2017), the Patient called his grandmother and also told her. He phoned his mother and told her he had called his grandmother. The Care Worker overheard him say to his grandmother "that the doctor had put his mouth on [the Patient]'s penis and [the Patient] put his mouth on his penis, and he didn't know if it was appropriate or not." [Transcript p 83, L 25–27]

[58] The Care Worker indicated the Patient had no history of oral sex ever reported. [Transcript p 84, L 1-4] Regarding truthfulness, the Care Worker reported there was a history of lying if sneaking money, or taking his debit card but usually if it was something important, he couldn't lie, especially talking to his mother: "[The Patient's mother] knew when he was lying and she would get right to the bottom of it" [Transcript p 84, L 11-12].

[59] Mr. Boyer asked how the Patient's behaviour was after the visit to Dr. Gebhardt. The Care Worker said the Patient was more emotional and angrier after the June 6, 2017 appointment. He had new aggression with slamming doors and banging things. She testified he was acting out but also noted the Patient was not allowed to "talk to anybody" [Transcript p 84, L 17]. The Care Worker said they didn't want the information getting out to the general public.

[60] Mr. Boyer referred the Care Worker to several written entries in a report [Exhibit 1, Tab 11, p 161]. The Care Worker confirmed her signature on the report. The first was an incident at the home on March 6, 2011. The Patient was in his bedroom with a 14-year-old friend and came out to tell the Care Worker that the boy had pulled the Patient's pants down and tried to spank him. The Care Worker noted that the Patient had come forward with the description of the incident. [Transcript p 85, L 22-26] A second incident involved the Patient taking fruit into his bedroom [Exhibit 1, Tab 11, p 164]. The Care Worker said he used it for masturbation [Transcript p 86, L 11].

[61] Another note involved the incentive pay envelope which the Patient opened and spent [Exhibit 1, Tab 11, p 170]. The Care Worker commented that she thought the Patient was lying and stealing mostly because he figured this was his money to spend [Transcript p 87, L 9-10].

[62] Mr. Boyer asked about a bowling alley incident in June of 2011 [Exhibit 1, Tab 11, p 195]. The Patient was going into the washroom with individuals with whom he had a history, one in particular. The Patient said they went into the same stall and they were touching each other [Transcript p 88, L 1-2]. The Care Worker testified about an incident [Exhibit 1, Tab 11, p 201] regarding C. The Care Worker testified the Patient knew C. and saw him at the mall where the Patient worked. The Patient asked permission to meet him for coffee. It was a mistake as the fellow was fondling and kissing the Patient in a public mall food court where the Patient was an employee. Another note from October 2013 [Exhibit 1, Tab 11, p 205], was explained by the Care Worker as concerning a bag of apples the Patient had in his room and explained he used them to play with himself [Transcript p 89, L 11-12].

[63] Mr. Boyer asked the Care Worker to confirm notes regarding the June 6, 2017 appointment [Exhibit 1, Tab 11, p 242-243]. Mr. Boyer asked why a note was made that the Patient showered. The Care Worker testified showering was a way for the Patient to unwind and calm himself [Transcript p 92, L 10-11].

[64] The Care Worker reviewed a note regarding an incident in July 2017 [Exhibit 1, Tab 11, p 244] and the Care Worker described asking the Patient to walk the dog but she was ignored. She knocked on his bedroom door, he got angry and yelled he'd had a bad day. The Patient then got really mad and slammed the door. The Care Worker thought that may have been the day he slammed the door on her arm. The Care Worker stated it was similar to past events in 2012 but it escalated quite a bit.

[65] Mr. Boyer asked if the Patient saw anyone regarding the anger and outbursts. The Care Worker gave evidence that in 2015, the Patient attended mental health sessions, then met with a family counselor every four to six weeks [Transcript p 92, L 21]. The Care Worker noted the Patient was engaged in discussion of issues in relation to his sexuality.

<u>Cross-Examination</u>

[66] The Care Worker confirmed that there had been about 25 visits by the Patient to Dr. Gebhardt from 2010 to 2017. She accompanied the Patient to most of the appointments, although his mother and one of the C.O.R.E. staff attended on a few occasions. The Care Worker agreed the visit on June 6, 2017 seemed relatively routine until the Patient was in the car headed home [Transcript p 99, L 6-9].

[67] At the June 6, 2017 visit, the Patient was asked to put on a gown. The Care Worker and her colleague left the examination room while he changed and waited outside the door. They re-entered the room and then Dr. Gebhardt knocked and entered the room. They discussed the chief concern which was that the Patient had recent weight loss of about 33 pounds. The Care Worker could not recall who suggested leaving the room and was shown page 242 of

Exhibit 1 which noted that the Care Worker said they would leave to allow the examination [Transcript p 101, L 25-27]. The Care Worker indicated "normally we don't stay in when there's the examination" [Transcript p 102, L 6-8]. The Care Worker agreed that leaving the room respected the Patient's privacy [Transcript p 102, L 11].

[68] The Care Worker testified that after leaving the examination room, she and her colleague went to the colleague's car to put the Patient's backpack into the Care Worker's car so the Patient could go home with her. The Care Worker said that her colleague left after transferring the bag from the colleague's vehicle to the Care Worker's vehicle. The Care Worker returned to the waiting room and her colleague drove away. The Care Worker estimated it took about ten minutes from the time they left the examination room until the Patient came out of the examination. [Transcript p 103, L 6-8]

[69] The Care Worker was asked about her notes made June 6, 2017 [Exhibit 3]. The Care Worker was questioned about her testimony that the Patient said that "Dr. Gebhardt put his mouth on my penis and I put my mouth on his penis." Her note only reflects: "Dr. Gebhardt put his mouth on my penis." The Care Worker agreed that "Dr. Gebhardt put his mouth on my penis" was the initial statement made by the Patient but the Care Worker said that a little later on the Patient repeated the assertion and added that he had put his mouth on Dr. Gebhardt's penis. [Transcript p 108, L 25-27 to p 109, L 1]

[70] Mr. Rudakoff took the Care Worker through aspects of the June 6, 2017 examination and the Care Worker agreed that the several aspects of the examination raised by Mr. Rudakoff were considered to be routine from the lay perspective. [Transcript p 109, L 1-27 to p 110, L 1-2] Mr. Rudakoff referred to the long shower June 6, 2017 in the evening and the weaning of risperidone earlier in 2017 and suggested that the Care Worker didn't think at that time a sexual assault of any sort had gone on in that examination room. The Care Worker replied "Yes, I did actually. And that is why I phoned my supervisor right away." [Transcript p 111, L 22-23]

[71] Mr. Rudakoff asked the Care Worker to agree that the Patient had been engaged in a series of "inappropriate sexualized activity" with males in the years leading up to June of 2017. The Care Worker responded "Partially, yes. Because you have to look at the other individuals that he was involved with. And you have to know their history." [Transcript p 112, L 5-14] The Care Worker testified the episodes varied and she was unable to tell who the instigator was in those circumstances. [Transcription p 112, L 24-25] Mr. Rudakoff questioned the Care Worker about a series of C.O.R.E. notes [Exhibit 1, Tab 11]:

a. Page 159 – March 16, 2011: outside the bowling alley waiting after bowling with another client who was talked to by a C.O.R.E. staff member about inappropriate behaviour. [Transcript p 114, L 12-24]

The Care Worker agreed with Mr. Rudakoff it sounded like inappropriate sexualized behaviour.

b. Page 161 – March, 2011: …"[C.] unbuttoned his pants, pulled them down around his knees and spanked his bum…." The Care Worker responded that the Patient said it was the boy that did it to him [Transcript p 116, L 1]. The Care Worker asked who is the victim and who is the perpetrator.

c. Page 180 – November 2016 to November 2017 (no specific date for the incident): identified by the Care Worker as a C.O.R.E. annual report. The Patient admitted touching his peer's bare chest in the washroom stall and at that peer's house behaviour towards each other was a concern. They were lying on each other. The Care Worker agreed the behaviour was inappropriate.

d. Page 185 – November 2016 to November 2017: the report refers to a desire to meet a male friend with history of "several incidents of inappropriate behaviour between the two guys."

e. Page 194 – June 2011: "outside the bathrooms, the Patient and another client came out of the bathroom at the same time." The Care Worker did not know specifics.

f. Page 199 – August 2012: "he asked if he could touch his cousin's private parts. I asked the Patient if that is what he asked and he said yes."

g. Page 234 – April 2017: another bathroom incident with no details discussed.

h. Page 239 – May 23, 2017: references the event where the Patient and a friend were watching a movie and the Patient asked the friend to lie on him.

[72] Mr. Rudakoff summarized the descriptions as "samples, but there's evidence of a continuous stream of sexualized behaviour by [the Patient] with other gentlemen that he came into contact with from time to time." The Care Worker testified that she agreed with the statement. [Transcript p 122, L 3-9]

[73] Mr. Rudakoff referred to a statement by the Care Worker in Exhibit 3: "I learned that the Patient was on risperidone to curb his sexual desires." Mr. Rudakoff confirmed a psychiatrist had prescribed the drug. The final dose of the drug was February 15, 2017. The Care Worker clarified the drug was for the pervasive developmental disorder. The side effect was to curb his sexual desires.

[74] The Care Worker was asked by Mr. Rudakoff about the note in Exhibit 3 regarding photos taken by the Patient with his new phone of his penis on February 27, 2017. The Care Worker said the Patient did not know how to send photos as the phone was new but he did bring it to show Dr. Gebhardt and ask if it was appropriate. [Transcript p 123, L 27]

[75] The Care Worker was asked about another incident on May 19, 2017 described in Exhibit 3: "in bathroom stall touching other individual." The Care Worker did not know the full details but commented: "you have to realize is [the Patient]'s mental age, just because he has got an adult body, his mental age may have been 3 years old or 5 years old, so it was exploring…" and "a lot of these things may have been sexual exploring that a 5-year old would do." [Transcript p 124, L 11-16]

[76] Mr. Rudakoff next asked about the Patient lying about sneaking money or using a debit card. The Care Worker agreed that the behaviour occurred. In addition, she agreed the Patient lied about sneaking fruit or vegetables into his room. Mr. Rudakoff asked if the Patient acted deceitfully in other ways and the Care Worker indicated that she could not think of other instances. Mr. Rudakoff next took the Care Worker through a number of records regarding truth telling from Exhibit 1:

a. Page 157: September 20-24, 2010: late for bowling Wednesday and home late two days before; report states: "I kept getting a different story."

b. Page 159: March 16, 2011: this incident was referred to previously. The Care Worker agreed it was an example of furtive, deceitful behaviour. [Transcript p 127, L 1-13]

c. Page 160: March 21, 2011: the Patient spoke to his mom on the phone then came and told the Care Worker his mom said he could hang out at the mall with "C." The Care Worker agreed with Mr. Rudakoff that it was a fib. [Transcript p 128, L 2-9]

d. Page 161: March 2011: the Care Worker bought yams and could not find them until she looked in the Patient's bedroom and they were wrapped in a sheet but the Patient denied putting them there. The Care Worker agreed it was "easily determined to be a falsehood." [Transcript p 129, L 1-2]

e. Page 165: March 12, 2012: the kitchen supervisor at the home reported that the Patient was kissing a female in the kitchen. The Patient said he did not kiss anyone in the kitchen area. The Care Worker testified it was "possibly" an example of lying behaviour.

f. Page 205: October 5, 2013: the report notes "found a bag of apples on his shelf…" The Patient said a [unnamed] doctor told him he could do

this. His mother said the doctor did not tell the Patient this. The Care Worker testified that the Patient got very confused about what was said to him and did not necessarily understand it. [Transcript p 131, L 21-23]

[77] Mr. Rudakoff asked the Care Worker about the alleged changes in behaviour following June 6, 2017. Mr. Rudakoff took the Care Worker to Exhibit 1, Tab 11, p 221, which states: "Since the Patient has gone off the Risperidone [sic], we have noticed unusual/atypical behaviours including: 1) anger in response to being redirected or receiving feedback 2) non-compliance 3) distracted/wandering, lack of focus 4) bossy, rude, in other people's business 5) ignores, does not answer if a person asks him something, or walk away 6) emotional/mood swings: crying, sudden changes in mood". The Care Worker agreed the note about behaviour changes was an accurate statement when she wrote it in 2017.

Re-Examination

[78] Mr. Boyer asked the Care Worker to explain the reference to "Flash Class" in Exhibit 3. The Care Worker testified she is not familiar with the material but they talk about relationships, not just sexual but also friendships and other types of relationships. The Care Worker confirmed these are classes for C.O.R.E. clients.

Hearing Tribunal Questions

[79] The Care Worker confirmed that the Patient had not voiced concerns about visits with doctors in the past. The Care Worker testified the Patient would discuss what happened in the visit or what he talked about.

[80] The Care Worker indicated that she was generally present in the examination room, except during the annual physical examinations. The Care Worker noted there were many visits for plantar wart treatments.

Exhibit 3

[81] During the hearing, the Care Worker referred to notes she had prepared. These were entered as Exhibit 3.

[82] The first page of Exhibit 3 is a note prepared by the Care Worker on June 6, 2017. The remaining pages describe the Patient, the Care Worker's experiences working with the Patient, record keeping, incidents that have occurred over the years, and medical and other information about the Patient.

Objection to the Expert Report and Testimony of Dr. MN and Dr. DH

[83] Ms. Reid, counsel for Dr. Gebhardt, made an application objecting to the evidence of Dr. MN and Dr. DH and to the Expert Report prepared by Drs. MN and DH [Exhibit 1, Tab 13]. She noted two grounds for the objection. First, the report is improper as it comments on the Patient's credibility and believability and second, the report shows an inherent bias.

[84] With respect to the first ground, Ms. Reid referred the Hearing Tribunal to *R v Marquard* and submitted that Drs. MN and DH are providing their opinion as to whether or not the Patient is telling the truth as opposed to proffering an opinion on whether the Patient can tell the truth or how his capacity issues can impact his behaviour and processing of information. Ms. Reid pointed to several excerpts from the report as examples of oath-helping and usurping the Hearing Tribunal's role regarding findings of credibility.

[85] Ms. Reid also took the position that the report was biased, citing the role of the expert in *R v Marquard*, *R v Lavallee* and *White Burgess v Abbott and Haliburton Co*. and stating that the entire purpose of the report was to support the Patient. Ms. Reid submitted that the report is highly speculative and one-sided. Ms. Reid also noted that the Patient was not interviewed in person nor was he asked any questions related to the alleged sexual assault. She also noted that the report provides litigation assistance to the CPSA on how best to obtain evidence from the Patient.

[86] Mr. Boyer noted that the *White Burgess* v *Abbott and Haliburton Co*. case is broader than what was presented by counsel for Dr. Gebhardt. The experts are being proffered to provide guidance to the Hearing Tribunal on witnesses with Autism Spectrum Disorder ("**ASD**") as the Hearing Tribunal will not have its own expertise in the knowledge of assessment, of cognitive functioning, and how individuals with autism will perceive, communicate, store information and retrieve information. Mr. Boyer cited the decision in *R* v *Mohan* that the expert opinion must meet the threshold of relevance, necessity and assisting the trier of fact. Mr. Boyer submitted that the Hearing Tribunal needed to first determine the issues of relevance and necessity. The Hearing Tribunal should first hear from the witnesses before determining issues of bias. If the Hearing Tribunal determines that the evidence is biased or not impartial, the Hearing Tribunal can choose to place no weight on the evidence.

[87] The Hearing Tribunal determined that it would accept the joint Expert Report of Drs. MN and DH [Exhibit 1, Tab 13] and hear their evidence and determine the weight to place on the report and testimony after having heard from the witnesses. The Hearing Tribunal considered the submissions made regarding the role of the expert witness and found that information regarding individuals with severe developmental delay would likely be of assistance to the Hearing Tribunal. The Hearing Tribunal further considered that it is for the Hearing Tribunal to determine if a witness is credible and that the

Hearing Tribunal could choose to place no weight on the report and testimony if it found that the experts had strayed into the role of decision-maker or had shown bias.

Dr. MN

Direct Examination

[88] Dr. MN was qualified as an expert in clinical psychology with particular focus on assessment and neuropsychology. There was no objection by counsel for Dr. Gerhardt to Dr. MN's qualification as an expert and Dr. MN then reviewed his background and experience.

[89] Dr. MN reviewed his report dated November 3, 2020 [Exhibit 1, Tab 12]. Dr. MN did not speak to the Patient, his mother or his caregivers prior to preparing the November 3, 2020 report. The report was based on a document review.

[90] Dr. MN confirmed that the CPSA had requested his opinion and he responded in a report dated November 3, 2020. Dr. MN was asked four questions by the Complaints Director, as follows:

1. Were there any significant events noted in the records submitted to him that were relevant from his perspective;
2. Whether the reaction and description provided by the Patient was consistent or inconsistent with the alleged assault from the physician, particularly considering the Patient's intellectual disability;
3. Should any further or additional information be gathered; and
4. Would the assistance of an expert in a different field be beneficial to the CPSA and whether he had any suggestions in the regard.

[91] In his report, Dr. MN noted he had not met either the Patient or Dr. Gebhardt. He recommended his opinions be considered suggestions and that appropriate cautions be taken in considering his report.

[92] Dr. MN noted in his report that it does not appear that the Patient's behavioural issues intensified in frequency or severity following the alleged assault by Dr. Gebhardt. Dr. MN noted the observed pattern of sexual behaviours due either to the Patient "explorations" or the actions of others. The documented events and teaching interventions carried out were noted. Dr. MN commented on the consistency of the Patient's statements and reports around the June 6, 2017 appointment.

[93] Dr. MN commented on the testimony of the Patient in criminal court and stated the court appearance was as expected with the Patient's history. He

noted the Patient's low IQ and commented that a court appearance would be difficult for the Patient.

[94] Mr. Boyer asked Dr. MN about whether the reports were consistent with an assault. Dr. MN noted the need to consider if there was blending of other events with the experience on June 6, 2017.

[95] Mr. Boyer asked Dr. MN if there were other sources of information of value to this investigation. Dr. MN recommended an update of the cognitive assessment done in 2001. Dr. MN emphasized the importance of input by caregivers as their knowledge is key regarding current and past behaviours in particular.

[96] Dr. MN addressed the fourth question asked by CPSA: the need for input from other experts. Dr. MN stated he had not initially recommended anyone but did later contact and work with Dr. DH.

[97] Dr. MN then reviewed the joint Expert Report [Exhibit 1, Tab 13]. He noted this is a shared report based on joint interviews and document review. Each of Drs. MN and DH took responsibility for separate aspects of writing but shared the final editing to ensure agreement of message.

[98] Mr. Boyer asked what the usual experience was for Drs. MN and DH in assessing patients; the answer was assessment is usually in the office but during the Covid pandemic they were required to use virtual modes of contact. Dr. MN commented that the difference between clinical and virtual assessment lies in the fact that new locations can be disorienting to ASD people and strange environments are stressful. Dr. MN stated that reliance on past assessment reports, documents, and input from people close to the ASD person is usual. This would include past psychologist reports and occupational reports. Dr. MN added that the questions addressed in the joint report were similar to those in the initial report he had authored.

[99] Dr. MN noted that the evaluation by Dr. P in 2001 revealed the Patient had low function and low IQ, both expected to change little with maturation according to experience. Asked why they did not meet the Patient in person, Dr. MN offered that the severity of the developmental delay, the support available, and the language and development level together with speaking limits and behavioural characteristics made the decision to work virtually the best option at the time. Dr. MN added that the Patient displays classic signs of ASD character. These include having some friends, poor level of judgment and problem solving, tendency to please that could have led to historic events, reporting to trusted people is usual, honesty is usual, ability to reciprocate is not well developed, and a fear of "trouble" is an egocentric development meaning the person focuses on themselves. There is a preference for order and routine.

[100] Dr. MN stated memories could be blended but put forward the opinion that was not likely. Typically, ASD people are not able to integrate fragments of memory. Also, the information may be accurate but the social integration is poor. The key is that autism does not connect experiences well and that leads to confused overall experience.

[101] Mr. Boyer asked Dr. MN if his opinion changed between his initial report and the joint report. Dr. MN answered that the new information he had received supported that behaviour changes had occurred after June, 2017.

[102] Dr. MN was asked to comment on the report of Dr. TD [Exhibit 1, Tab 14]. Dr. MN noted that Dr. TD suggests the Patient may have a milder version of autism, called Asperger's Syndrome. Dr. MN stated that the Patient's situation is anything but mild. Dr. MN also noted that Dr. TD's report addressed the benefit of an updated assessment. Dr. MN stated a general assessment was not performed and could be helpful but the opportunity and effect of such an assessment was deemed too great a risk to the Patient and the benefit would be minimal in determining if the assault occurred. Dr. MN further noted Dr. TD's comments on memory but noted that for individuals with autism, memories and information tend to be well presented. Dr. MN also commented on Dr. TD's statements that everyone has the ability to lie, but noted reported studies that children in the autism group were more poor at maintaining lies.

[103] Mr. Boyer asked what a formal assessment would offer if carried out; Dr. MN responded it would be on site, an IQ measure would be performed, there would be observed responses to activities, and the Patient would be compared in results to the average performance for his age. Dr. MN defended the virtual limited review as more relaxed in general and at a site more comfortable for the Patient.

<u>Cross-Examination</u>

[104] Dr. MN confirmed that he did not do a formal assessment of the Patient. Dr. MN pointed out the DSM-5 is a largely descriptive compendium. However, he acknowledges the possibility that a formal assessment could have provided additional information.

[105] Dr. MN acknowledged an increase in behaviours following discontinuation of risperidone. He could not say with certainty that the alleged assault caused the behaviour changes.

[106] Dr. MN confirmed that the interviews referred to in the joint report were conducted by Zoom with the Patient's mother present at the computer with the Patient.

[107] Dr. MN was challenged on whether he was making findings of credibility. He noted that he was asked to provide information on whether the events fit

with an individual who has been abused. Dr. MN confirmed he never asked the Patient about the events of June 6, 2017.

Re-Examination

[108] Dr. MN stated he had sufficient information to reach his conclusions.

Hearing Tribunal Questions

[109] In response to questions from the Hearing Tribunal, Dr. MN noted that an updated formal assessment would have provided information about the Patient's current IQ, his current functional deficits, his level of visual and verbal memory skills, and ability to learn new information, but noted that due to the severity of the deficits, there would likely not be any dramatic change in the Patient's abilities. Dr. MN indicated he did not ask the Patient about the alleged assault on June 6, 2017 because he is always reluctant to interfere with the individual's memory of the event. That role was best left to the investigators. With respect to the discontinuance of risperidone, Dr. MN noted that you would expect a pattern of greater emotional and behavioural difficulties. Dr. MN noted that what was helpful for him was the consistency in the Patient's reports and verbal statements. While the Patient struggles to get the words out, his story has not changed. It is difficult generally for people with autism, if they are fabricating, to sustain the fabrication.

Dr. DH

Direct Examination

[110] Dr. DH was qualified as an expert witness in the field of clinical psychology with a focus on practice dealing with autism patients. Mr. Rudakoff noted that there was no objection to her qualification as an expert. Dr. DH reviewed her background and experience.

[111] Dr. DH testified that she was approached by Dr. MN, given her background and work experience with individuals with ASD. In preparing the report, she was asked to consider if the Patient's reaction and description was consistent or inconsistent with the alleged sexual assault. She was also asked to address if the Patient's responses during the criminal proceedings, from the transcript, accurately represent the Patient's understanding and experience of what happened. Dr. DH described the methodology used by herself and Dr. MN.

[112] Dr. DH reviewed the joint expert report [Exhibit 1, Tab 13]. Dr. DH noted that the Patient has learned a set of basic rules to follow as an adult that focus on his safety, his emotional, and physical well-being, but he does not have the cognitive or language skills to engage in social reasoning, judgment, or problem-solving. He can be overly confused or overwhelmed in social situations. He is concrete in his memory of experiences and tends to

be very forthright and honest. Dr. DH noted that consistent with his severe delays in emotional and social functioning, the Patient is very egocentric and has difficulty seeing another person's point of view and thinks of events or actions as they relate to him. He typically, in the past, has taken responsibility, not changed information, tried to openly share, and may become quite confused. The Patient perceives the world through sensations that tend to remain fixed and unchanged with each unique situation. Dr. DH described that it is almost as though the Patient is taking a picture or video of what is happening with a focus on the objects or people in the room. [Transcript p 226, L 26 to p 227, L 3]

[113] Dr. DH noted that consistent with ASD wiring, at times the Patient's expressive language and vocabulary may appear stronger because he can repeat phrases that he has heard others speaking in similar contexts without really understanding the meaning or how it may apply. The Patient has learned to say yes when he is confused because he knows a pattern that if he says yes, people will accept that and will stop talking about something that he does not understand. He is often worried about getting into trouble.

[114] Dr. DH provided information regarding the questioning of the Patient in the criminal trial and the type of questions that would confuse the Patient. She testified that the Patient will not likely understand what a question means if he cannot pull up the context with which to reference. The Patient requires a piece of the context that is very concrete in order to understand what the question is and how to respond to the question. If the Patient does not understand the question, he will not necessarily tell you that he does not understand. He has learned to say yes or no in hopes that the conversation will end.

[115] Dr. DH was asked to comment on Dr. TD's report. She noted that she agreed with Dr. TD that everyone has the ability to lie. There are examples where the Patient has denied that he did or did not do something; he will say yes or no and that is a form of deception, but it is a very simple form of deception. It is an emotional response that is done to please the other person and because he does not want to get into trouble. Dr. DH stated that the Patient does not have the capacity to fabricate, create, organize a narrative, or put together a sequence of events that would describe a complex fabrication or a lie.

Cross-Examination

[116] Mr. Rudakoff noted that in the expert report, Dr. DH refers to herself as a "specialist in working with those with ASD." Dr. DH agreed there is no area of specialty within psychology in ASD, but that she is a specialist in clinical psychology working with those with ASD.

[117] Mr. Rudakoff also questioned Dr. DH on her experience as an expert witness in court proceedings. Mr. Rudakoff pointed to a case where Dr. DH's

testimony was generally accepted although the court found that she overstated her conclusions and accepted the expert opinion of a neuropsychologist. Dr. DH noted that she and the neuropsychologist both worked on the file for the plaintiff.

[118] Dr. DH confirmed that she observed the Patient, listened to him, collected information from other individuals and looked at documents in reaching her conclusions about the reliability of the Patient's reporting. She and Dr. MN were jointly assessing the Patient's credibility in what he reported regarding June 6, 2017. Dr. DH stated that she was trying to look at what level the Patient is functioning, and whether his words or recall are consistent with that level of function compared to what would be expected.

[119] Dr. DH provided information on why a formal assessment was not conducted and why the Patient was not interviewed in person. The direct contact with the Patient was two interviews of approximately 45 to 60 minutes each.

[120] Dr. DH was asked about her review of the C.O.R.E. notes, specifically with reference to the Patient fabricating or lying. She noted that there is evidence of the Patient denying, for example, with respect to objects taken to his bedroom. She noted that for inappropriate sexual activities with his peers, at times he may deny, say yes or no to a statement, in what Dr. DH described as an emotional response, but Dr. DH testified that the Patient does not fabricate or intentionally create a false belief.

[121] Mr. Rudakoff pointed to the C.O.R.E. notes as an example, where it states that the Patient was late getting to the bowling alley. The Care Worker's note states: "I tried to find out where he went, but I kept getting a different story." [Exhibit 1, Tab 11, p 157]. Dr. DH stated that the Patient may create one or two lines, but he does not create a story. Dr. DH also noted that the Patient may provide a detail of a real experience, but it may not be the answer to the question that the person asked. This is typical with ASD individuals.

[122] Dr. DH provided information about complex theory of mind versus simple theory of mind. The Patient has simple theory of mind. He may look at someone and know they are upset. He will think that if he says yes or no, that person will be less upset. That is an example of simple theory of mind. People with simple theory of mind are capable of denying, or saying yes to something they did not do, but they are not capable of creating a false belief, or fabricating.

<u>Hearing Tribunal Questions</u>

[123] The Hearing Tribunal asked Dr. DH why the two interviews with the Patient were for 45 to 60 minutes. She noted she and Dr. MN checked in frequently with the Patient and after about 45 minutes, he was done. Dr. DH was asked about the reporting made by the Patient to the Care Worker in the car after

the June 6, 2017 appointment. Dr. DH noted that if something confusing happened, he would approach someone he trusted to talk about it. Dr. DH's opinion was that while the events may be out of sequence, he would not say something happened that did not happen. Dr. DH did not believe a blending of memories would occur. For example, if a zipper came down with a friend, Dr. DH did not believe that the Patient would blend that the physical examination at the doctor's office.

Objection to Evidence of the Patient

[124] Mr. Rudakoff, on behalf of Dr. Gebhardt, brought an application objecting to the testimony of the Patient.

[125] The Hearing Tribunal determined it would close the hearing pursuant to section 78 of the HPA for the application. The Hearing Tribunal found that not disclosing confidential personal, health and other information, including information regarding the criminal proceedings, outweighed the benefit of an open hearing. In addition, Mr. Boyer and Mr. Rudakoff agreed to closing the portion of the hearing to address the application.

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[134] The Hearing Tribunal retired in-camera to consider the submissions of the parties. The Hearing Tribunal determined it would hear evidence from the Patient and would determine what weight to put on the Patient's evidence during its deliberations.

[135] Because the Hearing Tribunal was appointed to hear all evidence and determine weight in reaching its decision, the Hearing Tribunal decided it would hear the evidence of the Patient and weigh it appropriately during its deliberations at the conclusion of the evidence.

[136] The Hearing Tribunal was provided reports and testimony by expert witnesses Drs. MN, DH and TD regarding the diagnosed ASD population to which the Patient belongs in regard to understanding truth telling and ability to fabricate statements, which would be of assistance in understanding how the Patient gives evidence. The Hearing Tribunal felt it was important to hear from the patient and reach its own assessment of the patient's ability to perceive, remember and communicate.

The Patient

[137] The Patient's evidence was given in a closed portion of the hearing. Mr. Boyer brought an application, on behalf of the Patient's mother, for the hearing to be closed during the Patient's evidence, for the sake of the Patient's privacy. Mr. Rudakoff took no position on the application. The Hearing Tribunal considered the request and determined it would close the hearing for the Patient's evidence.

[138] The Hearing Tribunal considered under section 78(1)(a)(iii) that not disclosing the Patient's confidential personal and health information outweighed the desirability of having the hearing open to the public. The Hearing Tribunal further considered that the presence of the public might compromise the Patient's ability to testify (section 78(1)(a)(iv)). Finally, the Hearing Tribunal considered that the request was made by the Patient's mother, in order to protect his privacy while giving his evidence.

<u>Direct Examination</u>

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[143]

Cross-Examination

[144]

[145]

[146]

[147]

Re-Examination

[148]

Hearing Tribunal Questions

[149]

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[151] Following the Patient's testimony, the hearing was reopened to the public. Mr. Boyer confirmed the Patient was the last witness for the Complaints Director and Mr. Rudakoff called his first witness.

Dr. Ian Gebhardt

Direct Examination

[152] Dr. Gebhardt provided background personal information. He is a family physician. Dr. Gebhardt's education and credentials were reviewed. He obtained a computer science degree in 1989 and had a 20-year career in computers. In approximately 2000, he returned for further education and graduated medical school from McMaster University in 2005. He completed residency training through the University of Calgary in 2007.

[153] Dr. Gebhardt had some of his training at the Crescent Heights Clinic in Medicine Hat and after graduation remained as a member of the clinic medical staff. The work for Dr. Gebhardt consisted of four days each week in the clinic, one night per week in their walk-in clinic and one in five weekends in their walk-in clinic. One week of seven was dedicated to hospital work.

[154] Dr. Gebhardt described how his practice evolved after he joined the clinic. The practice he inherited had a lot of really complicated patients. Over time he added some families with help of units of the hospital such as the maternity ward. He also did a lot of medical assessments for male employees from the factories. Dr. Gebhardt estimated his patient panel at 1750 patients. He said he was the second busiest practice in the clinic. He also saw walk-in patients in the clinic. After 2017, Dr. Gebhardt left Crescent Heights Clinic. Dr. Gebhardt was provided his records and stated that he had seen 17,000 people in that time period.

[155] In June 2017, Dr. Gebhardt was working at the Crescent Heights Medical Clinic. It was made up of seven medical practices. There were staff members including Primary Care Network nurses and medical office assistants. There were billing staff, a medical office manager and reception staff as well. Dr. Gebhardt estimated 350 patients were seen in the clinic each day by the seven practices. The reception was at the front of a strip mall bay and doctors' offices were located along one of two hallways that led to a physician work area and an administrative office.

[156] Turning to June 6, 2017, Dr. Gebhardt stated his schedule was routine. It was busy and he was running late. He is usually running about an hour behind from an early hour. Dr Gebhardt stated: "that day was just a little bit more busy than some of my other days because I had my full day, but then I also had walk-ins starting in the evening." [Transcript p 346, L 22-24] He said he likes to start the evening walk-ins at 5:30 as he is a little slower.

[157] The Patient was a scheduled patient on June 6, 2017. Dr. Gebhardt agreed he was familiar with the Patient since 2010. Dr. Gebhardt noted the Patient was 19 years in 2010. Asked about the nature of the visits, Dr. Gebhardt said a lot of visits had happened and many were for wart treatments. He also saw the Patient at the request of C.O.R.E. staff for periodic check-ups. Dr. Gebhardt had seen the Patient for 24 visits before June 6, 2017. Dr. Gebhardt described his interactions with the Patient as "routine." [Transcript p 348, L 8]

[158] Describing the Patient as a patient, Dr. Gebhardt said a "nice fellow," but hard to communicate with and vague in his answers. [Transcript p 348, L 12-14] He was not very descriptive and "If you just asked him something directly, he might just agree with you that something is going on" [Transcript p 348, L 16-17]. Dr. Gebhardt said he looked after more the physical issues and the Patient also had a psychiatrist, Dr. B, since 2015 when the Patient's care was transferred from another psychiatrist. Dr. Gebhardt was given the role of laboratory monitoring of prolactin levels while the Patient was on an anti-psychotic medication named risperidone. Dr. Gebhardt said the drug was prescribed and managed by Dr. B but he may have written a prescription (a casual refill) once in a while [Transcript p 350, L 1]. Dr. Gebhardt was asked how familiar he was with the drug and Dr. Gebhardt remarked he'd seen it used for behaviour in teenagers but didn't know it could be used in adult care until he looked it up.

[159] Dr. Gebhardt said the Patient always arrived at the clinic with at least one staff person, although towards the end, he was coming in with two people. They would remain in the room if the issue was a routine issue, such as a wart treatment. The Patient would have the staff leave if he had something private to tell Dr. Gebhardt. This was at the Patient's request [Transcript p 350, L 25 to p 351, L 4]. Dr. Gebhardt stated "…because he's an adult, right. You know, even though he's… he does have mental disabilities, he does deserve respect. And so there was an understanding, and I had talked about this with him, with his caregivers. And that, you know, he's allowed to talk to me in confidence about things, but if it was something that was maybe dangerous to him, then I would have to – then I would have to tell. But if it was just something in private or something embarrassing, he was allowed to just talk to me about it. And I was his doctor. I would just keep it to myself." [Transcript p 351, L 5-15]

[160] Dr Gebhardt noted that four periodic physical examinations had been carried out with the Patient. These were regular and basic head-to-toe well person exams. They were quite routine with no abnormalities detected. Dr. Gebhardt added for the Patient he was unable to do his own testicular examination in the shower, so Dr. Gebhardt routinely during those examinations included a very brief, cursory check basically to rule out testicular cancer. [Transcript p 351, L 1-6]

[161] Dr. Gebhardt stated that the reasons for the visit on June 6, 2017 were: a profound weight loss of 33 pounds, using a telephone inappropriately at work, and questions from C.O.R.E. staff about a vitamin supplement following discontinuance of risperidone. Dr. Gebhardt noted Dr. B had discontinued the risperidone and recommended the supplement.

[162] The appointment was in the afternoon, although Dr. Gebhardt was not quite sure of the time. Asked again about the day up until the appointment he replied it was busy. He was running about an hour behind, as usual, but otherwise routine. Dr. Gebhardt said that he was in good condition. He was used to it but stated that it was a bit of a warm day in his rooms [Transcript p 353, L 26-27]. Dr. Gebhardt provided a description of the variation of temperature in his rooms when doors are closed and the thermostat is in the hallway. It can be pretty warm or really cold in his rooms.

[163] There is a chart entry reference to "physician unwell" for that day. Dr. Gebhardt explained they had been in the clinic room a little longer than usual, estimating 20 minutes to half an hour including the history. The examination was described as always about ten minutes but the other portion can be longer. Dr. Gebhardt noted the room is really small, and that the picture does not do it justice [Exhibit 4]. It's really tight and you had four bodies so he noted it got pretty stuffy in there. Dr. Gebhardt said since he is overweight he "got pretty hot at the end" [Transcript p 355, L 1].

[164] Dr. Gebhardt explained his note-taking practice, he makes scratch notes at the end of the visit to refer to later when completing the charting. He explained he is a slow typist, at 15 words per minute. He said he does that so not to keep the patients in the room and during billing he fills in the blanks. With the Patient he made that reference (physician unwell) in there because they talked about quite a few things. "So I was just thinking, oh, you know, what did we talk about, what did we talk about. Because I finished the notes the next day. I was just like I think I got everything down. But I just wanted to make a reference to myself, if I ever had to go back on this chart that, oh, yeah, that was that hot day and – and that I would remember, oh, yeah, okay, I might have – I might have missed something that day and then I could catch up with it on another visit." [Transcript p 355, L 15-25] Dr. Gebhardt denied anything going on in his life that could affect the proper conduct of his practice and described his life as super.

[165] Dr. Gebhardt was asked about his chart notes [Exhibit 1, Tab 4, p 24] which indicate that the chart was signed off on June 7, 2017 at 5:33. Dr. Gebhardt explained because he did the walk-in clinic that evening he put off signing off the chart until end of day June 7, 2017 rather than June 6, 2017.

[166] Turning to the appointment with the Patient again, Dr. Gebhardt explained he knocked on the door and entered the room. He greeted the Patient, who was in a gown, and the two staff people seated and enquired what he could help with that day. Dr. Gebhardt confirmed having seen one C.O.R.E. staff

member before and was not sure if she was the C.O.R.E. supervisor, but he did not recognize the other staff member.

[167] Dr. Gebhardt testified they talked about weight loss and symptoms. Dr. Gebhardt testified about types of symptoms and age group possibilities including risperidone discontinuation. Dr. Gebhardt said he was trying to avoid the need for a colonoscopy or CAT scan. Dr. Gebhardt explained his theory of weight loss due to risperidone and his plan for laboratory investigation. They then discussed the "enzyme" [Transcript p 359, L 9]. Dr. Gebhardt could not recall the name of it and noted he had never heard of it. He stated he looked it up on the internet and found it was a health food supplement. He searched for dangerous natural supplements using his phone 'app' and finding none, indicated there was no harm in giving it to the Patient. Dr. Gebhardt then discussed the phone issue with the Patient. The Patient had been on his phone during working hours. The Patient had said he was not feeling well and had been on a month leave. Dr. Gebhardt was asked about the Patient's fitness to return to the theatre job. Dr. Gebhardt confirmed he could go back to work.

[168] Dr. Gebhardt was asked what he was planning to do that day to determine the reason for the weight loss. Dr. Gebhardt described it basically as a general physical examination but a bit more aggressive on feeling for lymph nodes and stuff like that. Dr. Gebhardt described variance in examination with deeper palpation on the organs and "stuff like that." He let the Patient know he would be pushing a little bit harder on things. [Transcript p 360, L 19-21].

[169] Dr. Gebhardt also determined he would do a digital rectal examination ("**DRE**") to rule out a rectal tumour. Dr. Gebhardt said he did not tell the Patient at the time but told him right before he did the rectal check. Dr. Gebhardt said how important finding an anomaly would be as it would need urgent referral for colonoscopy. He felt missing such an anomaly would be unforgiveable. Dr. Gebhardt testified that the staff members did not remain in the room for the physical examination. He stated, it is a given and always what the Patient wants. Two reasons: privacy and a chance to complain about his caregivers. Dr. Gebhardt said he gives the patient the choice of who is in the room unless it is for a Pap test, disability or not, there is a medical office assistant in the room. [Transcript p 362, L 2-9]

[170] Mr. Rudakoff asked Dr. Gebhardt to detail how he performed the physical examination. Dr. Gebhardt began by describing an eye exam, and an ear canal check as a touch ice breaker. During the ear examination Dr. Gebhardt said he began by asking the Patient about seeing friends, bowling, that sort of thing.

[171] Dr. Gebhardt testified the Patient mentioned his friend E. who he had mentioned several other times and described wrestling with E. and they had been lying on top each other. Dr. Gebhardt said he probed a bit further. Dr.

Gebhardt stated the Patient is so "suggestible" and so asked if anyone had been touching his private areas (bathing suit area) and the Patient said not. [Transcript p 363, L 5–10]. Dr. Gebhardt said he found out more detail later but did not know anything about it at that visit. He did not bring it up with the caregivers at the visit. He talked to the Patient about his texting while working.

[172] Dr. Gebhardt continued his examination with neck palpation, lymph nodes in that area and the shoulders. Next with the patient lying supine, he did chest palpation and auscultation for tumours and heart sounds and listened to the stomach sounds. Feeling of the organs was next with explanation of abnormalities that may suggest a tumour. He then checked the lower limbs and between the toes. Finally, "anything underneath the underwear." [Transcript p 364, L 18] Dr. Gebhardt noted that no abnormalities were found to that point.

[173] Dr. Gebhardt stated that he then explained to the Patient that the testicle check was next. He asked the Patient to pull his underwear down far enough for him to do that. He put on latex gloves that are yellow in colour. He did a standard examination beginning as is his habit with the left testicle searching for the epididymis at back and that no other mass is present. He then examined the right testicle and then asked the Patient to pull his underwear up again. Mr. Rudakoff asked if Dr. Gebhardt touched the penis of the Patient since the Patient testified Dr. Gebhardt checked for lumps. Dr. Gebhardt asserted the lumps would be on the testicles not the penis and said the difference between penis and testicles is lost on the Patient. [Transcript p 365, L 25–26] Mr. Rudakoff asked if the examination technique was the same used in past to assess the Patient and Dr. Gebhardt said the examination was the same.

[174] Dr. Gebhardt stated he next asked the Patient if examination of the "bum area" was okay and the Patient agreed. [Transcript p 366, L 10] The Patient was asked to lie left on ribs and hip, raise his knees and pull down his underwear. Dr. Gebhardt applied gel to his glove and the Patient lowered his underwear. Dr. Gebhardt further lowered the underwear for access to examine. Dr. Gebhardt explained the rectal examination requires a sweep back and forth to cover the rectal surface. Examination completed, Dr. Gebhardt said he handed the Patient tissue to wipe himself and removed his gloves. Mr. Rudakoff asked how long the examination took and Dr. Gebhardt estimated five seconds. Dr. Gebhardt offered the Patient the garbage receptacle for the tissue and proceeded to wash his hands and use the computer to print a laboratory requisition. Dr. Gebhardt confirmed the findings were negative and stated that the Patient's reaction was "totally neutral." [Transcript p 367, L 24]

[175] Dr. Gebhardt told the Patient to get dressed and to take the form with him. Dr. Gebhardt then left the room. Dr. Gebhardt stated he went to the back for a drink of water and was sort of watching the room. The Patient did not

appear for a couple of minutes so Dr. Gebhardt returned to the room, knocked, and found the Patient dressed and seated in a chair. He offered the Patient the requisition and took him toward the front office waiting area. He said he did not see who the C.O.R.E. worker was but now knows it was the Care Worker. The Patient went straight toward that person. Dr. Gebhardt went on with patient work. Dr. Gebhardt stated he estimated the total time alone with the Patient was ten minutes. He agreed that was the usual time for such an examination. The earlier history portion of the appointment with the two C.O.R.E. staff in the room took "longer" because of all the history needed to be taken.

[176] Dr. Gebhardt denied the allegation against him. Asked how the Patient's demeanour seemed as they walked from the clinic room, Dr. Gebhardt replied "Usual self." [Transcript p 371, L 11] Mr. Rudakoff asked to clarify if the Patient seemed upset or agitated and Dr. Gebhardt said "not at all." [Transcript p 371, L 16] Mr. Rudakoff asked if Dr. Gebhardt heard what the Patient may have said in the waiting room but Dr. Gebhardt said he didn't see the worker or hear anything and the Patient said nothing to Dr. Gebhardt.

[177] Mr. Rudakoff asked Dr. Gebhardt to characterize the visit of the Patient to the office and Dr. Gebhardt replied that it was routine and normal and uneventful except for dealing with weight loss. [Transcript p 371, L 26-27] Mr. Rudakoff asked Dr. Gebhardt to describe his conduct during the visit with the Patient on June 6, 2017 and Dr. Gebhardt replied "completely professional." [Transcript p 372, L 3]

[178] Mr. Rudakoff asked how the allegation affected Dr. Gebhardt and his family. Dr. Gebhardt noted the effects on his wife and family and on his reputation. He went on to explain the history of withdrawal from practice and the effects on livelihood.

Cross-Examination

[179] Dr. Gebhardt confirmed that he did not testify at the criminal trial in December, 2018. Mr. Boyer clarified that the clinic room that Dr. Gebhardt was in with the Patient for the visit on June 6, 2017 was the one shown in Exhibit 4.

[180] Mr. Boyer then asked if the detail in Dr. Gebhardt's testimony was from the records or memory. Dr. Gebhardt replied that when a warrant was delivered by police he began writing a narrative and that "a month out my memory would be a lot clearer" [Transcript p 375, L 20-27].

[181] Mr. Boyer asked what information Dr. Gebhardt had about the Patient's sexual interests and where he got the information. Dr. Gebhardt said he did not have much information but gave examples of self-stimulation and using fruit to stimulate. He said he discussed it with the Patient at staff request in

light of the "germs." Dr. Gebhardt added he was filling a form for competency assessment in 2015 when the incident of a fellow coming into the Patient's apartment to watch the Patient urinate occurred. [Transcript p 376, L 19-22] The form related to fitness to live on his own and risks of food handling and stranger entering.

[182] Mr. Boyer noted Dr. Gebhardt had mentioned the Patient's friend E. Mr. Boyer suggested this also constituted information that Dr. Gebhardt had about the Patient's sexual interests. Dr. Gebhardt responded he didn't know about any sexual thing going on. [Transcript p 377, L 15-16] Dr. Gebhardt went on to describe further knowledge regarding kissing fellows at the mall and stated he thought the activity was "pretty light." [Transcript p 377, L 21] Mr. Boyer confirmed Dr. Gebhardt had spoken to the Patient about using fruit to self-stimulate and about E. and wanted to know if there had been any touching. Dr. Gebhardt acknowledged the conversation was at the previous visit.

[183] Mr. Boyer turned questioning to the DRE, confirming a DRE was part of a 2015 examination as recorded in Exhibit 1. Dr. Gebhardt acknowledged he uses a template charting method, which is basically a copy and paste and he deletes the aspects not carried out. [Transcript p 378, L 17-20] Dr. Gebhardt stated that in 2015 there was no DRE and that it was an error in the chart. [Transcript p 379, L 6-18]

[184] Mr. Boyer asked Dr. Gebhardt to confirm he was behind schedule on June 6, 2017 and Dr. Gebhardt agreed. Mr. Boyer noted that the Care Worker who was in the clinic testified that the appointment was at 2:00 PM. Dr. Gebhardt agreed it was probably accurate but they would have met about 3 PM. Mr. Boyer noted the Care Worker said she and her colleague left at 3:10 PM. Dr. Gebhardt did not recall the statement. Mr. Boyer added that the C.O.R.E. staff note stated the Care Worker left the examination at 3:10 PM. Dr. Gebhardt did not dispute the time. Mr. Boyer added the Care Worker's notes indicated the Patient did not come out of the clinic room until 3:25 PM [Exhibit 3]. Dr. Gebhardt stated it was ten minutes. Mr. Boyer confirmed there was no information to dispute the notes made by the Care Worker. [Transcript p 381, L 1-2]

[185] Dr. Gebhardt stated that physical examinations were scheduled for 30 minutes. Mr. Boyer asked how many patients had yet to be seen by Dr. Gebhardt that day and Dr. Gebhardt noted 12 patients. [Transcript p 382, L 7-9] He also had the evening walk-in patients. Dr. Gebhardt stated he would have completed the day around 5 PM, taken a supper break and been ready for walk-in duty early at 5:30 PM. Dr. Gebhardt confirmed he did the walk-in clinic that evening as planned. Mr. Boyer responded that with the workload and the clinic room described as warm and uncomfortable, he wondered why Dr. Gebhardt would record "physician unwell?" Dr. Gebhardt explained it as a reminder note for the time he completed the chart entry and he would recall that he felt "gross." [Transcript p 382, L 22 to p 383, L 4]

[186] Mr. Boyer asked Dr. Gebhardt about the testicular examination, asking Dr. Gebhardt if he is suggesting the Patient confused his testicular examination with a penis examination. Dr. Gebhardt replied "there's no real – there's no penis exam." [Transcript p 383, L 9-11] Mr. Boyer asked whether Dr. Gebhardt was saying the Patient was referring to the testicular examination when he referred to his penis. Dr. Gebhardt stated that was what he believed "him to be referencing because he really doesn't know the difference between the two." Dr. Gebhardt suggested the Patient didn't have any understanding that is beyond "down there" and that he could be referring to "testicles, penis, groin, anal area, anything." [Transcript p 383, L 12-21]

[187] Mr. Boyer asked if Dr. Gebhardt had any information about the Patient's ability to describe his genitals since the June 6, 2017 appointment. Dr. Gebhardt spoke at length how the Patient learned a bit of description in 2015 and 2016 but "down there" could reference anything in the underwear area basically. Dr. Gebhardt stated that in 2017, the difference between penis and testicles would have been basically synonymous for the Patient. Mr. Boyer challenged that the Patient described what amounts to an ejaculation and Dr. Gebhardt stated "It certainly does." [Transcript p 384, L 12-15]. Dr. Gebhardt explained the Patient had never referenced the word testicles. Dr. Gebhardt admitted he did not know if the Patient knew the difference or vocabulary for testicles.

[188] Dr. Gebhardt has testified that the Patient showed no sign of distress after the visit of June 6, 2017. Mr. Boyer put it to Dr. Gebhardt that he inappropriately touched the Patient and invited the Patient to touch him. Dr. Gebhardt denied the allegation. [Transcript p 385, L 10-16] Mr. Boyer further said Dr. Gebhardt asked the Patient to keep it all a secret. Dr. Gebhardt said "secret" is a "trigger" word for him and his family. Dr. Gebhardt said "that it would be a trigger word. That would be utter stupidity." [Transcript p 385, L 25-26]

<u>Re-Examination</u>

[189] Dr. Gebhardt confirmed with Mr. Rudakoff that the appointment was about ten minutes and stated, "It's 10 minutes…it's just always the same….it's a standard exam." [Transcript p 386, L 17-19]

<u>Hearing Tribunal Questions</u>

[190] The Hearing Tribunal asked Dr. Gebhardt to outline the processes in the clinic. Dr. Gebhardt said the staff show the patient to the room and tell them to get ready for the appointment. Dr. Gebhardt was asked about the likelihood staff would interrupt the appointment. Dr. Gebhardt stated that was unlikely except in urgent cases. Asked in what manner an interruption would occur, Dr. Gebhardt said that staff could unexpectedly enter the room but there would be a second or two before entry. Dr. Gebhardt was asked if

it is his usual practice to return to the clinic room after completing an examination. Dr. Gebhardt said it was not his usual approach and he would usually go on to the next patient. He further explained he "just happened to be waiting by the water cooler… And just noticed that the Patient didn't come out of the room." [Transcript p 389, L 8-16] Dr. Gebhardt said after opening the clinic room door he saw the Patient "just sitting there… calm as can be in the chair." [Transcript p 389, L 20-22]

[191] The next question was in regard to the physician form that the C.O.R.E. staff bring to the appointment. Dr. Gebhardt reported the form could have been completed at the beginning of the visit being discussed. Dr. Gebhardt was asked to clarify if the staff usually re-enter the examination room and Dr. Gebhardt stated they usually wait in the waiting room. He described the medical office assistant role as stopping people (such as C.O.R.E. staff) from finding their own way around the clinic to avoid the wrong room being entered. The Hearing Tribunal next asked Dr. Gebhardt to estimate the number of patients seen June 6, 2017 in his practice. Dr. Gebhardt did not have a number but calculated about 40 people including those he fit in. [Transcript p 391, L 17-26] The day began at 9:00 AM, went to noon and began again at 1:00 PM, and bookings ended at 4:00 PM. Dr. Gebhardt confirmed that was a typical day on June 6, 2017. [Transcript p 392, L 3]

[192] Dr. Gebhardt was asked to further describe the examination and in particular the practice of routine rectal and genital examinations in the Patient's age group. Dr. Gebhardt testified he did not routinely exam until age 50 years unless indicated, such as weight loss in the Patient's case. For the Patient, Dr. Gebhardt noted in reference to genital examination: "because of his cognitive disability, I always did it". [Transcript p 393, L 2-3] Clarifying, the Hearing Tribunal asked how often he did a genital examination for the Patient and Dr. Gebhardt said "…just on the complex medical exams." [Transcript p 393, L 10]

[193] The Hearing Tribunal asked specifically about the June 6, 2017 examination. The Patient initially sat on the examination table wearing a gown as prepared by the medical office staff. Dr. Gebhardt confirmed males typically wore a gown over underwear during an examination. In addition, he uses a drape cloth lying on the underwear. Dr. Gebhardt said to examine the back he unties the gown. He then has them lie down supine for the examination of the chest and abdomen while the drape covers the underwear area. Dr. Gebhardt noted the underwear area is a "sensitive exposure". [Transcript p 394, L 22] Dr. Gebhardt testified that the position for the testicle examination was flat on the patient's back. Dr. Gebhardt was asked why this was not done standing. Dr. Gebhardt said it was more likely the penis would dangle near the testicles. Asking if touching the penis was expected he said he does a supine examine and "you don't end up touching the penis." [Transcript p 395, L 15].

[194] The Hearing Tribunal asked about the presence of a chaperone during examination of a patient. Dr. Gebhardt stated that a chaperone was present during pap examinations of female patients in his clinic. Dr. Gebhardt was asked if chaperones were present typically in any other patient examinations. Dr. Gebhardt added a child normally had a parent present. Dr. Gebhardt was asked if he considered having a chaperone present for the Patient's physical examination. [Transcript p 399, L 13-15] Dr. Gebhardt said the first physical examination occurred when the Patient was 21 years or so and he wanted privacy; this caught him off guard, but it went well and Dr. Gebhardt accepted his choice as an adult. Dr. Gebhardt said he did check for CPSA recommendations, but found none, so he went ahead without a chaperone for the Patient. [Transcript p 399, L 24 to p 400, L 9]

[195] Dr. Gebhardt was asked about an entry in the record for August 18, 2016, as follows [Exhibit 1 Tab 4, p 24]: "Erection painful x1. Not painful since. No genital anomaly seen." Dr. Gebhardt was asked to describe the events of that appointment. Dr. Gebhardt stated he did not write great notes. [Transcript p 401, L 4] He referred to MRI results and provided details. Dr. Gebhardt said the Patient wanted to talk about the painful erection and since the examination dealt with genitalia the C.O.R.E. staff person left the room. Dr. Gebhardt said the assessment was visual not palpation: "his caregiver left the room basically so that we could – so that he could show me – show me his genitalia. And so I just take a – took a look basically and I didn't see anything. It was an erection so there wasn't a need for a testicular exam. And I didn't see any sores or anything on it. There's no real palpation sort of exam, sort of like, you know, touching exam that you would do for that. So it was just based on – on looking at it." [Transcript p 401, L 13-22] Dr. Gebhardt said he did not put much stock in the concern and the Patient proceeded to talk about an incident when the Patient said he saw a "plumber's crack." [Transcript p 401, L 23-26] Dr. Gebhardt said he normalized the situation.

[196] Dr. Gebhardt was asked about the Care Worker's notes that stated he talked to the Patient in private and called her back in five to ten minutes later. Dr. Gebhardt stated the Patient "had a little semen back-up in the tube." [Exhibit 3, page 4] Dr. Gebhardt confirmed the Care Worker's notes of the appointment were probably what he said as "[The Patient's mother] keeps pretty good notes… Because you can't quite figure out for sure what he's talking about. Because the Patient can't give you a lot of – a lot of detail." [Transcript p 403, L 1-5] Dr. Gebhardt examined and addressed general male concerns with periodic penis discomfort and said his assumption was that the symptom was not an issue.

[197] Dr. Gebhardt was asked by the Hearing Tribunal to walk through the examination with the Patient of June 6, 2017 from the moment the C.O.R.E. staff left the room until he opened the door to leave the room.

[198] Dr. Gebhardt stated he began with an eye examination using his guiding finger for the eyes to follow. The Patient was sitting in his gown, legs dangling off the edge of the table. Next Dr. Gebhardt began to examine the Patient's ears and at the same time asking him about friends. The examination of cranial nerves with a "crude" check followed. [Transcript p 405, L 9] Lymph node examination followed in the neck and clavicle areas. Examination of the back followed with slight rotation of the Patient's body. Dr. Gebhardt stated he unties the top string of the gown so the back is partially exposed to the scapula level (shoulder blades). A brief examination of listening to the chest (auscultation), percussion to eliminate consolidation sounds, then pushing along the spine looking for pain.

[199] Following that, he would have the Patient move left to lie supine on the table (face up) and rest feet on the moveable rest. A two by four-foot drape was next placed around the abdominal pelvic area. The gown was next lowered to the rib margin exposing the chest area. Auscultation of the lungs and heart sounds followed and upon completion the gown was moved back up and the drape sheet was grasped while the gown was pulled upward, leaving the drape covering the underwear and the abdomen exposed for examination. The abdomen was next observed then auscultated for abnormal sounds including aortic renal vessels. Abdominal palpation was initially gentle then deep palpation including the left lower quadrant for bowel abnormality and right upper quadrant focused on liver (hepatic) enlargement.

[200] Dr. Gebhardt described that the gown is lowered again and he performed a leg examination especially along the 'sides' for muscle, soft tissue, skin abnormalities. A brief movement of both legs was conducted as part of a standard examination. At the ankles, Dr. Gebhardt checks for pulses and reflexes.

[201] Dr. Gebhardt asked the Patient to lower his underwear while he put his gloves on for the testicular examination. Dr. Gebhardt placed the drape over the penile area as it is not what he is looking at. He added this helped move the penis up and out of the examination area, "you can sort of just move the cloth and just sort of, you know, get things moving with, you know – sort of defying gravity." [Transcript p 409, L 2-6] With gloves on, Dr. Gebhardt commenced the testicular examination with left side with a two-handed top to bottom using fingers and the same on the right side.

[202] Next the Patient was asked to pull up his underwear and Dr. Gebhardt explained the DRE necessity to the Patient and sought verbal consent. Lying in the left lateral decubitus position, facing the wall, head near the room door, the underwear was lowered by the Patient and adjusted further by Dr. Gebhardt followed by digit insertion at 3 o'clock position or 9 o'clock position sweeping up to 6 o'clock position and palpating prostate and continuing to the opposite extreme, completing a 360-degree sweep feeling for any abnormality.

[203] Dr. Gebhardt next removed a glove to reach for a tissue for the Patient to wipe and removed the other glove. He offered the waste basket for the Patient’s tissue. The Patient was likely left lying still and raised his underwear. The Patient rose to a seated position again to finish the examination with a check of reflexes at the knee and brachial (arm fold) areas. Finally, Dr. Gebhardt tied up the top of the gown and washed his hands.

[204] Dr. Gebhardt then typed a laboratory requisition and placed it on the edge of the desk. Dr. Gebhardt noted that the desk is kitty corner to the examination table. The Patient was instructed to dress and go and Dr. Gebhardt then left the room.

[205] Dr. Gebhardt was asked about when he wears blue gloves. Dr. Gebhardt only wears those if there is an allergy to latex. Dr. Gebhardt stated that at no time was the Patient lying on the table on his right side. Dr. Gebhardt stated that the Patient did not have an erection or ejaculate during the examination.

Additional Questions by Counsel

[206] In response to questions from Mr. Boyer, Dr. Gebhardt confirmed the photos of Exhibit 5 appeared to be photos of the clinic room where the appointment took place on June 6, 2017.

[207] Mr. Rudakoff had no further questions.

Dr. TD

Direct Examination

[208] Dr. TD was called by Dr. Gebhardt as an expert witness. Dr. TD reviewed his CV, background and experience. Mr. Boyer had no objection to Dr. TD being qualified as an expert witness and the Hearing Tribunal qualified Dr. TD as an expert in psychology, forensic psychology and neuropsychology.

[209] Dr. TD reviewed his expert report [Exhibit 1, Tab 14]. Dr. TD was asked to comment on the reports of Drs. MN and DH. Dr. TD noted he was surprised at the unusual number of experts in psychology asked to address the same questions. Also unusual according to Dr. TD was the preparation of a joint report by two experts.

[210] Dr. TD was asked to explain the Patient’s diagnosis. Dr. TD stated he understands that "autism" is the key focus. A summary and history of "autism" was provided by Dr. TD. The term "autism" originated in the DSM-III in 1980 with descriptions of cases being published. Within the diagnosis of "autism" there are various groups such as "Asperger's" normal IQ group and the PDD group. The term "autism" was expanded to be a spectrum. Recently, the Centre of Disease Control noted that one of 46 children meet the

diagnostic criteria for autism. The presentation varies over a range, with some along the low end of the spectrum being highly disabled.

[211] Dr. TD focused on the Patient who was diagnosed with ASD from the 2001 diagnosis of PDD-nos. The signs are the connections to others, communication skills, upset caused by change, and tendency to obsessive-compulsive behaviours. Dr. TD emphasized it is hard to individualize the findings of research studies of groups, statistical analysis, and the make-up of groups studied. It is an error to individualize the findings as individuals in a group can be quite different.

[212] Dr. TD suggested there was no valid explanation as to why the original diagnosis in 2001 for the Patient was never updated despite changes in the DSM diagnostic criteria. Development of the brain with age and stabilization of signs of autism would be expected. Dr. TD was asked about the risk of disruption to the Patient from repeating a full assessment and Dr. TD replied that he had "no idea what that's about" and could envision no harm to come of reassessment. Dr. TD said the diagnosis could be clarified by repeating the assessment. He acknowledged that the Covid pandemic was a factor, although he stated he did many assessments during Covid.

[213] Dr. TD was asked about the autism diagnosis and the Patient's ability to describe historical events. Dr. TD responded that "autobiographical memory" is key for recall and the Patient would be expected to have memory problems if his IQ is 44.

[214] Dr. TD was asked about ASD and the ability to create false memories. Dr. TD stated everyone has the ability to create false memories. Dr. TD emphasized that all recall is subject to inaccuracy.

[215] Dr. TD was asked about Dr. MN's report of 2020 [Exhibit 1, Tab 12] and the joint report of Dr. MN and Dr. DH [Exhibit 1, Tab 13]. Dr. TD focused on the ability to lie and said it is true for us all. Dr. TD further stated he was "disappointed" in the quality of the reports and felt "offended" as a forensic psychologist. [Transcript p 436, L 25 and p 437, L 3-4]. He added that assessment of witness credibility is not the role of an expert to decide. Dr. TD stated he had no idea where Dr. DH got her information regarding event recall for ASD people. Dr. TD said Dr. DH's comments on event recall are too wide; that we cannot generalize about memory and that we need science to back up conclusions. Dr. TD's advice to the Hearing Tribunal was to use its own common sense, and that backtracking, regarding behaviour after an alleged assault, is not allowable.

<u>Cross-Examination</u>

[216] In his response to questions from Mr. Boyer, Dr. TD described his practice as encountering a range of clients. He noted that given the number of

individuals with ASD, he runs into ASD people, but it is more incidental. He acknowledged that his practice is not focused on low IQ assessments.

[217] Mr. Boyer asked about the role of records created shortly after an event and Dr. TD agreed they would be important sources of information.

[218] Mr. Boyer referenced to several articles cited in Dr. TD's report and made reference to three published papers and they were accepted into the record as Exhibits 6 to 8.

Hearing Tribunal Questions

[219] The Hearing Tribunal asked Dr. TD for an opinion in regard to ability to maintain a narrative, and an opinion of the statement that it is impossible for ASD individuals to fabricate a narrative. Dr. TD responded that the conclusion is not defensible and there is variation amongst individuals.

[220] Dr. TD also referred to the three articles offered and suggested "black swans" demonstrate that generalization about ability to fabricate and to lie is not valid; the three articles offer examples of such black swans saying the exception disproves the rule.

CLOSING SUBMISSIONS

Closing Submissions for Complaints Director

[221] Mr. Boyer noted the complexity of the issues in the hearing, given the nature of the Patient's pervasive developmental delay and the criminal proceedings. Mr. Boyer noted that the criminal charges against Dr. Gebhardt were stayed by the crown in the criminal trial and the limit of one year to re-institute the charges against Dr. Gebhardt has passed.

[222] Mr. Boyer referred to the court case *Walsh v Council* where three roles of the trier of fact are spelled out as: making findings of fact, determination of the appropriate standard, and application of the facts to the standard. In this situation the appropriate standard is the CPSA Standard of Practice: Sexual Boundary Violations which was in force in June, 2017 [Exhibit 1, Tab 18]. The Standard of Practice sets out a number of prohibited acts and conduct by a physician in relation to a patient. Mr. Boyer pointed out the reporting by the Patient as described during his testimony (and in the contemporaneous notes made by the Patient's mother and the Care Worker) describes conduct which is prohibited conduct as outlined in paragraphs 1 and 2 of the CPSA Standard of Practice: Sexual Boundary Violations.

[223] Mr. Boyer noted that the civil standard of proof applies, which is the balance of probabilities (*F.H. v McDougall*). The Complaints Director bears the burden of proof. The Hearing Tribunal will need to make assessments of credibility

for the witnesses. Guidance is found in the often-cited case of *Faryna v Chorny* which notes that several factors are to be considered and that "[t]he test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions" (paragraph 111). Harmony with the preponderance of the probabilities is a key factor in accepting a witness as credible and the role of the Hearing Tribunal is to satisfactorily appraise the testimony of the witness. Because the Patient is a member of the ASD population, the acceptance of him as a witness is complicated. This is where the finding of fact and application of the appropriate standard is the key role of the Hearing Tribunal.

[224] Mr. Boyer acknowledged there are separate versions of the events in the clinic room on June 6, 2017. Mr. Boyer summarized the contemporaneous notes in Exhibits #2 and #3 written by the Patient's mother and the Care Worker that contain unsolicited reports from the Patient after the clinic visit on June 6, 2017.

[225] Mr. Boyer noted that the reports and testimony of Dr. MN and Dr. DH offer an overview of ASD people. While Dr. Gebhardt suggested that they took on the role of advocates, Mr. Boyer suggested there is no conflict arising as the role of Drs. MN and DH was to assist the Hearing Tribunal to understand the ASD population that the Patient belongs to, and to assist the Hearing Tribunal to understand how individuals with ASD communicate, deal with language, and how they are able to describe their experiences.

[226] The Hearing Tribunal must look at the totality of the evidence to determine what occurred during the examination of the Patient on June 6, 2017, including the contemporaneous notes made by the Care Worker and the Patient's mother. Mr. Boyer noted the testimony of Dr. TD and his acknowledgment of the importance of contemporaneous records in hearing evidence.

[227] Mr. Boyer noted the evolution of court attitudes toward victims who delay in reporting. What is key in this case is the unsolicited report of the Patient to the Care Worker after the clinic appointment, and again later to his mother.

[228] Mr. Boyer addressed the Patient's confusion reflected in the Patient's mother's note [Exhibit 2] that the Patient was "not sure if he's lying or telling the truth". It is possible to understand that statement with the benefit of Dr. DH's testimony, as well as the articles entered as Exhibits 6, 7 and 8.

[229] According to Mr. Boyer, Dr. DH offered the information that confusion would be expected in this circumstance after being asked to not report when the Patient had been trained to report. Dr. DH offered experience and insight into the Patient's confusion. Mr. Boyer also noted that Exhibits 6, 7, and 8, although dealing with higher-functioning autism people, describe that higher-functioning autism individuals cannot maintain and sustain that type of fictional story.

[230] Dr. TD criticized Drs. MN and DH for the approach taken, but after all they assess ASD people, and Dr. TD is more population focused. The grounds for Dr. TD's criticism of Drs. MN and DH are weak and Drs. MN and DH bring valued perspective to the Hearing Tribunal.

[231] Mr. Boyer noted the difference between telling fabricated stories, which the Patient does not do, versus telling lies, for example about whether or not he has made his bed or whether he saw someone at the mall. Those are experiences that are real and he is lying to avoid getting in trouble. This is consistent with the articles provided.

[232] Mr. Boyer suggested that when analyzing the Patient's testimony, it is important to consider the Patient's low function, low IQ, and the need to couch questions in concrete realms, like showing him the photo of the clinic room, and he can then tell his story. Complex questions confuse the Patient while he can answer concrete and simple questions. "Yes" questions are problematic because the Patient will answer "yes" to please the examiner. The Patient has the ability, as is usual in ASD, to repeat his story accurately and his is one version of what happened in the clinic room. Dr. DH suggests a snapshot of the room leads to a concrete event description by the Patient but no connection to other memories. This is not the experience of those who don't have such developmental challenges. Mr. Boyer noted that if the Patient has a history of lying, why would he answer "yes" to questions about lying.

[233] Mr. Boyer drew an analogy to trauma-informed testimony of crime victims but noted this is disability-informed: that is, how does someone with a developmental disability communicate. How do they process questions and information, how do they respond to those questions? The situation the Patient was in led to his confusion as he was forced to consider the words of Dr. Gebhardt and the need to tell those he trusted.

[234] Mr. Boyer noted the evidence of Dr. Gebhardt, who described the appointment as an uneventful, routine examination. This runs contrary to why the Patient would be so upset immediately after an otherwise uneventful examination. Dr. Gebhardt said that the Patient was confused between his penis and his testicles; however, the Patient described that his penis was rubbed and it felt good to the point that the white stuff came out. The Patient was describing an ejaculation. Dr. Gebhardt stated that he had very little knowledge about the Patient's prior sexual interests and sexual activity prior to June 2017. Mr. Boyer suggested that this was an understatement and Dr. Gebhardt was trying to downplay his knowledge. Mr. Boyer referenced the chart notes which he stated contradict Dr. Gebhardt [Exhibit 1, Tab 4, p 9 to 26, 61].

[235] In addition, Dr. Gebhardt noted in his chart "physician unwell during exam" [Exhibit 1, Tab 4, p 27], yet he continued to see his booked patients that day

and saw walk-in patients in the evening. If he was momentarily unwell, why would he note this in the record.

[236] Mr. Boyer further noted that Dr. Gebhardt denied touching the Patient's penis on June 6, 2017. However, this is highly unlikely given that he was doing a testicular examination when the patient was lying flat on the table. The denial is not plausible.

[237] In closing, Mr. Boyer said the trier of fact usually asks if the person's testimony is credible and reliable. In this case, there is a witness with a developmental disability. The Patient is not a standard witness, and denying his testimony because he does not fit the model of a standard witness will result in individuals like the Patient never being given a voice.

[238] The Hearing Tribunal has to decide what happened in the clinic room without the benefit of other witnesses. However, there are contemporaneous records and a quick report by the Patient. The Hearing Tribunal may accept all, some, or none of the testimony of any witness. At the end of the day, before a finding of unprofessional conduct is made, the Hearing Tribunal must be satisfied that the totality of the evidence before the Hearing Tribunal proves on a balance of probabilities that improper conduct by Dr. Gebhardt toward the Patient occurred in the clinic room on June 6, 2017.

<u>Closing Submissions for Dr. Gebhardt</u>

[239] Mr. Rudakoff began with a summary of the Patient's mother's statements under oath recounting the diagnosis of the Patient's developmental delay and IQ testing at about age 9 years and finding him in the 0.1 percent of intellectual activity of his peers. The Patient has a history of showing confusion and engaging in numerous incidents of acts of sexualized behaviour and inappropriate sexual activity long before June 2017. The Patient has a history of lying, fibs, and untruths. While his supporters spoke of his honesty, voluminous examples of the Patient's proclivity to tell lies, tell stories, and be sneaky and furtive countered the testimony of the Patient's mother and the Care Worker. The value of the contemporaneous notes made by the Patient's mother and the Care Worker was emphasized by Mr. Boyer, but the notes show that within hours of the June 6, 2017 clinic visit, the Patient was not sure if he was lying.

[240] Mr. Rudakoff addressed the evidence presented that the Patient acted more aggressively and in a changed manner following the alleged assault. However, the behaviour also directly coincided with the discontinuance of his risperidone medication in February 2017. Mr. Rudakoff reviewed the summary of events from February to June, 2017 regarding behaviours noted in the C.O.R.E. records after risperidone was stopped in February, 2017. The examples of events included the Patient taking photos of his penis on his phone in February 2017, a short time after stopping risperidone. In May 2017, there are two examples of sexualized behaviours, documented by the

Care Worker, and behaviours at work that led to time off work. Mr. Rudakoff pointed out that Dr. MN called the period after the clinic visit of June 6, 2017 "intense" for the Patient and his family, with a member diagnosed with cancer.

[241] Mr. Rudakoff provided a summary of testimony of the Patient and noted that he had brought an application to prevent the Patient from testifying on the basis it would provide no credible or probative value for the Hearing Tribunal. Mr. Rudakoff submitted that the Patient's testimony in cross-examination was near word for word when compared to the testimony in December 2018 at the criminal trial. This despite his cross-examination using simple and contextual questions asked without trickery and with respect. The Patient testified he could not be certain if he was telling the truth and that his memory was not good. He has trouble remembering and gets confused. The Patient told his mother within hours of the alleged event that he did not know if he was lying or telling the truth. In his testimony in the hearing, the Patient even admitted that he was lying and that Dr. Gebhardt never touched his penis, he was just examining his testicles and that he was lying about Dr. Gebhardt placing his mouth on the Patient's penis or about the Patient placing his mouth on Dr. Gebhardt's penis. In conclusion, Mr. Rudakoff submitted that the Patient's testimony was unreliable and should be ignored by the Hearing Tribunal.

[242] Mr. Rudakoff submitted that the report of Drs. MN and DH is an advocate report substituted for independent, unbiased, impartial, fair opinion, which was their duty and their role. Mr. Rudakoff suggested the witnesses ignored evidence that did not support their chosen narrative and only accepted the flawed characterization provided by the Patient's mother and the Care Worker. Mr. Rudakoff submitted that Drs. MN and DH participated in "oath helping" and that the Hearing Tribunal will need to weigh their reports and testimony in reaching its decision. Drs. MN and DH showed disregard for information at hand as they based their evidence on a faulty and incorrect foundation regarding fib telling, lies, and untruths. By urging the Hearing Tribunal to find the Patient credible and telling the truth, Drs. MN and DH substituted opinions on behaviour, for opinions on credibility. Drs. MN and DH adopted the role of ultimate trier of fact rather than expert.

[243] In addition, Mr. Rudakoff stated that neither Dr. MN nor Dr. DH thought it worthwhile to ask the Patient directly about the accusations against Dr. Gebhardt. They did not rely on any formal assessments except for Dr. P's 2001 evaluation. The report of Dr. MN and Dr. DH speaks assertively of the Patient's capacity and capability of being believed. Mr. Rudakoff submitted that Dr. DH overstated her evidence. Dr. DH presents herself as a specialist in the field of ASD while admitting that there is no such speciality recognized by the College of Alberta Psychologists. According to Mr. Rudakoff the result is advocate experts attempting to save the Patient's contradictory evidence, bolstered by saying he is credible and telling the truth.

[244] Mr. Rudakoff summarized Dr. TD's expert testimony as saying he was disappointed by the actions of Drs. MN and DH and calling their actions outrageous. Dr. TD said ASD individuals can fabricate stories. The Hearing Tribunal cannot reach the conclusion that it is impossible for the Patient to fabricate if you rely on the science. Mr. Rudakoff asked the Hearing Tribunal to reject the evidence of Drs. MN and DH wherever it differs from that of Dr. TD.

[245] Mr. Rudakoff stated that Dr. Gebhardt's evidence was highly detailed especially under the questioning by the Hearing Tribunal. His evidence was consistent and his memory was sharp as to the details. His evidence was credible, genuine and had an air of reality to it.

[246] Mr. Rudakoff responded to Mr. Boyer's suggestion that the "physician unwell" note was inconsistent. Mr. Rudakoff denied it was inconsistent and that Dr. Gebhardt explained the note. It was written because he was putting in late notes the next day because it was hot in the room and he had many patients. He went back on June 7, 2017 and added more fulsome notes. There is nothing deceitful or nefarious in the note but rather the note was made as a memory aid.

[247] Mr. Rudakoff noted that Dr. Gebhardt's description of the process in the clinic room would take the full extent of the appointment time. Dr. Gebhardt's testimony has an air of reality as truth and in the end Dr. Gebhardt's testimony was consistent, sensible, and credible despite Mr. Boyer's questions and the Hearing Tribunal questions. Dr. Gebhardt was doing a physical examination in the midst of a hectic day in a very busy office where sudden interruptions were always a possibility. Dr. Gebhardt's description of events June 6, 2017 is highly believable. The Patient's story is a worst nightmare for a practitioner and is improbable. Mr. Rudakoff said the evidence suggests the Patient has been victimized too many times, as recorded in the C.O.R.E. notes.

[248] Dr. Gebhardt was prevented from telling his story in the criminal proceeding as the Crown stayed the case, "throwing in the towel" before even closing their case. This hearing offered Dr. Gebhardt an opportunity to tell his story.

[249] Mr. Rudakoff concluded by stating the preponderance of evidence after four days of evidence is that the examination occurred as described by Dr. Gebhardt and the allegation must be dismissed.

DECISION

[250] The Hearing Tribunal found that Allegation 1, particulars (a), (b), (c), (d) and (e) were proven on a balance of probabilities, for the reasons that follow.

[251] The Hearing Tribunal found that the proven conduct constituted unprofessional conduct as defined in section 1(1)(pp)(ii) and (xii) of the HPA,

in that it was a breach of the Standard of Practice: Sexual Boundary Violations and conduct that harms the integrity of the profession.

FINDINGS AND REASONS

[252] The Hearing Tribunal carefully reviewed the evidence, consisting of the exhibits and witness testimony, and considered the submissions of counsel for the parties.

Background

[253] The Patient is a 31-year-old male living in a supported living residence. He has been diagnosed with ASD, formerly known as PDD-nos.

[254] The Patient attended an appointment with his family physician, Dr. Gebhardt, on June 6, 2017. The Patient was 25 years old at the time. The Patient reported conduct by Dr. Gebhardt to his care worker and his mother, following the appointment, including that he touched Dr. Gebhardt's penis, that Dr. Gebhardt placed his mouth on the Patient's penis and that the Patient placed his mouth on Dr. Gebhardt's penis.

[255] The matter was reported to the Medicine Hat Police Service one week later according to the Patient's mother. Then on August 17, 2017, the CPSA was informed of the allegation against Dr. Gebhardt by the Medicine Hat Police Service and a complaint was initiated by the Complaints Director under section 56 of the HPA.

[256] Dr. Gebhardt signed undertakings with the CPSA on August 17, 2017 and January 29, 2019 and continues to practice pursuant to an undertaking, which requires that he have a chaperone present in the clinic room.

[257] In 2018, a criminal proceeding commenced against Dr. Gebhardt, but the charges were stayed following the testimony of the Patient. The time to re-initiate the criminal charges has since passed.

[258] The Complaints Director investigated the complaint and reports were obtained from Drs. MN and DH in 2020 and 2021. The complaint was referred to a hearing.

[259] In the hearing, Dr. Gebhardt and the Patient gave evidence about what occurred in the clinic room on June 6, 2017. Dr. Gebhardt described a routine examination planned to check for cause of weight loss since an anti-psychotic behaviour management drug, risperidone, was stopped in February 2017. The Patient also described a physical examination by Dr. Gebhardt but also testified that Dr. Gebhardt placed his mouth on the Patient's penis, the Patient placed his mouth on Dr. Gebhardt's penis, and that Dr. Gebhardt touched the Patient's penis and the Patient touched Dr. Gebhardt's penis. The Patient stated that Dr. Gebhardt asked him to keep "the promise with

him and not saying anything to anybody else" [Transcript p 333, L 21-22]. Dr. Gebhardt denies the allegation.

[260] Given the nature of the allegation and that only two individuals were present in the clinic room on June 6, 2017, the Hearing Tribunal was required to assess the credibility and reliability of the testimony of the Patient and Dr. Gebhardt.

[261] Dr. Gebhardt argued that the Patient was not a reliable witness. It was noted that the Patient has a diagnosis of developmental delay with a low IQ and functional age of between 9 and 14 years. Dr. Gebhardt noted the Patient's past behaviours, including past inappropriate sexual activity and a history of lying, fibs and untruths. Dr. Gebhardt argued that the weaning of risperidone in February 2017 led to increased sexualized activity by the Patient and changes in his mood and behaviour. Dr. Gebhardt also pointed to the Patient's mother's contemporaneous note made on June 6, 2017 where it is stated that the Patient doesn't know if he is lying or telling the truth.

[262] The Hearing Tribunal carefully considered whether the evidence supported that the Patient was lying, blending memories or fabricating events based on past experiences.

[263] The Hearing Tribunal also considered the evidence of the Patient's mother and the Care Worker. While they were not present during the examination of June 6, 2017, they have intimate knowledge of the Patient, and the Patient reported the events to them following the examination. In addition, the Hearing Tribunal considered the notes made by the Patient's mother [Exhibit 2] and the Care Worker [Exhibit 3] and the notes from C.O.R.E. staff [Exhibit 1].

[264] The Hearing Tribunal also considered the evidence of Drs. MN, DH and TD who were called as expert witnesses.

<u>Testimony of the Patient's mother and the Care Worker and Exhibits 2 and 3</u>

[265] The Hearing Tribunal found both the Patient's mother, and the C.O.R.E. staff member with whom the Patient was living, to be credible and reliable witnesses. They provided information which assisted the Hearing Tribunal in understanding the Patient. In addition, they each made notes contemporaneous to the occurrence of events, in particular both prepared notes on June 6, 2017.

[266] While the Hearing Tribunal recognizes that the notes do not prove that the events occurred, they are evidence that a reporting by the Patient occurred immediately following the event (to the Care Worker) and later the same day (to the Patient's mother).

The Patient's Mother

[267] In testimony, the Patient's mother described her son's upbringing and events along his development path. She also described his ability to learn and to live on his own, ending in 2010 for safety reasons and leading to his residence with the Care Worker under C.O.R.E. staff supervision.

[268] The Patient's mother described her son as generally honest and socially engaging with limited ability to understand risk in relationships and thus in jeopardy of being taken advantage of. This opinion was reinforced by the C.O.R.E. staff notes which have multiple entries regarding the need for counselling to deal with interpersonal close relations, and risk from those approaching him for inappropriate contact in public. The Patient has been trained to report to his mother and those in his "bubble" (C.O.R.E. staff members, including the Care Worker) if he needs to talk to someone or needs help.

[269] The typical routine for the Patient appears to be close contact with his mother; they talk on the phone each day and he reports to her issues that arise. The Patient reported the event to his mother on June 6, 2017 and felt confused by what had occurred. The Patient's mother noted that a plan was made in response to the reporting by the Patient because she and the C.O.R.E. team wanted to "make sure that stories were not made up, stories didn't change, that everything was the same as the way he described to be true" [Transcript p 36, L 24-27] prior to reporting to the police. The event was reported to the police one week later.

[270] The Hearing Tribunal found the Patient's mother to be a credible and reliable witness and accepted her evidence. The Hearing Tribunal also placed weight on the notes made by the Patient's mother [Exhibit 2]. The notes document the time of the call between the Patient's mother and the Patient at 4:50 PM, which was shortly after the appointment, and detail what he reported to her. While the notes do not prove that the sexual conduct by Dr. Gebhardt occurred on June 6, 2017, the notes establish how the Patient described the appointment to the Patient's mother. The Patient's mother's notes indicate that the Patient "didn't know if in trouble but wanted to tell the truth" [Exhibit 2].

The Care Worker

[271] The Care Worker, as a C.O.R.E. employee who cared for the Patient, knows the Patient very well. The Patient lived with the Care Worker in her household for about ten years, starting in 2010, before moving to a house with on-site C.O.R.E. staff supervision.

[272] The Care Worker gave evidence of the reporting made to her by the Patient upon leaving the clinic appointment on June 6, 2017. The Patient said to the Care Worker that he didn't know who he should tell, her or his mom. Asked

by the Care Worker what he needed to tell, the Patient said Dr. Gebhardt had put his mouth on the Patient's penis and the Patient had put his mouth on Dr. Gebhardt's penis.

[273] The Care Worker's notes reflect her caution regarding the information, minimizing the discussion which, she testified, was to avoid influencing the Patient's report, and letting her superiors know there was an issue before contacting the Patient's mother. She was also witness to the Patient's call with his mother the evening of June 6, 2017. The Care Worker testified that she heard the Patient telling his mother the same information she was told by the Patient earlier. The Care Worker stated in her testimony that the Patient's mother is able to get to the bottom of things with the Patient.

[274] Following the reporting to the Care Worker, a formal process was initiated by the C.O.R.E. administration. The C.O.R.E. administrators together with the Patient's mother formulated a plan to determine if a call to Medicine Hat Police Service was in order. The Patient's repeated comments about the clinic visit were consistent as reported by C.O.R.E. staff. C.O.R.E. administration and the Patient's mother determined a complaint to Medicine Hat Police Service was indeed in order.

[275] The Care Worker also knew the history of visits to Dr. Gebhardt having accompanied the Patient on most of his 25 documented visits to the clinic. The Care Worker was often in the room unless requested to leave by the Patient, or if an intimate examination was planned (such as on June 6, 2017).

[276] The Hearing Tribunal found the Care Worker to be a credible and reliable witness and accepted her evidence. The Hearing Tribunal also placed weight on the notes made by the Care Worker [Exhibit 3] at the time of the reporting, which assist in confirming the report made to the Care Worker by the Patient and the steps that followed the report by the Patient. As with Exhibit 2, Exhibit 3 does not prove what occurred in the clinic room on June 6, 2017, but is evidence of the spontaneous reporting made by the Patient and the repeated reporting thereafter.

<u>Exhibit 1, Notes from C.O.R.E. Staff</u>

[277] The notes of C.O.R.E. staff [Exhibit 1, Tab 11] were carefully reviewed and considered by the Hearing Tribunal.

[278] The C.O.R.E. notes are detailed and include information about the Patient's daily routines, accomplishments, and incidents such as inappropriate behaviours and influences of others. The Hearing Tribunal found the information helpful in creating an impression of the Patient as a 25-year-old male in June of 2017 of developmental age around nine to 14 years.

[279] There are notes that refer to explorations around the Patient's body and that of others. There were examples of self-exploration behaviour, including masturbation. There were also examples of sexualized behaviours with others including interactions in the mall, the bowling alley, and private homes, including the Patient's bedroom. The Hearing Tribunal viewed this as conduct typical of a pre-teen male.

[280] A review of the history of incidents, such as admitting a stranger into his apartment around age 18, demonstrates that the Patient is a vulnerable individual. The notes show the need for counsel and direction to the Patient to avoid trouble. Techniques such as red light, green light to assess relationships have been taught and reinforced [Exhibit 1, Tab 11, p 166, 200 and 202]. The C.O.R.E. staff notes support that the Patient can tell the difference between healthy and unhealthy relationships. [Exhibit 1, Tab 11, p 166]

[281] From reviewing the notes and testimony, the Hearing Tribunal determined that there were no described incidents of oral sex or sexual intercourse. In addition, there was no evidence to support predatory behaviours by the Patient.

[282] The Hearing Tribunal found that the nature of the allegation made against Dr. Gebhardt is unique in the history of the Patient.

Behaviours Following the Discontinuance of Risperidone

[283] The Hearing Tribunal considered the notes regarding the Patient's behaviour following discontinuation of the drug risperidone in February 2017. These paint a picture of a fellow more prone to acting out, more irritable, and sometimes violent (door slamming and harm to the Care Worker's arm in July 2017).

[284] While there was a suggestion that the behaviours may have reflected a traumatic incident, the Hearing Tribunal placed little weight on this theory because the behaviours started prior to the June 6, 2017 clinic visit.

[285] In addition, Dr. Gebhardt argued that there was an increase in sexualized behaviour following the weaning of the risperidone. While there were incidents of sexualized behaviour noted in the record in 2017, there were also incidents prior to 2017. As such, the Hearing Tribunal placed little weight on this argument.

Expert Reports and Testimony of Dr. MN, Dr. DH, and Dr. TD

[286] The reports and testimony of qualified experts informed the Hearing Tribunal of the nature of the ASD diagnosis of the Patient and whether there is a tendency to blend past experiences.

[287] However, the Hearing Tribunal was mindful that none of the experts was able to give evidence on whether the Patient was telling the truth. The Hearing Tribunal understood that the assessment of credibility and reliability of the Patient's evidence is for the Hearing Tribunal alone to determine. The Hearing Tribunal considered the expert reports and testimony of Dr. MN, Dr. DH and Dr. TD. The evidence of these witnesses assisted the Hearing Tribunal in understanding someone with the Patient's developmental disabilities.

[288] The developmental delay of the Patient documented in 2001 by Dr. P estimated the Patient would reach a functional age of about 11 years, give or take two years and no matter how long he lived. The Patient's IQ level in 2001 was estimated to be in the 0.1 percent range meaning of a thousand people, 999 have a higher ability to function.

[289] The Hearing Tribunal considered the argument raised that the Patient has not been re-assessed since the 2001 assessment by Dr. P. Dr. MN and Dr. DH testified that a re-assessment would be unlikely to cast new light on the abilities of the Patient because IQ changes little with age and the Patient's level of development will likely remain so for life. The Hearing Tribunal considered the advantage of an update of the assessment but found this would have provided only a limited benefit to the process of the Hearing Tribunal.

[290] The explanations in testimony and the reports offered by Drs. MN, DH, and TD outlined the characteristics of ASD and described the variations inherent in populations of people with that diagnosis. The Hearing Tribunal considered and accepted the statements of the experts as sufficient for the purpose of understanding the characteristics of an individual such as the Patient.

[291] In addition to developmental delay, individuals diagnosed with ASD have certain characteristics such as egocentric world view and inability to formulate more complex memories than individual snapshots of experience. As noted by Dr. DH, it is like the individual is taking a picture or video of what is happening with a focus on objects or people [Transcript p 226, L 26 to p 227, L 3]. This characterization helped the Hearing Tribunal understand the Patient's egocentric approach to life which channels all events through his own outlook. As noted by Dr. DH and Dr. MN, the "'egocentric' tendency means that he believes he is often to blame in problem social situations." [Exhibit 1, Tab 13, p 280]. The Hearing Tribunal found this explanation consistent with why the Patient asked his mother if he was in trouble on June 6, 2017.

[292] Under cross-examination, Dr. DH suggested that blending of experiences is unlikely to happen because of the nature of the discreet memories that ASD individuals tend to have. Dr. TD testified that everyone has the ability to create false memories. The Hearing Tribunal accepted Dr. TD's evidence that

all populations, despite diagnosis, are made up of people with varied abilities to create false memories and tell lies. [Transcript p 434, L 2-3]

[293] However, the Hearing Tribunal considered whether the reporting of the incident by the Patient on June 6, 2017, was a blending of prior experiences. The Hearing Tribunal found there was no evidence to support that this was the case. There was no evidence in the records or witness testimony of the Patient blending other memories. Furthermore, there is no evidence that the Patient had experiences of the nature described on June 6, 2017 that could be blended.

<u>Hearing Tribunal Findings Regarding the Credibility of the Patient</u>

[294] The Hearing Tribunal found that the Patient can distinguish between the truth and a lie. For the reasons set out below, the Hearing Tribunal concluded that the Patient has the ability to perceive, remember and communicate. When the Hearing Tribunal looked at the Patient's testimony as a whole, it found that the Patient's statements formed a believable report. The Patient's testimony regarding the events of June 6, 2017 can be relied on, though the testimony was given in the manner of an ASD individual.

Evidence of the Patient

[295] Mr. Boyer showed the Patient a photograph of the clinic room and the Patient confirmed the clinic room was in the doctor's office and that he had been in the room with Dr. Gebhardt. The Patient testified that Dr. Gebhardt was doing a physical on him.

[296] The Patient was asked what happened in the examination. The Patient confirmed that Dr. Gebhardt touched his stomach. The Patient testified that Dr. Gebhardt touched the Patient's penis and his "butt crack". The Patient testified that Dr. Gebhardt was checking to see if there were any lumps or anything on his penis. The evidence of the Patient was that Dr. Gebhardt asked the Patient to touch Dr. Gebhardt's penis and that the Patient touched Dr. Gebhardt's penis. The Patient also testified that Dr. Gebhardt put his mouth on the Patient's penis and the Patient put his mouth on Dr. Gebhardt's penis.

[297] In addition, the Patient testified that Dr. Gebhardt was making his penis "feel good" and was making the "white stuff" come out. The Hearing Tribunal found that the Patient was describing that Dr. Gebhardt touched the Patient's penis and made the Patient ejaculate.

[298] The Patient testified that Dr. Gebhardt wanted the Patient to keep a promise with him. In the Patient's words "Dr. Gebhardt was saying to keep a promise because he wants to – I don't really know the name of it. He just wants me to keep it between me and -- me and him" [Transcript p 333, L 15-17].

[299] Under cross-examination, Mr. Rudakoff suggested to the Patient that he was lying. The Patient answered "yes" to several questions by Mr. Rudakoff asking him if he was lying. However, in redirect, the Patient stated that he did not think he had been lying in what he described to Mr. Boyer.

Making a Promise

[300] In his testimony, the Patient said that he did not want to make a promise with Dr. Gebhardt [Transcript, p 322, L 25-26]. This is consistent with his disclosure to the Care Worker immediately following the visit and to his mother later that day. This is also consistent with the Patient's mother's notes [Exhibit 2] and testimony, that the Patient did not know if he was in trouble but wanted to tell the truth.

Arguments re Fibs, Lies and Untruths

[301] The Hearing Tribunal considered Mr. Rudakoff's argument that the Patient tells fibs, lies and untruths. The Hearing Tribunal also considered the likelihood that the Patient fabricated his report to the Care Worker upon on leaving the clinic.

[302] In the reports of C.O.R.E., there are examples of the Patient telling lies, but this appears to be in a situation where he is answering falsely to avoid getting into trouble. The Hearing Tribunal considered the evidence about lies, fibs and untruths brought forward by Dr. Gebhardt, regarding instances of missing fruit or vegetables later found in the Patient's room, using the debit card without permission, spending his incentive pay, denying kissing a female, stories when he was late for bowling or outside the bowling alley, and hanging out with C. at the mall.

[303] The Hearing Tribunal found that there was no parallel between the reported instances of lies and the allegation in this case. The documented notes show support that these are instances of simple lies. The allegations in this case are complex and have been repeated by the Patient many times, over several years.

[304] The Hearing Tribunal rejected the suggestion that because the C.O.R.E. notes document instances of fibs or untruths, this is sufficient for the Hearing Tribunal to conclude that the Patient was lying about or fabricating the June 6, 2017 incident.

Arguments re Blended Memories

[305] The Hearing Tribunal considered whether the Patient had blended memories. There was no evidence in the record or testimony that the Patient had a history of blending memories. Furthermore, there is no evidence that the Patient had experiences of the nature described on June 6, 2017 that could be blended.

[306] The Hearing Tribunal placed weight on the documentation regarding the behaviours and attitudes of the Patient. A large part of Exhibit 1 is dedicated to the notes of C.O.R.E. staff including day-to-day, specific events, and periodic reviews. These notes were very helpful. They allowed the Hearing Tribunal to see several years of behaviours of the Patient particularly relative to his developmental age of 9 to 14 years. Also, the Hearing Tribunal considered the number of visits to Dr. Gebhardt's clinic in the past ten years and the fact that no reports similar to that of June 6, 2017 have been documented. The June 6, 2017 visit was an unusual event.

[307] The Hearing Tribunal considered the immediate and unprompted reporting by the Patient to the Care Worker following the appointment of June 6, 2017, which he also reported to his mother the same day and to his grandmother. There has been a consistency in the Patient's reporting since June 6, 2017, including the Patient's evidence in the criminal trial and in this hearing.

[308] The Hearing Tribunal considered the note made by the Patient's mother that the Patient "doesn't know if telling truth or lying – so confused" [Exhibit 2]. The Hearing Tribunal considered the evidence of Dr. DH that the Patient has learned a set of social rules that guide his behaviour and decisions. [Transcript p 238 L 5-7] This is consistent with the red light and green light teaching from C.O.R.E. staff in terms of the Patient's interactions with others. The Hearing Tribunal found the Patient would be confused if a green light person, such as a doctor, asked him to keep a promise when he had been trained to disclose.

Manner of Questioning

[309] Dr. Gebhardt suggested the Patient was an unreliable witness because he has been assessed to have low IQ, ASD and developmental delay. The Hearing Tribunal considered the expert evidence, in particular that of Dr. DH, in determining if an ASD individual could provide reliable testimony. Dr. DH noted the need to provide a reference, such as a geographic location, when asking a question. [Exhibit 1, Tab 13, p 289] Dr. DH also said that if questions are asked in a concrete style, there would be less chance of confusion for the ASD person. This method of questioning was used by Mr. Boyer, who oriented the Patient by providing a photograph of the clinic room. The Patient then went on to describe what happened in the room.

[310] Dr. DH further noted that: "Yes or no questions will not necessarily provide accurate information especially if they use phrases like, 'Do you agree that…', or if they contain abstract words. He will agree with the statement to please the listener." [Exhibit 1, Tab 13, p 289] The Hearing Tribunal considered the pattern of answers by the Patient in cross-examination. The Patient agreed with Mr. Rudakoff during cross-examination to questions that elicited a yes response, such as asking the Patient to agree that he was lying in response to various questions.

[311] Dr. TD did not provide evidence or challenge Dr. DH's suggestion for how to question an ASD witness. The Hearing Tribunal placed significant weight on the testimony obtained in direct examination by Mr. Boyer, counsel for the Complaints Director, which used a method of questioning in line with advice from Dr. DH. The Hearing Tribunal dismissed the Patient's evidence in cross-examination based on the manner in which the questions were posed. In fact, Mr. Rudakoff predicted this pattern of responses, which was similar to the Patient's testimony in cross-examination in the criminal trial.

[312] The Hearing Tribunal also considered the transcript from the criminal trial. The Hearing Tribunal noted that the testimony given by the Patient in direct examination in the hearing, was similar to his testimony in the criminal trial, including the specific nature of the allegations that Dr. Gebhardt placed the Patient's hand on his penis and that the Patient put his mouth on Dr. Gebhardt's penis. In addition, the evidence given in cross-examination by defense counsel at the criminal and in cross-examination in this hearing was very similar. Both lawyers asked questions in a similar manner that elicited "yes" responses from the Patient.

[313] The Hearing Tribunal placed significant weight on the immediate and unprompted reporting by the Patient to the Care Worker and to the Patient's mother on June 6, 2017 and the evidence that he reported to his grandmother. Based on the immediate reporting, the Hearing Tribunal did not find that there were issues regarding the Patient's memory. In addition, there has been a consistency in how the Patient describes the events that occurred on June 6, 2017, including at the criminal trial and in the hearing.

Examination on June 6, 2017

[314] The Hearing Tribunal considered that the Patient and Dr. Gebhardt's evidence about the examination of June 6, 2017, is to some extent consistent. Both describe some aspects of a normal physical examination.

[315] The Hearing Tribunal also carefully reviewed the transcript of the evidence given by the Patient during the criminal trial and the testimony of the Patient in this hearing. The Hearing Tribunal considered the manner in which the Patient reported to his mother and the Care Worker.

[316] The Patient described the examination. The Patient stated that Dr. Gebhardt put his hands on his chest and his stomach. The Patient testified that Dr. Gebhardt asked him if he felt pain in his chest and stomach and the Patient said no. The Patient described touching his legs and feet and was asked if he had any pains in his legs and feet. The Patient described that Dr. Gebhardt touched him on his "butt". This is consistent with Dr. Gebhardt's description of the examination.

[317] The Patient told the Care Worker that Dr. Gebhardt touched his stomach and his "butt crack". He confirmed this in his testimony. This confirms the palpation of the stomach and DRE described by Dr. Gebhardt.

[318] The Patient and Dr. Gebhardt described that Dr. Gebhardt was wearing gloves, and that there was gel on the gloves. The Hearing Tribunal noted that there was a discrepancy in the colour of the gloves. The Patient described wearing an "apron", which the Hearing Tribunal found would be either the gown or the drape. Dr. Gebhardt testified that the Patient was wearing a gown and was covered by a drape.

[319] Both describe that the Patient was still wearing his underwear and that Dr. Gebhardt moved the underwear during the DRE. There was also consistency in how the Patient and Dr. Gebhardt described the Patient's positioning on the bed, in general, that he was lying down or supine.

[320] This confirmed for the Hearing Tribunal that despite the Patient's developmental status, the Patient had an ability to perceive, had a good memory of the examination, and was able to describe what occurred on June 6, 2017.

[321] The degree of overlap in describing a standard physical examination was seen by the Hearing Tribunal as a significant support for the testimony of the Patient, recognizing that Dr. Gebhardt is trained in examination protocol and the Patient's description significantly overlapped the protocol.

Hearing Tribunal Findings Regarding the Credibility of Dr. Gebhardt

[322] Dr. Gebhardt's testimony was carefully reviewed by the Hearing Tribunal. The Hearing Tribunal considered the credibility and reliability of Dr. Gebhardt's evidence. Dr. Gebhardt testified that the examination on June 6, 2017 was a routine examination. For the reasons that follow, the Hearing Tribunal found that Dr. Gebhardt's testimony lacked credibility regarding the examination of the Patient on June 6, 2017.

[323] Dr. Gebhardt described his practice as a typical community practice. He described his take-over of the practice as initially oriented to complex patients but as time passed he accepted more families, including young, healthy people and more male patients from the local industrial work force.

[324] The Hearing Tribunal concluded that Dr. Gebhardt was experienced working with adult males requiring a medical assessment. While the Patient is an adult male, he is not a typical adult male patient as he is an ASD patient with a developmental age of nine to 14 years. The Hearing Tribunal concluded that the Patient was a vulnerable disabled patient.

Visits with the Patient

[325] The nature of the visits with Dr. Gebhardt were mostly for simple interventions, such as wart treatments, but the C.O.R.E. staff at times asked Dr. Gebhardt to discuss other issues with the Patient, such as issues related to his work and relationships. The Patient was also treated by Dr. B, psychiatrist, and received counselling from Family Services and training from C.O.R.E.

[326] The Hearing Tribunal found that in his testimony, Dr. Gebhardt downplayed the nature of the discussions and examinations with the Patient that involved the genital area or discussions of a sexual nature. These undermined Dr. Gebhardt's credibility.

[327] Dr. Gebhardt categorically denied touching the Patient's penis on June 6, 2017 [Transcript p 370, L 18-21]. However, Dr. Gebhardt did a testicular examination of the Patient who was lying supine on the examination table, wearing a gown and draped by a 2-by-4-foot drape cloth. Dr. Gebhardt described keeping the penis out of the testicular examination area by using the drape cloth and stated "I take that drape cloth and sort of put it sort of over the penile area" [Transcript p 408, L 24-25] and "you can sort of just move the cloth and just sort of, you know, get things moving with, you know --- sort of defying gravity." [Transcript p 409, L 2-6] The Hearing Tribunal found that some incidental contact with the penis was likely to occur during a testicular examination. In addition, Dr. Gebhardt's description involves touching the penis, albeit with the drape cloth. For these reasons, Dr. Gebhardt's categorical denial of any contact with the Patient's penis seemed implausible to the Hearing Tribunal.

[328] In addition to denying that he touched the Patient's penis on June 6, 2017, Dr. Gebhardt stated: "there's no real – there's no penis exam, right. What are you going to examine on a penis?" [Transcript p 383, L 5-8] However, there are examples in the chart notes of assessments involving the Patient's penis, including notes regarding erections and masturbation, as well as examinations of the genitalia. These are as follows: [Exhibit 1, Tab 4]:

a. July 13, 2011 Visit For: Complete Exam [p10]: "genitourinary" examination noting "no genital sores, abnormal discharge, venereal disease" [p 11]; "genitalia" examination [p 13]; and perineal examination documented "perineal candida" [p 13];

b. September 1, 2011 Visit For: wart [p 13]: "mild exczema [sic] to scrotum – moisturizer prn" [p 14];

c. July 19, 2012 Visit For: Complete Exam [p 14]: "genitourinary" examination noting "no genital sores, abnormal discharge, venereal disease" [p 15]; "genitalia" examination [p 17];

d. October 11, 2012 Visit For: Swelling in groin area [p 17]: chart notes state: "RT sided groin lump RT testes/Palpable ? defect spigelian line/ Ultrasound: Abdominal wall" [p 17];

e. April 18, 2013 Visit For: plantars wart [p 17]: chart notes indicate: "irritation on scrotum. Use already Rx'd cream" [p 18];

f. October 21, 2013 Visit For: Office Visit GP [p 18]: "privately [the Patient] discussed persistent itch penis scrotum and perianal area. Looks normal." [p 18];

g. November 25, 2014 Visit For: Complete Exam [p 18]: "genitourinary" examination noting "no genital sores, abnormal discharge, venereal disease" [p 20]; "genitalia" examination [p 21]; and DRE examination [p 21] (which note appears to be an error based on Dr. Gebhardt's testimony); and added notation "No concerns" [p 21];

h. August 8, 2016 Visit For: Office Visit GP [p 24]: "Erection painful x1. Not painful since. No genital anomaly seen." [p 24];

i. June 6, 2017 Visit For: Complete Exam [p 24]; genitourinary" examination noting "no genital sores, abnormal discharge, venereal disease" [p 25]; "genitalia" examination [p 27]; and DRE examination [p 27].

[329] The Hearing Tribunal considered that Dr. Gebhardt uses a drop-down menu, which is relevant to the genitourinary and genitalia chart entries. Dr. Gebhardt testified "basically it's sort of a copy and paste, and then I delete out what I don't do." [Transcript p 378, L 17-20] Dr. Gebhardt testified that the chart notation for the DRE examination on November 25, 2014 was an error [Transcript p 379, L 7], but did not deny any of the other examinations and so the Hearing Tribunal is left to conclude that genitourinary and genital examinations occurred as noted in the chart.

[330] In addition, in response to a question by the Hearing Tribunal about Dr. Gebhardt's typical approach to genital examinations in male patients, Dr. Gebhardt summarized his usual approach to male genital examinations. He testified: "No, I wouldn't -- I wouldn't do that. At that time I offered it as an option for people between the ages of 15 and 35. But I would say it's controversial whether you do it. You know, more or less if you're doing it, I don't have to. If you're not doing it, I can optionally do it. But with [the Patient], because of his cognitive disability, I always did it. Just because I would assume his care workers wouldn't do it. And I also just assumed that he wouldn't do it." [Transcript p 392 L 23-27 and p 393, L 1-5]. Dr. Gebhardt stated the genital examination was done just during the complex medical examination.

[331] Dr. Gebhardt's evidence was that he had limited conversations with the Patient about the Patient's sexuality or sexual interests. There are examples

of discussions with the Patient around sexuality or sexual interests. These are as follows: [Exhibit 1, Tab 4]:

a. September 8, 2010 Visit For: NP Office Visit [p 9]: "Sexual History, [the Patient] is not sexually active" [p 9];

b. July 13, 2011 Visit For: Complete Exam [p 10]: the chart states: "PDD Some sexualization but not grabbing or exposing in public" [p 12];

c. April 18, 2013 Visit For: plantars wart [p 17]: "Wanted to talk about 'feelings' in groin area. Worker thought perhaps about erections." [p 18];

d. October 21, 2013 Visit For: Office Visit GP [p 18]: "masturbating with fruit by himself in his room. Likes the 'pressure'. Discussed playing with his young cousins at Grandma's house. Does not appear to be a concern for exploitation there but all parties are aware. Privately [the Patient] discussed persistent itch penis scrotum and perianal area. Looks normal." [p 18];

e. August 8, 2016 Visit For: Office VisitGP [p 24]: "Discussed seeing males top of buttock crease on some clothes when they sit. Reassured that eyes being drawn to that is not abnormal."

f. June 6, 2017 Visit For: Complete Exam [p 24]; "Still preoccupied with masturbation and friend [E]. Possibly budding romance with him. Denies sexual activity but they lie on each other." [p 26].

[332] In addition, the Care Worker testified that in one of the first meetings they had with Dr. Gebhardt he said "you know, this is a safe place, if you need to talk, you can come to me and talk to me anytime. We can talk in private." [Transcript p 68, L 21-27].

[333] The Hearing Tribunal found that Dr. Gebhardt downplayed the nature of the issues around sexuality and the examinations involving the penis or genitalia he addressed with the Patient. The Hearing Tribunal found that this undermined Dr. Gebhardt's credibility.

[334] Dr. Gebhardt also stated that the Patient did not know the difference between his body parts and that it "was just recently he was able to have any understanding that it's beyond down there. I mean, down there could refer to testicles, penis, groin, anal area, anything." [Transcript p 383, L 18-21] However, this did not reconcile with the Patient's evidence where he clearly described his penis in his testimony when he described the "white stuff" coming out. This was also directly contradicted by the notes taken by the Care Worker and the Patient's mother on June 6, 2017 [Exhibits 2 and 3] where the Patient reported that Dr. Gebhardt touched his penis and placed his mouth on the Patient's penis. Finally, the Patient described his rectum and the DRE when he referred to Dr. Gebhardt touching his "butt crack". The Hearing Tribunal again found that this undermined Dr. Gebhardt's credibility.

Lack of Chaperone

[335] Dr. Gebhardt testified about the use of chaperones in examinations. He acknowledged he has a chaperone present in certain situations involving female patients, such as a pap test, whether or not the patient is disabled. Dr. Gebhardt also noted that for a child patient, the parent would be in the room. A chaperone or parent is present in such circumstances given the vulnerability of the patient or sensitive nature of the examination. The Hearing Tribunal was particularly concerned that Dr. Gebhardt carried out a sensitive examination on a developmentally delayed adult without a chaperone present in the room.

[336] Dr. Gebhardt stated: "I had some disabled patients that wanted people in the room and some who didn't. And it was totally up to them. Yeah, I was fine either way." [Transcript p 362, L 2-4] In response to a question from the Hearing Tribunal about whether he had considered the need for a chaperone when examining the Patient, Dr. Gebhardt testified that when he first saw the Patient, the Patient was about 20 years old and the Patient asked for people to leave. Dr. Gebhardt stated he was caught a bit off guard but then "just sort of went with it" and that "I don't really have a reason not to, and he's an adult." [Transcript p 399, L 16-21] Dr. Gebhardt went on to testify that he looked for recommendations or guidance from the CPSA or from other jurisdictions but found no specific guidance. He noted that "the exams were always fine, so keep – keep on doing the same thing." [Transcript p 400, L 8-9]

[337] Dr. Gebhardt noted that the Patient did not want to have his caregivers in the room during the examination, for privacy and because he liked to complain about his caregivers. However, Dr. Gebhardt acknowledged the Patient was vulnerable, and stated "usually I don't like asking things because the Patient is so suggestible." [Transcript p 363, L 4-5] Dr. Gebhardt also acknowledged the Patient's developmental delay where he testified that he did genital examinations on the Patient since he assumed the Patient would not do it "because of his cognitive disability." [Transcript p 393, L 2-5]

[338] The Hearing Tribunal was left to question why given the Patient's development age of nine to 14 years and Dr. Gebhardt's acknowledgement of the Patient's disability, Dr. Gebhardt did not insist on having a chaperone in the room, whether it was one of the Patient's caregivers or a medical office assistant. The Hearing Tribunal found that Dr. Gebhardt was aware of the Patient's disability and suggestibility and chose to perform sensitive medical examinations, including a DRE and testicular examinations, with no chaperone in the room, leaving the Patient vulnerable. This again undermined Dr. Gebhardt's credibility.

Evidence about the June 6, 2017 appointment and Chart Notes

[339] The Hearing Tribunal considered the evidence given by Dr. Gebhardt about the examination on June 6, 2017. In response to a question from the Hearing Tribunal, Dr. Gebhardt described the examination of June 6, 2017 in step-by-step detail.

[340] The Hearing Tribunal reviewed the notes for the June 6, 2017 examination. [Exhibit 1, Tab 4, p 25-27] Dr. Gebhardt uses a drop-down menu in the Electronic Medical Record ("**EMR**") and stated: "my notes are basically templated, which I know you're not really supposed to do. But basically it's sort of a copy and paste, and then I delete out what I don't do." [Transcript p 378, L 17-20] The Hearing Tribunal reviewed the EMR notes and found Dr. Gebhardt's use of the drop-down menu in the EMR notes without added details to be of limited value in determining what happened during the examination. The Hearing Tribunal had difficulty matching what was in the chart notes to Dr. Gebhardt's testimony. The lack of information charted by Dr. Gebhardt (aside from the drop-down menu that was not generally modified) was a challenge for the Hearing Tribunal and undermined Dr. Gebhardt's credibility.

[341] Dr. Gebhardt described his process of making "scratch notes" consisting of sentence fragments in the electronic chart during a visit to refer to later on when he completes his charting. [Transcript p 355 and 375] The Hearing Tribunal found Dr. Gebhardt's notes to lack detail and in fact, Dr. Gebhardt acknowledged that his notes for a visit on August 8, 2016 were not great. [Transcript p 401] The Hearing Tribunal concluded the following are the notes generated by Dr. Gebhardt for the June 6, 2017 appointment that are not from the EMR drop-down menu: [Exhibit 1, Tab 4, p 26]

> "Still preoccupied with masturbation and friend [E].
> Possibly budding romance with him. Denies sexual activity but they lie on each other.
> Discussed using cell phone at work, getting int rouble [sic] and distracted.
> Recommended only use during breaks of [sic] keep at home.
> Was taken off work for a month. No foreseeable problem with working at CORE again.
> Dr. B trying patient off meds and on vitamins.
> Has lost weight off risperidone.
> Exercising once weekly.
> Check for diabetes."
>
> And at Exhibit 1, page 27:
>
> "physician unwell during exam. Best possible recollection
> No red flags for neoplastic disease.
> Check for DM
> Weight loss likely due to stopping risperidone."

[342] The Hearing Tribunal also reviewed the computer audit showing timing of the computer entries on June 6 and 7, 2017. [Exhibit 1, Tab 9, p 132–151] The record establishes that the Patient had his blood pressure measured at 2:33 PM. [Exhibit 1, Tab 9, p 137-138] Entries were made in the computer at 3:20 PM and 3:43 PM which the Hearing Tribunal assumed to be the computer in the clinic room (00224134A815). [Exhibit 1, Tab 9, p 139-140] This helped to substantiate the timing of the visit as described by both the Care Worker and Dr. Gebhardt. There is an additional entry on June 6, 2017 at 4:41 PM from a different computer (90B11C85C33A). [Exhibit 1, Tab 9, p 140] It was not clear if Dr. Gebhardt modified the chart notes at that time or if he waited until June 7, 2017 at 5:33 PM when he signed off on the entry. [Exhibit 1, Tab 4, p 24 and Tab 9, p 141]

[343] Dr. Gebhardt provided detailed evidence about the examination. He stated that he wrote a narrative of the appointment when the police came to his office, weeks later. However, the notes created by Dr. Gebhardt after he was contacted by police are not in evidence and so the level of detail Dr. Gebhardt claims to have from those notes cannot be independently verified. There is a fulsome note by Dr. Gebhardt in the record which is Dr. Gebhardt's letter to the Complaints Director dated January 25, 2019 but this was written almost a year and a half after the events. [Exhibit 1, Tab 7]

[344] The Hearing Tribunal also considered the notation in the chart notes for June 6, 2017 that "physician unwell during exam. Best possible recollection". Given this notation, it appears unlikely that Dr. Gebhardt would have a detailed recollection weeks later, let alone years later at the time of the hearing, of an uneventful physical examination. In addition, in his busy practice, Dr. Gebhardt would have seen dozens or possibly hundreds of patients between June 6, 2017 and the time he was contacted by police. These factors were taken into account by the Hearing Tribunal in assessing Dr. Gebhardt's credibility.

[345] Further, Dr. Gebhardt testified he was unfamiliar with the C.O.R.E. workers' names and did not recognize the Care Worker as at the June 6, 2017 appointment, even though the Care Worker testified she had been in the room with Dr. Gebhardt and the Patient that day and had accompanied the Patient to multiple appointments. The Hearing Tribunal found this difficult to reconcile with Dr. Gebhardt's ability to recount specific particulars of the examination. This further undermined Dr. Gebhardt's detailed testimony about the appointment of June 6, 2017.

[346] For these reasons, the Hearing Tribunal found it implausible for Dr. Gebhardt to have a detailed recall of an uneventful examination of the Patient on June 6, 2017 and placed limited weight on Dr. Gebhardt testimony about the events of June 6, 2017.

Not an Uneventful Examination

[347] Dr. Gebhardt stated that June 6, 2017 was a routine, busy day. He described the visit with the Patient that day as "routine and normal and uneventful." [Transcript p 371, L 27] Despite Dr. Gebhardt's evidence that the examination was an uneventful examination, the patient chart notes support a conclusion that something unusual happened in that room that day.

[348] Dr. Gebhardt stated that the room was hot and he felt unwell. Dr. Gebhardt noted in the patient record "physician unwell during exam. Best possible recollection." [Exhibit 1, Tab 4, p 27]

[349] Dr. Gebhardt left the clinic room and went to get water and was "just sort of watching the room. And he [the Patient] didn't come out after a couple of minutes." [Transcript p 368, L 11-12] Dr. Gebhardt returned into the clinic room, found the Patient sitting in the chair and then walked the Patient out to the waiting room where the Care Worker was waiting for him. Dr. Gebhardt stated that his usual practice was to leave the clinic room and move on to the next patient. [Transcript p 389, L 8] Dr. Gebhardt also testified that generally, the Patient would leave the clinic room on his own. [Transcript p 390, L 21-22] Finally, Dr. Gebhardt acknowledged that he is usually running about an hour behind on his patient appointments. He noted that June 6, 2017 was particularly busy because he had a full day and evening walk-ins. [Transcript p 346, L 18-24] He stated that he probably saw a total of 40 patients between 9 AM and 5 PM and that he had another 12 patients to see after the Patient left, and prior to starting the evening walk-in clinic. [Transcript p 382, L 7-9 and p 391, L 23-25]

[350] The fact that a busy Dr. Gebhardt who did not feel well, who was running about an hour behind schedule, had 12 patients left to see before starting the evening walk-in clinic, monitored the clinic room door, went back to get the Patient and escorted him to the waiting room supports that something unusual happened in the clinic room. The Hearing Tribunal concluded that something unusual happened and that Dr. Gebhardt's statement that this was an uneventful visit was not supported by the evidence. For this reason, the Hearing Tribunal placed limited weight on Dr. Gebhardt's evidence.

Conclusion

[351] In considering the test set out in *Faryna v Chorny*, the Hearing Tribunal considered the testimony of both the Patient and Dr. Gebhardt, and its "harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions." (*Faryna*, para. 11)

[352] For all of the reasons noted above, the Hearing Tribunal preferred the evidence of the Patient to that of Dr. Gebhardt. The Hearing Tribunal finds that Allegation 1 is proven on a balance of probabilities.

[353] The Hearing Tribunal recognized that testimony by people with challenges to their ability needs to be tailored to support their delivery of testimony, not disregarded because it is not mainstream. In this way the voice of a challenged witness can be heard and the decision-maker can then decide if the information is reliable. A parallel can be found in the history of criminal sexual assault testimony in which the word of the victim was challenged on the basis of their own history.

<u>Unprofessional Conduct</u>

[354] The Hearing Tribunal found that the proven conduct constitutes unprofessional conduct under section 1(1)(pp)(ii) and (xii) of the HPA.

[355] The Hearing Tribunal determined that the conduct is a breach of the Standard of Practice: Sexual Boundary Violations (January 1, 2010) [Exhibit 1, Tab 18], which was the Standard of Practice in place at the time of the conduct (2017). Dr. Gebhardt breached the following provisions from the Standard of Practice: Sexual Boundary Violations:

(1) A physician must maintain professional boundaries in any interaction with a patient and must not sexualize any interaction with a patient through conduct including, but not limited to, the following:

(j) making physician-patient sexual contact.

(2) Subsection (1) … is focused on the sexualization of physical contact with the patient…

(3) A physician must not:

(a) Initiate any form of sexual advance toward a patient …

[356] The proven conduct is an egregious breach of the Standards of Practice and constitutes unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA. The HPA grants the medical profession in Alberta the privilege of self-governance based on the expectation that members will practice in accordance with the Standards of Practice set by the CPSA.

[357] The Hearing Tribunal also finds that the conduct harms the integrity of the profession and constitutes unprofessional conduct pursuant to section 1(1)(pp)(xii) of the HPA. The nature of the breach, being sexual abuse of a vulnerable disabled patient, clearly harms the integrity of the profession of medicine. The conduct undermines the public's confidence in the profession. Patient trust and the public interest are severely undermined where a physician takes advantage of a patient for their own selfish interests.

[358] The egregious breaches in this case constitute an abuse of the trust placed by the public and by patients in physicians. Dr. Gebhardt exploited his role as a trusted health professional and abused a vulnerable disabled adult who was

sexually suggestible. This is an aggravating factor. This behaviour is intolerable to the profession and the public and is extremely serious.

CONCLUSION

[359] The Hearing Tribunal finds Allegation 1 (a) to (e) proven on a balance of probabilities and that the conduct constitutes unprofessional conduct under the HPA. The Hearing Tribunal will now receive submissions on sanction from the parties on any orders to be made by the Hearing Tribunal under section 82 of the HPA.

[360] The Hearing Tribunal requests that the parties consult each other with respect to the process for submissions and advise the Hearing Tribunal of the proposed procedure for submissions on sanction within 3 weeks of receipt of this decision. If the parties are unable to agree on the process for submissions, the Hearing Tribunal will provide further direction.

[361] Section 80(2) of the HPA provides that:

> 80(2) If the hearing tribunal is of the opinion that there are reasonable and probable grounds to believe that the investigated person has committed a criminal offence, the hearing tribunal must direct the hearings director to send a copy of the written decision under section 83 to the Minister of Justice and on the request of the Minister of Justice also send a copy of the record of the hearing.

[362] The parties are asked to address if section 80(2) of the HPA applies given that this matter was originally reported to the police, resulting in a criminal trial and a stay of the charges.

Signed on behalf of the Hearing Tribunal by the Chair:

Dr. Randall Sargent

Dated this 27th day of June, 2023.