COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

("THE COLLEGE")

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. PHU VU

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

August 29, 2022

INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Phu Vu on March 16-17, 2022 and May 9, 2022. The members of the Hearing Tribunal were:

   Dr. Douglas Faulder, Chair;
   Dr. Eric Wasylenko;
   Ms. June MacGregor (public member);
   Ms. Archana Chaudhary (public member).

2. Ms. Katrina Haymond acted as independent legal counsel to the Hearing Tribunal.

3. The following persons were also in attendance:

   Mr. Craig Boyer, legal counsel for the Complaints Director;
   Dr. Phu Vu, investigated person;
   Ms. Megan McMahon and Ms. Anika Winn, legal counsel for Dr. Vu.

PRELIMINARY MATTERS

4. There were no objections to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing, and there were no other preliminary matters raised at the outset of the hearing.

5. Ms. McMahon indicated she would be making an application to close part of the hearing with respect to one of the witnesses called on behalf of Dr. Vu, however she indicated she would proceed with that application when she called that witness to testify.

OPENING STATEMENT ON BEHALF OF THE COMPLAINTS DIRECTOR

6. Mr. Boyer made a brief opening statement. He indicated that the allegations against Dr. Vu relate to two female patients and the manner of an examination or physical touching that occurred on November 1, 2017 and February 4, 2020. Mr. Boyer indicated that the significance of the dates is that the conduct that allegedly occurred in February of 2020 was governed by the new boundary violation Standard of Practice. The essential issue in the hearing was whether the conduct should be characterized as sexual abuse or something else.

7. Ms. McMahon indicated that she wished to defer the opening statement on behalf of Dr. Vu until the commencement of Dr. Vu's case.

ALLEGATIONS

8. The Notice of Hearing listed the following allegations:

   On November 1, 2017, during an examination of your patient, [redacted][1]., you did inappropriately provide commentary along with digital pressure inside the vagina to demonstrate to your patient the point of contact of a penis if the patient were having intercourse using different sexual positions when your patient had made no complaint about sexual difficulties and did not request advice from you on that subject.

   On February 4, 2020, during an examination of your patient, [redacted], you did inappropriately provide commentary along with digital pressure inside the vagina to demonstrate to your patient the point of contact of a penis if the patient were having intercourse using different sexual positions when your patient had made no complaint about sexual difficulties and did not request advice from you on that subject.

9. It was further alleged that the above conduct is contrary to the College of Physicians of Surgeons of Alberta Standards of Practice, including Boundary Violations: Personal Standard of Practice and/or Boundary Violations: Sexual Standard of Practice.

EVIDENCE

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

    Exhibit 1 Agreed Exhibit Book, Tabs 1-19;

    Exhibit 2 *Curriculum Vitae* of James Edward Bell;

    Exhibit 3 *Curriculum Vitae* of J. Thomas Dalby;

    Exhibit 4 Report of Dr. Thomas Dalby.

11. The following individuals were called as witnesses on behalf of the Complaints Director:

    [redacted];
    [redacted];
    Dr. James Edward Bell.

[1] The Notice of Hearing referred to the patients by their full names however patient names have been anonymized for the purposes of the Hearing Tribunal's decision.

12. The following individuals were called as witnesses on behalf of Dr. Vu:

    Dr. Vu;
    Dr. Thomas Dalby.

Summary of Witness Testimony of Witnesses Called on Behalf of the Complaints Director

13. Set out below is a summary of the testimony of each witness called on behalf of the Complaints Director.

[redacted]

14. [redacted] testified that she started seeing Dr. Vu as her physician in 2014 at the Brentwood Family Medical Clinic (the "Clinic"). In February of 2020, she attended with Dr. Vu for a cyst in her armpit. While she was there, she wanted a vaginal swab done to check for Sexually Transmitted Diseases (hereinafter referred to as "Sexually Transmitted Infections" or "STIs"). Although she was concerned about the cyst under her armpit, she had no other concerns or issues.

15. [redacted] stated that Dr. Vu asked her about her recent sexual encounters, and that while she was on the treatment table he asked if it was okay for the nurse to leave since the room was too small and a little cramped. He also asked her whether she had been in touch with [redacted], the patient who had initially referred her to see Dr. Vu. In retrospect these things ought to have been a red flag, however at the time she had no concerns as she trusted Dr. Vu.

16. When the vaginal exam proceeded, while he was doing the swabs, Dr. Vu began to ask [redacted] about her previous sexual encounters and dating relationships. He then did an internal examination and while moving his gloved hand told her "this is the position that the penis needs to be to have the most maximum pleasure of a woman of your size." [redacted] stated that she could not recall how many positions were demonstrated, and said that it could have been one, two or three, but there were probably a few different movements. [redacted] testified that she was frozen on the table and that she felt violated.

17. [redacted] confirmed that she was not having pain with intercourse when she came to see Dr. Vu in February of 2020. While she could not recall if Dr. Vu asked her if she was experiencing pain, she stated that if he had asked her, she would have said "no" because she was not experiencing pain with intercourse at the time.

18. She testified that she had seen Dr. Deborah Rotzinger, who headed women's wellness at the Clinic, on January 17, 2019, and on that occasion Dr. Rotzinger did not perform any digital demonstration regarding where the penis should be during intercourse.

19. After the appointment ended, [redacted] decided to report the incident to the Calgary Police Service (CPS). [redacted] testified that she did so because she felt it was inappropriate for Dr. Vu to have his hand inside of her while giving her sex advice that she didn't ask for and was not the reason for her visit. She felt incredibly violated by Dr. Vu, who was in a position of power and responsibility. Dr. Vu was not charged criminally with any offence.

20. [redacted] indicated that the incident had a significant emotional impact on her, and that it had a massive ripple effect on her life.

21. On cross-examination, [redacted] confirmed that she did not actually start seeing Dr. Vu until August 9, 2016. She also confirmed that in order to prepare for the hearing, she reviewed the Complaint she submitted to CPS (**Exhibit 1, Tabs 2 and 3, pp. 3-5)** (the "[redacted] Complaint") but had not reviewed any other documentation, and had not spoken to anyone about the matter other than Mr. Boyer and her therapist.

22. Ms. McMahon asked [redacted] about her previous attendances with Dr. Vu, including her attendance with him on September 6, 2018, when she was experiencing bleeding after she took Plan B. [redacted] did not recall the specific details of the prior visits, but agreed that on a subsequent visit on January 17, 2019, she reported that she was having pain with sexual intercourse when she attended with Dr. Vu. [redacted] stated that Dr. Vu performed an internal exam on January 17, 2019, and denied that she was mistaken about the date of the internal exam. According to her patient chart **(Exhibit 1, Tab 7, pp. 23-105)** [redacted] did attend for a pelvic ultrasound on January 20, 2019, at which time no abnormalities were identified.

23. [redacted] was asked about the [redacted] Complaint and further details about the encounter with Dr. Vu on February 4, 2020. [redacted] confirmed that she had expected to be swabbed for STI's, but was not expecting an internal pelvic exam. [redacted] said this was not explained to her prior to the internal exam being conducted.

24. Ms. McMahon asked [redacted] about being offered a chaperone. [redacted] confirmed that the offer was made but Dr. Vu stated that the examination room could be crowded. Because she trusted Dr. Vu, she declined.

25. [redacted] was asked whether she could see Dr. Vu during the internal portion of the pelvic exam, and stated that she could not recall seeing him during that

portion of the exam as he was at the end of the table. She recalled Dr. Vu putting two fingers inside her vagina and placing his hand on the outside of her lower abdomen area. She didn't recall him asking about abdominal or pelvic pain, but recalled very clearly Dr. Vu telling her about the sexual position the penis needs to be in to have maximum pleasure of a female her size. [redacted] stated that at no time did Dr. Vu ask her about her pain, and only referred to the position of the penis for "maximum pleasure".

26. [redacted] was asked to review a copy of the [redacted] Complaint, and confirmed that nowhere in the [redacted] Complaint did she indicate that Dr. Vu had stated that the penis needs to be positioned for "maximum pleasure." [redacted] testified that this was something she missed in her statement. On re-direct by Mr. Boyer, [redacted] stated that at the time she gave her statement things were pretty raw, and she was trying to write everything down while processing the emotional weight that comes with being triggered.

27. Ms. McMahon also asked [redacted] about a conversation she had with [redacted] in or around February or March of 2020. [redacted] sent [redacted] a text message asking if she had any negative experiences with Dr. Vu. Following the text message, they spoke for about an hour. [redacted] testified that they each discussed their experience with Dr. Vu, which was exactly the same. [redacted] confirmed that she had not spoken to [redacted] since then.

28. Following examination of the witness by counsel, the Hearing Tribunal asked [redacted] to clarify what Dr. Vu was doing with his fingers during the pelvic examination. [redacted] stated that his hand was inside of her and his fingers were moving from one side to another while he was telling her the direction the penis needs to go in order for her to have maximum pleasure.

[redacted]

29. [redacted] testified that she became a patient at the Clinic in 2011 and saw a physician named Dr. Trung Vu. When Dr. Trung Vu passed away unexpectedly in 2015, she accepted Dr. Phu Vu as her new primary care physician.

30. [redacted] indicated that prior to the appointment with Dr. Vu on November 1, 2017, she had been experiencing bleeding from her cervix. She had an IUD and wanted to confirm that it hadn't moved. This was her only concern when she attended with Dr. Vu.

31. When she arrived that day, Dr. Vu told her she could have a chaperone, but said it was very busy and might take a while. She had the impression it was a major inconvenience, and since she had no issues with Dr. Vu when he did a pap smear in January of 2017, agreed to proceed with the examination without a chaperone.

32. [redacted] testified that the first part of the exam felt normal. Dr. Vu had made some comments early in the exam about using a smaller speculum because he wanted her to feel more comfortable and feel less pain. This made [redacted] feel even more relaxed and that she was in good hands. After he inserted the speculum, Dr. Vu made comments about whether she shaved or waxed. This had nothing to do with the reason she was there and seemed unprofessional and unnecessary, and [redacted] felt a little bit on edge.

33. She described that after Dr. Vu removed the speculum, he inserted his fingers into her vagina and said "this is how it would feel if you were in x sexual position, this is how it would feel if you were in this position." [redacted] said that there were about three positions. Dr. Vu also stated if you have pain in this position, you could move to this position and it wouldn't feel as painful. [redacted] could not understand what was happening, and advised Dr. Vu that she did not come to see him because she was having pain during sex. Dr. Vu then removed his fingers and said that he does this for all patients with small vaginas.

34. [redacted] testified that she had no interest in hearing Dr. Vu's advice on sexual positions, and had no recollection of ever saying anything to Dr. Vu about pain during sex.

35. [redacted] felt very unsafe and after she left the clinic, she called her boyfriend and her best friend who confirmed this was abnormal. She also spoke to her older brother, who said this sort of thing probably happens all the time. She looked into the procedure for reporting, but feared retaliation and did not think anything would come of it.

36. Although she did not report the incident initially, in March of 2020 she was contacted by [redacted] who had worked for her back in 2016. [redacted] sent her a message asking her whether she ever had any uncomfortable experiences with Dr. Vu. [redacted] had not been in touch with [redacted] as they parted on poor terms. When she received the message her heart sank because she had referred [redacted] to the Clinic in the fall of 2016. [redacted] and [redacted] spoke for about 45 minutes. She recalls saying "I don't want to tell you anything" as she did not want her experience to impact [redacted]'s experience. [redacted] stated that [redacted] had no way of knowing what had happened to her, since she only told three people. After she spoke to [redacted], she promised she would report the incident to the College so that they knew it had happened more than once, and then submitted her complaint (the "[redacted] Complaint") to the College on March 30, 2020 **(Exhibit 1, Tab 9, pp. 107-111).**

37. [redacted] stated that she did not return to the Clinic following her attendance on November 1, 2017.

38. On cross-examination, [redacted] confirmed that prior to November 1, 2017, she had a good relationship with Dr. Vu and had recommended him to a number of patients. In retrospect, she testified, there were some warning flags. For example, when he was getting her medical history he asked her if she had a boyfriend. It might have been his way of asking whether she was sexually active, which would have been more clinically appropriate.

39. [redacted] also confirmed that generally Dr. Vu was very good at talking things through and getting consent before doing things. However, she was surprised when he removed the speculum and inserted his fingers into her vagina, as this was unexpected. [redacted] stated she was not exactly sure about the sequence of events. She wasn't sure if Dr. Vu did an internal pelvic exam, then inserted the speculum, then inserted his fingers and advised about sexual positions, or whether his fingers were only inside her after the speculum was removed, and the pelvic exam was done at that time, followed by the advice about sexual positions (while moving his fingers at the same time).

40. Ms. McMahon asked [redacted] whether Dr. Vu may have used the words "petite vagina" instead of "small vagina." [redacted] denied that Dr. Vu referenced "petite vagina" and confirmed he used the word "small vagina" during the exam.

41. [redacted] was asked to clarify what Dr. Vu said when his fingers were inside of her. She confirmed that he mentioned at least three different sex positions and stated "this is how you could feel if you were in this position, and if that hurt then you could move to this position, which would feel better." [redacted] was sure there were at least three positions he went through.

42. Ms. McMahon asked [redacted] about the reference in the [redacted] Complaint to "doggy style". [redacted] denied that Dr. Vu used this terminology only in response to a request from her for clarification. [redacted] also confirmed that at no time did Dr. Vu use the words "pleasure" or "arousal."

43. The Hearing Tribunal asked [redacted] for clarification regarding evidence she provided that she had four pelvic examinations and treatments that were "traumatic." [redacted] stated that in addition to the incident with Dr. Vu on November 1, 2017, she recalled the insertion of her IUD as it was very painful. Similarly, she recalled having her IUD removed as that was also painful. She also recalled a recent pelvic exam in the fall of 2021, which was traumatic as she had been undergoing therapy following her disclosure of the incident concerning Dr. Vu. Finally, she recalled a colposcopy that was very painful.

Dr. James Edward Bell

44. The next witness called on behalf of the Complaints Director was Dr. Bell. Dr. Bell reviewed his *Curriculum Vitae* **(Exhibit 2)**, including his background, experience and training. Dr. Bell testified that he graduated from medical school at the University of Alberta, and then went to New Zealand and did a year as a house surgeon in New Zealand, and then returned to Alberta. He then did a pre-licensure program, before doing some locums and then joined the Grandin Medical Clinic. For the last 20 years of his practice, Dr. Bell assumed the role of being the overall coordinator and person responsible for residency training. Dr. Bell stated that he had active involvement in residency and medical student training until about two years before he retired from the practice of medicine (in April of 2021).

Submissions Re: Qualification of Dr. Bell as an Expert

45. Following a review of Dr. Bell's qualifications, Mr. Boyer sought to qualify Dr. Bell as an expert to provide evidence on the standard and conduct of care of a family physician in the circumstances the Hearing Tribunal is dealing with.

46. Ms. McMahon objected, stating that although she understood that Dr. Bell was an expert on the standard of care, she did not believe it had been established that he was an expert on the standard of conduct, which is broader than the standard of care. Ms. McMahon expressed concern regarding an intention to have Dr. Bell testify on the ultimate issue.

47. Mr. Boyer confirmed that when he used the phrase "standard of care and conduct", it is intended to cover the fact that Dr. Bell has opined that certain aspects of the physical exam by Dr. Vu were inappropriate and not within the standard of care. Mr. Boyer submitted that standard of care is how you treat a patient, and that "conduct" is another way of saying what the doctor does in in the circumstances.

Decision on Admissibility of Expert Evidence and Qualification of Expert

48. After hearing submissions from the parties, the Hearing Tribunal adjourned to determine whether to hear Dr. Bell's testimony and the parameters on which he was qualified to testify.

49. The Hearing Tribunal advised the parties that it was prepared to accept Dr. Bell as an expert in the standard of care and conduct, and that if there were objections to his evidence as the hearing proceeded, the objection would be dealt with at that time.

50. Before expert evidence is admitted, the Hearing Tribunal must decide whether the testimony is relevant, necessary, whether there is any exclusionary rule prohibiting the admission of the evidence, and whether the expert is properly qualified.

51. The primary dispute between the parties was not with respect to the relevance or necessity of Dr. Bell's evidence. Nor was there a dispute regarding Dr. Bell's qualifications to provide an opinion with respect to the standard of care. The primary concern raised on behalf of Dr. Vu was whether Dr. Bell was qualified to provide expert evidence on the standard of conduct expected of a physician in Dr. Vu's circumstance, and whether qualifying him as an expert on the standard of conduct would inappropriately infringe on the Hearing Tribunal's role, which is to make a determination regarding whether the charges are proven.

52. Dr. Bell has a significant amount of experience during his career coordinating residency training on behalf of the Grandin Clinic. The Hearing Tribunal was satisfied that Dr. Bell's lengthy experience as a family physician in Alberta, coupled with his 20+ years of experience coordinating the Grandin Clinic's involvement in training family physicians in Alberta, provided him with the expertise necessary to comment on the standard of care applicable to family medicine practice. Further, to the extent that the standard of care and standard of conduct are not identical concepts, the Hearing Tribunal was satisfied that Dr. Bell had the necessary expertise to provide an opinion on both the standard of care and standard of conduct to be expected of a family physician conducting an internal pelvic exam or providing advice on sexual health issues.

53. As Dr. Bell's expert opinions were provided to the Hearing Tribunal in advance of the hearing, the Hearing Tribunal had an opportunity to review the opinions in advance, and determined that Dr. Bell did not inappropriately comment on the "ultimate issue". Further, there was nothing in his opinions that inappropriately usurped the Hearing Tribunal's role.

54. As such, the Hearing Tribunal determined that it would qualify Dr. Bell as an expert on the standard of care and conduct of a family physician, properly qualified to provide evidence regarding the standard and conduct of a family physician when conducting an internal examination and providing advice on sexual health issues.

55. While the Hearing Tribunal agreed to qualify Dr. Bell as an expert on the basis set out above, it reserved its right to consider whether it agreed with Dr. Bell's opinions, and to give the opinions the appropriate weight once it heard Dr. Bell's testimony.

Dr. Bell's Testimony

56. Dr. Bell reviewed his written expert opinions in relation to both [redacted] and [redacted] (**Exhibit 1, Tabs 14 and 15).** With respect to [redacted], Dr. Bell testified that [redacted]'s recollection of certain events may not be accurate. For example, her recollection that a nurse had done a past vaginal exam did not seem likely. Similarly, her recollection that swabs were taken prior to the speculum exam also did not seem likely.

57. Regarding the exam performed by Dr. Vu on [redacted] on February 4, 2020, Dr. Bell testified that the vaginal exam up until the point when he began to demonstrate the effect of various sexual positions met acceptable standards. However, the portion of the exam where he demonstrated the effect of various sexual positions was not acceptable, unless the patient had indicated she was having problems of a sexual nature. There was no indication that [redacted] complained of any such issues.

58. Dr. Bell also testified that a discussion regarding STIs would be within acceptable practice, however other sexualized comments regarding different sexual positions would not be acceptable unless the patient had complained or asked for advice regarding sexual matters.

59. In addition, Dr. Bell testified that it was his view that a chaperone should be present during a sensitive examination, and if the patient refuses a chaperone, they should be sent elsewhere.

60. With respect to [redacted], Dr. Bell testified that the majority of Dr. Vu's conduct would meet acceptable standards of care. He was not certain whether [redacted] had been offered a chaperone, but opined (contrary to what was written in his report) that the opportunity to decline a chaperone should <u>not</u> be an option.

61. With respect to Dr. Vu asking [redacted] whether she had a boyfriend, Dr. Bell stated that this was not the best way to communicate the question. The reference to using a smaller speculum was puzzling, as it would be difficult to know this was required before commencing the exam. Further, the question as to whether [redacted] waxes or shaves was not clinically indicated, although probably not outside of the area of an acceptable standard of care.

62. As was the case with respect to [redacted], Dr. Bell testified that the discussion of sexual positions and how they may impact pain on intercourse was unacceptable, as there was no indication that the patient was experiencing pain on intercourse. This falls below the acceptable level of professional behavior, and is an unnecessary invasion of the patient given its very personal and sensitive nature. Further, such a discussion should be reserved for situations where the patient requests this advice, and a

discussion of this nature in the absence of a chaperone is even less acceptable.

63. Dr. Bell testified that any discussions about sexual issues should occur before an examination takes place. If the patient does not have any sexual issues and does not give their consent to this sort of examination, it should not take place.

64. Following his testimony, Dr. Bell was cross-examined by Ms. McMahon on behalf of Dr. Vu. Dr. Bell confirmed that in preparing his reports, he utilized the same headings/language as used in the instruction letters received from K. Ivans, CPSA Investigator (**Exhibit 1, Tab 13, p. 188).**

65. Dr. Bell was asked whether he considered the College's Standards of Practice to see whether they provided any guidance on the use of chaperones, and confirmed that he did not. However, he stated that as far back as 2017, it was common teaching that a chaperone was necessary. Although an article by the Canadian Medical Protective Association (CMPA) issued in March of 2019 **(Exhibit 1, Tab 6, p. 10)** suggested that it is the patient's choice whether to have a chaperone, Dr. Bell opined that a chaperone was nevertheless required, and if a patient declined, they should be referred elsewhere.

66. On cross-examination, Dr. Bell confirmed that he had not reviewed the College Standard of Practice on Sexual Boundary Violations **(Exhibit 1, Tab 17, p. 207)** before providing his opinions, and could not recall whether the standard mandated the use of chaperones for sensitive exams. However, when asked about the Advice to the Profession which strongly recommends the use of chaperones, Dr. Bell indicated that he does not believe the College's guidance to the profession totally encompasses the standard of care during a sensitive exam.

67. Dr. Bell was further asked by Ms. McMahon whether he felt that the exams were sexual in nature. Dr. Bell confirmed that the exams were sexual in nature because they were performed without clinical indication. If they were not clinical in nature, then he would regard the exams as being sexual in nature. He testified that when it comes to sensitive physical examinations such as pelvic examinations, one needs to be very clear that the exam is indicated, and that consent has been obtained before a sensitive exam is performed. Where there is no indication and no consent, then Dr. Bell opined that he would regard it as a form of sexual encounter, and did not believe there was a middle ground.

68. When asked whether there was any indication that Dr. Vu experienced sexual gratification or whether there was anything sexy or carnal about the

exams, Dr. Bell stated that he was not able to get inside Dr. Vu's head and does not know whether there was any form of gratification. While there was no evidence of sexual gratification, he could not say one way or another.

69. In response to a question by Ms. McMahon, Dr. Bell confirmed that if [redacted] or [redacted] had indicated they were having pain with intercourse, the portion of the exam that is the subject of the allegations would have been appropriate.

70. On re-direct, Mr. Boyer asked Dr. Bell to clarify what he meant when he said the exam would have been appropriate if the patient reported having pain on intercourse, and asked whether he had ever provided a digital demonstration of the same nature provided by Dr. Vu to a patient who requested advice and guidance about sexual health. Dr. Bell clarified that if he had patients complain of pain on intercourse, he would conduct a pelvic exam. The first part of the exam would consist of taking cultures and a pap smear. He would then ask the patient whether he could identify the source of their pain and proceed with a digital vaginal exam, in which he would move his finger around to various parts of the vagina to see if there was one area that consistently caused trouble. This would only be undertaken if the patient had a current complaint about pain on intercourse, and if the patient consented to the examination. Such consent should be obtained prior to conducting the examination, not during the examination.

71. Dr. Bell testified that he had never taken this as far describing different sexual positions and how they might impact pain. While it may be appropriate to try to determine the source of pain, Dr. Bell opined that he did not have the appropriate training in sexual health to determine which sexual positions are causing pain or not.

OPENING STATEMENT ON BEHALF OF DR. VU

72. Ms. McMahon made a brief opening statement on behalf of Dr. Vu. She indicated that the issues relate to whether Bill 21 applies to Dr. Vu's care of [redacted] (since she attended with Dr. Vu before Bill 21 was in force). Further, the issues include whether the conduct constitutes sexual abuse or sexual misconduct, as defined in the legislation.

73. Ms. McMahon indicated that Dr. Vu disputes all of the charges, and will be asking the Hearing Tribunal to find that his examinations and advice were not of a sexual nature, and thus not meeting the definitions of sexual abuse or sexual misconduct.

74. She submitted that Dr. Vu would be calling evidence to speak to the clinical nature of the care he provided during the two visits. Dr. Vu would testify on his own behalf, and then she would seek to qualify Dr. Thomas Dalby as an

expert. Ms. McMahon indicated that she understood there would be an objection to Dr. Dalby's qualification as an expert, and this would therefore be addressed prior to Dr. Dalby's testimony.

SUMMARY OF WITNESS TESTIMONY FOR WITNESSES CALLED ON BEHALF OF DR. VU

Dr. Phu Vu

75. Dr. Vu obtained a Bachelor of Science from the School of Health Information Science from the University of Victoria. He then obtained a Master's in industrial mechanical engineering from the University of Toronto in 2003. He then worked for the Calgary Health Region, before starting medical school in Sydney, Australia, which he completed in 2010. In 2010, he started his family medical residency through Dalhousie University, which he completed in 2012. He then worked as a civilian doctor for the Canadian Forces in Gagetown, New Brunswick, before he started a family practice at the Clinic in July of 2014. He continued to practice at the Clinic until May of 2020, at which time he moved to a new clinic after the Brentwood Clinic closed.

76. While at the Clinic, Dr. Vu practiced with a number of other doctors. Brentwood had a regular family clinic, and a walk-in clinic, and Dr. Vu provided services in both clinics. There was also a well women clinic, which focused on female health topics such as pap smears, breast exams, STI testing, and pelvic exams, and was staffed by Dr. Deborah Rotzinger. The well women clinic was available to Dr. Vu's patients.

77. There were also many staff members at the Clinic, including two medical office assistants, an LPN, and a full-time nurse on the family medicine side. None of the nurses carried out sensitive examinations.

78. Dr. Vu testified that by 2017, it was his practice to always offer patients a chaperone for sensitive examinations. In April of 2019, after receiving an email from the CMPA, he began to record in his chart whether a chaperone had been offered and declined.

79. Dr. Vu confirmed that after receiving complaints from [redacted] and [redacted], he prepared written responses (**Exhibit 1, Tabs 6 and 10)**. The purpose of his responses was to respond to the College's questions, describe his standard practices, and indicate changes he made to his practice.

80. He then confirmed that when charting the patient encounters with [redacted] **(Exhibit 1, Tab 7, p. 23)** and [redacted] **(Exhibit 1, Tab 11, p. 117)** he used a

SOAP methodology (subjective, objective, assessment, plan). He recorded pertinent positives and negatives of the examination and history.

81. He then explained that during examinations, he always provides a running commentary to educate patients and hopefully reduce any surprise for the patient, and a running commentary is provided during breast and pelvic examinations.

82. Dr. Vu testified that he had no specific recollection in relation to the care he provided to [redacted]. Dr. Vu was then asked questions about the care he provided to her. Referring to [redacted]'s chart, Dr. Vu stated that he first met [redacted] at a meet and greet on May 26, 2015. On that occasion, he charted that [redacted] had a boyfriend, the purpose of which question was to see what social supports she had, and provides context for her health. Other information regarding [redacted]'s employment history was also charted to provide further context.

83. Dr. Vu referred to a note dated September 25, 2015, regarding an IUD replacement. Dr. Vu stated that he did not perform a pelvic exam on that date, since if he had he would have charted it.

84. He testified that [redacted] attended with Dr. Rotzinger on September 13, 2016 for an STI screen, then attended with him for a general physical exam (including a pap) on January 3, 2017. Dr. Vu stated that on that date, he would have offered [redacted] the option of having a chaperone present, as it was his standard practice. However, at that time he did not chart whether the offer was accepted or declined. Dr. Vu testified that he would have performed an internal pelvic exam on January 3, 2017, but did not think that he provided any advice or counselling to [redacted] about dyspareunia on that occasion, since she had not raised any concerns about it.

85. The last time that Dr. Vu provided care to [redacted] was when she attended with him on November 1, 2017. On that date, she had concerns of vaginal bleeding and IUD placement. Dr. Vu did not recall telling [redacted] that she could have a chaperone, but that it was busy and waiting for a chaperone might delay things. Rather, he advised that, because it was a busy clinic, if a patient wanted a chaperone he might indicate that they might have to wait a bit.

86. Dr. Vu was asked about [redacted]'s statement in the [redacted] Complaint that she was not offered a chaperone, and indicated that this was incorrect as by November of 2017 it was his standard practice to offer a chaperone and leave the choice to the patient.

87. Following the initial discussions with [redacted], Dr. Vu performed a pelvic exam which was indicated due to concerns about vaginal bleeding and placement of the IUD. Prior to the exam, he would have given her a brief overview of the examination, saying that the exam had three portions: an external, speculum portion and an internal portion. Further, he would have indicated a swab was necessary to rule out STIs. Dr. Vu testified that at the time of this discussion, he would have known that she did not have dyspareunia because he would have asked about it in the medical history. However, he would not have known whether she had a short vaginal canal, low-lying cervix or prolapsed uterus until examination.

88. Dr. Vu testified that he would have followed his usual practice which included an external inspection. If he saw no ingrown hairs, he would have commented on it to encourage her to continue whatever grooming techniques she was using to prevent a common problem he observes. He did not chart this as it was a negative finding, and only charted the existence of a small wart-like lesion on the right side.

89. During the second portion of the examination, he would utilize the speculum to observe the inner structures. Before he started, he would show the patient the speculum and reassure them he would use the smallest speculum for their comfort. He always starts with the smallest size.

90. Dr. Vu explained that the third portion of the exam is the internal portion. Prior to proceeding, he would discuss that he will be using gloved digits to bimanually palpate the patient's cervix, uterus and ovaries. He would then proceed, examining for cervical or uterine tenderness and looking for bulky or enlarged uterus for potential fibroids. He would then palpate the adnexal areas or the ovaries for signs of mass or tenderness. He would have followed this usual practice when examining [redacted]

91. Following this, he believes he would have followed his standard of practice regarding counselling on dyspareunia. He does not recall referencing a "small vagina" but would have used the terminology "petite vagina" to refer to a short vaginal canal or a low-lying cervix. In that case, he would have provided counselling on pelvic anatomy and preventing dyspareunia, including sexual positions to prevent dyspareunia. It was at the time his standard practice to provide this type of counselling for all patients with a history of dyspareunia, a short vaginal canal or low-lying cervix, or a uterine prolapse.

92. Dr. Vu described that during this counselling, he would narrate identification of the cervix, state that the cervix had many sensory cells, and if hit during intercourse it can cause pain. He would then identify areas to the left, right and anterior of the cervix that can be utilized to prevent the cervix being hit. He would discuss that the most problematic position for dyspareunia is

where the male is on top and, if the patient is having dyspareunia with that position, to have the partner point to the left or right or the patient to adjust their position. He would discuss, for patients who have dyspareunia that the best position is where the male is behind or the female is on top, and these positions likely utilize the area anterior to the cervix.

93. Dr. Vu could not recall if he told the patients in advance of proceeding with this portion of the exam that is what he was going to do.

94. During the exam, he described identifying the cervix with his hand, then pointing or palpating to the area to the right, left and anterior of the cervix (four movements in total). The purpose of the exam was not to provide advice on how the patient felt, other than to prevent future cases of dyspareunia.

95. Dr. Vu stated that in relation to [redacted], he would not use colloquial terms such as "doggy style" unless a patient specifically asks about it, but could not recall whether [redacted] had asked a question using those terms.

96. Dr. Vu stated that he could not recall [redacted] providing any indication that she did not wish to engage in the dyspareunia counselling, and that he typically drapes the patient in such a way that he can see their face during the third part of the exam. If he sees any sign of discomfort, he will stop the examination or ask the patient if they would like him to stop. He does not believe [redacted] voiced any concerns since he would have stopped and documented it in his notes.

97. Dr. Vu also testified about the care he provided to [redacted] and confirmed that he had no independent recollection of his attendance with her on February 4, 2020, or any prior visits. According to his chart, he first saw her at a meet and greet on August 8, 2016. He then performed a general physical on August 15, 2016, but she attended with Dr. Rotzinger for her pap and breast exam on August 23, 2016.

98. He testified about the care provided to [redacted] prior to February 4, 2020, including sensitive exams where he would have offered [redacted] a chaperone. Dr. Vu stated that [redacted] attended with him on January 17, 2019. According to his chart notes **(Exhibit 1, Tab 7, p. 31)**, she reported left pelvic and epigastric pain, and also complained of intermittent dyspareunia. Dr. Vu did not recall but believes he would likely have provided some advice on preventing dyspareunia. No pelvic exam was completed on this date. [redacted] returned again on May 2, 2019 for sinus congestion and ear pain.

99. [redacted]'s next visit was on February 4, 2020. According to Dr. Vu's chart note (**Exhibit 1, Tab 7, p. 28)** she requested a complete physical, including a pap smear, and she had a concern about a lump in her left axilla. Dr. Vu

did not agree that [redacted] only came in for STI swabs, since he had written in his chart she attended for a complete physical.

100. Dr. Vu testified that [redacted] was offered a chaperone, which she declined, and he then noted it in her chart. Dr. Vu did not agree with [redacted] that a nurse was already in the room or that he asked if the nurse could leave due to the room being crowded. He would have the conversation about chaperones before a nurse was present, and if a chaperone was requested, would wait until the nurse was available. He indicated that after the chaperone was declined, he may have made a comment that other patients had declined a chaperone because the room was crowded, but this was only for the sake of conversation.

101. Dr. Vu then followed his standard practice for a complete physical, and described that he would complete a number of examinations including respiratory, cardiovascular, abdominal, ear, nose, and throat. He would have also reviewed with her the need for a pelvic exam, and recommended vaginal swabs for STI testing. He then would have proceeded with the cardiovascular, abdominal and other less sensitive exams, before he left the room to allow [redacted] to disrobe for the sensitive exam.

102. He indicated that he would have performed the pelvic exam in accordance with his standard practice, including the external inspection, insertion of the speculum, and then the internal exam. Dr. Vu did not specifically recall providing dyspareunia counselling but based on the [redacted] Complaint and her testimony, believes that he did. Further, although Dr. Vu did not believe that [redacted] complained of dyspareunia when she attended on February 4, 2020, he would likely have provided dyspareunia counselling as a result of her previous report of intermittent dyspareunia on January 17, 2019.

103. Regarding his examination of [redacted], Dr. Vu confirmed that he would not have inserted his hand into her vagina, it would have been his gloved digits. Further, he denied advising her about the position of the penis for maximum pleasure, and denied advising her on suitable positions for a woman of her shape and build.

104. Dr. Vu could not recall whether he advised [redacted] why he was carrying out this portion of his exam, but stated he probably would have mentioned he was going to talk about dyspareunia.

105. At the time he examined [redacted], he had received emails from the College about the Standards of Practice about boundary violations, but at that time was not familiar with it. He believed he took steps to avoid potential misinterpretation of his exam by offering a chaperone, asking for consent, and narrating throughout his examination.

106. With respect to chaperones, Dr. Vu disagreed with Dr. Bell's interpretation that it was mandatory to have a chaperone present, and referenced the CMPA Article **(Exhibit 1, Tab 6, p. 10)** which indicated it was a physician's duty to provide the option, but if a chaperone was declined, it was up to the physician to determine whether to proceed.

107. Dr. Vu also did not agree with Dr. Bell that dyspareunia counselling should only be provided where a patient complains of dyspareunia and asks for advice about it. He provided such counselling to patients in the past, and had been advised that it was very helpful. Nevertheless, since becoming aware of the complaint, he stopped completing pelvic examinations and has decided not to provide advice on dyspareunia anymore while doing the pelvic exam. He has also decided that he will obtain the patient's express consent and document the express consent.

108. According to Dr. Vu, the examinations of both [redacted] and [redacted] were not intended to be sexual in nature; he was trying to educate the patients with respect to a common problem.

109. On cross-examination, Dr. Vu confirmed that he would have received communications from the College with respect to Bill 21, but was too busy to read them.

110. When asked whether he provides advice during rectal exams provided to male patients about positions in the event of anal sex, Dr. Vu indicated he would only do so if the patient requested it at the time.

111. Dr. Vu was then asked about the sequence of the pelvic exam and whether, after conducting his bimanual exam to check for masses, he removed his fingers from the patient's vagina before discussing pain on intercourse. Dr. Vu confirmed that he did not, but looking back it would have been prudent to do so.

112. Dr. Vu also confirmed that although he had two months of residency in obstetrics and gynaecological care, he had no specific training or research to support his methodology or practice around providing dyspareunia counselling.

113. In response to questions from the Hearing Tribunal, Dr. Vu confirmed that he did not provide dyspareunia counselling to [redacted] previously as he did not find a history of dyspareunia until January 17, 2019. For [redacted], he likely did not notice her cervix was low lying prior to the appointment on November 1, 2017.

114. Regarding documentation, Dr. Vu viewed the dyspareunia counselling as "extra advice" but did not include it as part of his notes. Looking back, he realizes it would have been important to document this.

115. When asked how he would share information about dyspareunia standardly, and whether he used diagrams and models, he stated that he would proceed as described earlier, but if a patient was not there for a pelvic exam, he may use a diagram or model (which was available in the treatment room).

116. Dr. Vu was also asked to clarify whether the dyspareunia counselling was provided standardly for all patients (which was suggested in his letter of response to the [redacted] complaint (**Exhibit 1, Tab 10, p. 115).** Dr. Vu confirmed that he wanted to correct a mistake in his letter, and that he had intended to indicate that he shares the information standardly but only in three circumstances: for patients who have a short vaginal canal or a low-lying cervix, those with a history of dyspareunia, or those with a uterine prolapse.

117. The Tribunal also asked Dr. Vu to reconcile his position that a low-lying cervix was a variation of normal, and as such no chart notation was required, but on the other hand when a patient had a low-lying cervix, Dr. Vu would standardly conduct further examinations and special education on dyspareunia. Dr. Vu confirmed that the position of a low-lying cervix may change, but on days when it is low-lying, it could cause intercourse to be painful, which is something that could be easily alleviated with different positioning of the partner or themselves.

Dr. Thomas Dalby

Submissions Regarding Admissibility of Dr. Dalby's Evidence

118. Following Dr. Vu's testimony, Ms. McMahon indicated that she wished to call Dr. Thomas Dalby, a forensic psychologist, to provide expert evidence on his psychological assessment of Dr. Vu, and proposed to have Dr. Dalby give some evidence with respect to his qualifications.

119. Mr. Boyer indicated that the Complaints Director objected to Dr. Dalby's evidence as it will not assist the Hearing Tribunal in its task. At this stage of the proceedings, the Hearing Tribunal must determine whether the allegations are proven and if the conduct constitutes unprofessional conduct. In the event that the allegations are proven, Dr. Dalby's evidence could be relevant to sanction, but at this stage Dr. Dalby's evidence is irrelevant and is an attempt to have him speak on the ultimate issue, which is whether the conduct constitutes sexual abuse.

120. Given the objection on behalf of the Complaints Director, the Hearing Tribunal asked Ms. McMahon to summarize the opinion to be provided by Dr. Dalby, so that it could further understand the nature of the evidence proposed to be provided. Ms. McMahon indicated that the opinion is with respect to whether or not Dr. Dalby found any pathology or diagnosis that was relevant to the issue of sexual abuse.

121. Ms. McMahon also referred to a written brief submitted on behalf of Dr. Vu in relation to the issue of admissibility of the expert evidence. She submitted that the test that should inform the Hearing Tribunal's assessment as to whether the conduct constitutes sexual abuse is derived from the Supreme Court of Canada's decision in *R. v. Chase*, which has been applied in the health professions context in Ontario. According to *Chase*, determining whether conduct is of a sexual nature depends on whether the carnal or sexual nature of the conduct is visible to a reasonable observer. In conducting its assessment, the Hearing Tribunal will have to consider a number of factors, including: the intent or purpose and whether there is any demonstrable arousal on the part of Dr. Vu, sexual intent, motivation or purpose, and whether the physician believed the treatment was in the best interests of the patients.

122. She further submitted that Dr. Dalby's report is relevant in assessing whether Dr. Vu has any mental pathology, and whether there was any sexual intent on the part of Dr. Vu when he conducted the examinations, which is one of the factors referred to in *R. v. Chase*.

123. Further, Dr. Dalby's opinion is necessary, since the Hearing Tribunal does not have specific expertise with respect to this issue. In contrast, Dr. Dalby is a forensic psychologist with significant experience conducting assessments that goes beyond the expertise possessed by the Hearing Tribunal.

124. Finally, Ms. McMahon submitted that Dr. Dalby was not opining on whether Dr. Vu's conduct met the standard of care, and as such he was not opining on the ultimate issue. While the case law demonstrates that there must be a cost-benefit analysis when determining whether to hear expert evidence, and the Hearing Tribunal must perform a "gatekeeping" function, the benefit of receiving the report outweighs the potential prejudice of admitting it, especially given the serious consequences that Dr. Vu potentially faces if found guilty of the allegations.

125. In reply, Mr. Boyer submitted that the Complaints Director was prepared to acknowledge that Dr. Vu did not have any mental pathology. However, based on the evidence, it did not appear that there was any dispute with

respect to the facts alleged in the Notice of Hearing. The question is whether the conduct is unprofessional in the sense that it is below the standard of care. Dr. Vu did not intend to call an expert to opine on the manner of the examination, or to rebut Dr. Bell's evidence. Accordingly, the issue to be determined by the Hearing Tribunal related to the interpretation of legislation and the application of it to the facts.

126. Further, Mr. Boyer submitted that permitting the expert to testify would be allowing the expert to provide evidence on Dr. Vu's credibility, which role is reserved for the Hearing Tribunal.

Decision on Admissibility of Dr. Dalby's Evidence

127. After hearing submissions from the parties regarding the admissibility of Dr. Dalby's expert opinion, the Hearing Tribunal adjourned to consider the matter. Upon reconvening, Ms. Haymond advised the parties of the advice she had provided to the Hearing Tribunal. Ms. Haymond advised that whether or not there is sexual motivation or intention is one of the factors referenced in *R. v. Chase*, however in the criminal context, the absence of evidence of sexual motivation or intention is not determinative with respect to whether there has been a sexual assault. A person may be found guilty of sexual assault despite the absence of sexual intent. As such, Dr. Dalby's opinion on this issue is not necessarily determinative with respect to whether the conduct is of a "sexual nature."

128. Ms. Haymond further advised that one option available to the Hearing Tribunal was to hear Dr. Dalby's evidence, then determine what weight to give Dr. Dalby's opinion after hearing his testimony.

129. The Hearing Tribunal then advised the parties that subject to Dr. Dalby being qualified as an expert witness, it was prepared to hear Dr. Dalby's opinion, but would reserve their determination with respect to what weight to give the opinion until after hearing from Dr. Dalby and engaging in deliberations.

130. In deciding to hear from Dr. Dalby, the Hearing Tribunal considered that the rules of evidence applicable in judicial proceedings do not apply in the context of these proceedings. As such, there is increased flexibility when deciding whether to hear expert testimony. Nevertheless, the Hearing Tribunal recognizes that opinion evidence is presumptively inadmissible and that admission of expert evidence is an exception to the general rule. As such, when there is a dispute about the admission of expert evidence, it should only be admitted when the evidence has been determined to be admissible. The Hearing Tribunal considered the test for admissibility of expert evidence, as established by the Supreme Court of Canada in *White Burgess Langille Inman v. Abbott and Haliburton Co.* and other cases such

as *R. v. Mohan*. In particular, the Hearing Tribunal considered whether the testimony is relevant and necessary, and whether it is subject to any other exclusionary rule.

131. The proposed expert evidence related to whether Dr. Vu has any mental pathology that may assist in determining whether his actions were motivated by sexual intent or purpose. While this factor is not in and of itself determinative, it is part of the constellation of factors that could inform the Hearing Tribunal's analysis with respect to whether the conduct is of a "sexual nature."

132. Further, Dr. Dalby was not attempting to opine on the ultimate issue, which involves a determination with respect to whether the allegations are factually proven, and if so, whether the conduct breaches the standards alleged in the Notice of Hearing.

133. Finally, after performing the cost-benefit analysis established in *White Burgess,* the Hearing Tribunal determined that the benefit of having Dr. Dalby's testimony is that it could potentially assist the Hearing Tribunal, and the potential benefit outweighed the cost of hearing from Dr. Dalby, which would extend the time required for the hearing.

134. With respect to the submission, on behalf of Dr. Vu, that the consequences to Dr. Vu are serious, and as such the Hearing Tribunal should provide him the opportunity to call expert evidence, this was not a factor which was determinative. A party who wishes to call expert evidence must satisfy the Hearing Tribunal that the test for admissibility has been met. While the Hearing Tribunal must ensure that its proceedings meet the requirements of fairness, the potential consequences to the party are not specifically relevant, since otherwise, expert evidence would almost always be admissible when the allegations are serious.

135. Accordingly, the Hearing Tribunal indicated it was prepared to hear Dr. Dalby's evidence, subject to proper qualification.

Application to Close the Hearing

136. Prior to Dr. Dalby testifying, Ms. McMahon made an application on behalf of Dr. Vu pursuant to s. 78 of the HPA to close the portion of the hearing involving Dr. Dalby's testimony. Section 78 provides that the Hearing Tribunal may close a portion of the hearing where not disclosing a person's confidential personal, health, property, or financial information outweighs the desirability of having the hearing open to the public. In this case, Dr. Dalby's evidence relates to personal health information about Dr. Vu, and also contains personal information about Dr. Vu's family members.

137. Mr. Boyer submitted on behalf of the Complaints Director that the expectation of privacy for regulated members is diminished because of the transparency and accountability requirements in the HPA. Further, Dr. Dalby's report is not accessible to members of the public in any event, and finally there were no members of the public present.

138. After hearing from the parties, the Hearing Tribunal deliberated and then advised the parties that it was prepared to close the hearing under s. 78 only for the duration of Dr. Dalby's testimony. Although there is a presumption that hearings held under the HPA will be open to the public, pursuant to s. 78 there are circumstances where the hearing or a portion of the hearing may be closed. Dr. Dalby's testimony related to his opinion with respect to whether Dr. Vu has any mental pathology that might be the cause of his actions. Dr. Dalby's opinion would necessarily relate to sensitive health information pertaining to Dr. Vu.

139. While the Hearing Tribunal determined that it was prepared to close the portion of the hearing involving Dr. Dalby's testimony with respect to his opinion, the Hearing Tribunal recognizes the interest and value in the transparency of its proceedings. Hearings should not be closed routinely, nor should hearings be closed to avoid embarrassment or discomfort on the part of the regulated member. While the Hearing Tribunal was prepared to close the portion of the hearing involving Dr. Dalby's testimony, it is noted that every application to close the hearing must be considered based on the facts and context, and the decision in this case is not intended to be binding or to serve as precedent in other cases.

Dr. Dalby's Testimony Regarding His Qualifications

140. Dr. Dalby reviewed the highlights from his *Curriculum Vitae* (**Exhibit 3).** He testified that he obtained a Bachelor's degree in Psychology from York University in Toronto in 1975. He then obtained a Master's of Applied Psychology from the University of Guelph in 1977, and obtained his PhD from the University of Calgary in Psychopathology in 1979. He has been a registered member of the College of Alberta Psychologists since 1977.

141. Dr. Dalby practices in forensic psychology and neuropsychology. He has taught continuously since 1976 for various universities, and teaches a course in sex crimes. He provides consulting services to many institutions, including police services and government agencies, and often consults when there is some suspicion of aberrant behavior.

142. Dr. Dalby stated that he has been qualified to testify as an expert about 1000 times at all levels of courts in Alberta, British Columbia and Saskatchewan, and before various tribunals, including tribunals involving

physicians, accountants, massage therapists, chiropractors and physiotherapists.

143. After Dr. Dalby testified regarding his qualifications, Ms. McMahon requested that he be qualified as an expert in the area of psychology and providing psychological assessment. Mr. Boyer had no objection on behalf of the Complaints Director.

144. Given that there were no objections on behalf of the Complaints Director, and in light of his experience and qualifications, Dr. Dalby was qualified as an expert in the area of psychology and psychological assessment.

Dr. Dalby's Testimony Regarding His Opinion

145. Prior to Dr. Dalby providing evidence with respect to his opinion, the hearing was closed to the public, and the observers were asked to exit the hearing.

146. [redacted]

147. [redacted]

148. [redacted]

149. [redacted]

150. [redacted]

151. [redacted]

152. [redacted]

153. Following Dr. Dalby's testimony, the Hearing Tribunal re-opened the hearing to the public.

154. The Hearing Tribunal then adjourned the hearing to enable the Complaints Director to consider whether he wished to apply to call rebuttal evidence with respect to some evidence that arose during Dr. Dalby's testimony.

CLOSING ARGUMENT

155. After the hearing was adjourned, counsel for the Complaints Director confirmed that the Complaints Director did not intend to make an application to introduce rebuttal evidence.

156. As such, deadlines were established for the exchange of written closing argument, and a date was scheduled to resume the hearing and hear oral argument from the parties.

157. The parties attended before the Hearing Tribunal on May 9, 2022 to make final submissions.

Closing Argument on Behalf of Complaints Director

158. Mr. Boyer, in written submissions dated April 14, 2022, and oral submissions made when the hearing resumed, submitted that the allegations in the Notice of Hearing were proven.

159. The Complaints Director submitted that Dr. Vu had admitted that the conduct outlined in the Notice of Hearing is factually correct but maintains that his conduct was clinically appropriate.

160. Mr. Boyer also submitted that because the February 2020 conduct with respect to [redacted] occurred after April 1, 2019, the date when Bill 21 came into force, the issue is whether the conduct amounts to "sexual abuse" under the HPA. The November 2017 conduct with respect to [redacted] was not subject to the amendments in the HPA. As such, the mandatory revocation provisions would not be engaged if solely the conduct in relation to [redacted] was proven.

161. Mr. Boyer submitted that the Hearing Tribunal must determine:

    a. Does the evidence demonstrate on a balance of probabilities that the conduct in the Notice of Hearing has been proven?
    b. Does the conduct as found by the Hearing Tribunal amount to unprofessional conduct under the HPA?
    c. Does the conduct as found by the Hearing Tribunal in relation to [redacted] amount to "sexual abuse" as defined in the HPA?
    d. Does the mandatory revocation provision set out in s. 81.1 of the HPA apply in regard to the conduct against [redacted]?

162. On behalf of the Complaints Director, Mr. Boyer submitted that there is no dispute that Dr. Vu engaged in the conduct alleged in the Notice of Hearing, and on a balance of probabilities the conduct was proven.

163. With respect to whether the conduct constitutes unprofessional conduct, Mr. Boyer referenced Dr. Bell's expert opinion evidence, who opined that Dr. Vu's actions fell below the standard of care when he made digital demonstrations of the position of the penis and verbal comments about sexual positions to [redacted] and [redacted] when neither had requested this advice, and neither had complaints of pain.

164. Mr. Boyer referenced a number of previous decisions involving physicians who were disciplined or sanctioned after providing inappropriate sensitive examinations. For example, in *R. v. Nqumayo*, 2010 ABCA 100, the Alberta Court of Appeal upheld findings of guilt with respect to four counts of sexual assault after Dr. Nqumayo conducted vaginal examinations on four complainants. During the examinations, he repeatedly used a finger to make an in and out motion in the vagina, which went beyond the consent that had been provided.

165. Other cases cited on behalf of the Complaints Director included:

- *Litchfield v. College of Physicians and Surgeons of Alberta*, 2008 ABCA 164: Dr. Litchfield was found guilty of sexual assault after conducting inappropriate breast exams and performing unnecessary vaginal exams.
- *Re Dr. Delacruz*, 2012 CanLII 68734: Dr. Delacruz, an Ear Nose and Throat surgeon, was found guilty of misconduct after conducting an inappropriate examination of one patient's buttocks and labia, and inappropriate examinations of another's patient's breasts, buttocks and labia.

166. It was further submitted that the conduct in relation to [redacted] should be characterized as "sexual abuse" as that term is defined in the HPA. Mr. Boyer submitted that Dr. Dalby's evidence with respect to this issue was of little help, and that Dr. Dalby's evidence was more in the nature of testimony as an advocate rather than being objective in nature. Further, Dr. Dalby was of the opinion that Dr. Vu did not present with the requisite mental intent to sexually abuse patients, but on cross-examination admitted he was referring to specific intent and the intent for sexual gratification. In essence, Dr. Dalby is arguing that Dr. Vu could not be found responsible for his conduct, due to lack of specific intent.

167. Mr. Boyer submitted, on behalf of the Complaints Director, that in accordance with the Supreme Court of Canada's decision in *R. v. Chase,* specific intent is not required to prove that sexual abuse has occurred.

What must be proven is general intent to perform the physical acts, not that the accused has specific intent of a sexual nature.

168. Dr. Dalby's opinion ignores the fact that Dr. Vu described what he intended and did in providing the digital demonstration and sexual advice on penile positions in each patient's vagina. Further, his opinion regarding Dr. Vu's insight and awareness is irrelevant as it was clear from Dr. Vu's testimony that he intended to provide the digital demonstration and verbal advice on sexual positions after conducting his pelvic exam.

169. With respect to whether the examination of [redacted] amounted to sexual abuse, the decision in *R. v. Chase* is helpful since the Court outlined a number of factors to consider in determining whether the conduct is sexual (in the context of sexual assault) including:

- Was the sexual integrity of the victim violated?
- Is there a sexual or carnal context to the assault visible to the reasonable observer?
- What was the nature of the contact?
- What was the situation in which it occurred?
- What words or gestures accompanied the act?

170. As noted in *Chase* the existence or absence of sexual gratification is only one of the factors to be considered, and is not determinative.

171. In the circumstances, the totality of factors weigh in favor of concluding that the digital demonstration of penile positions and commentary on different sexual positions was of a "sexual nature" given the testimony of [redacted] and Dr. Bell's evidence that it was not clinically appropriate.

172. Mr. Boyer also made a number of submissions with respect to whether the mandatory revocation provisions were applicable in regard to the allegation concerning [redacted], and reviewed a number of cases where similar mandatory revocation provisions had been subject to constitutional challenge, and had been upheld by the Courts. He submitted that the purpose of reviewing these cases was to demonstrate that zero-tolerance provisions are within the Legislature's authority to enact. According to these provisions, the Hearing Tribunal has no option but to cancel Dr. Vu's registration following a finding of unprofessional conduct in relation to the allegation concerning [redacted]

173. Further, Mr. Boyer submitted that Dr. Vu's naivety or ignorance of the law was not an excuse and was not a proper defence: *R. v. Pontes*, [1995] 3 S.C.R. 44; *Sliwin v. College of Physicians and Surgeons of Ontario*, [2017] O.J. No. 1507.

174. With respect to [redacted], it was noted that the conduct occurred prior to April 1, 2019, and accordingly the Hearing Tribunal retains authority to determine sanction in all respects.

175. Mr. Boyer submitted that in regard to the credibility of [redacted] and [redacted], the Hearing Tribunal can accept some, none or all of their evidence. The fact that a witness may be mistaken with respect to a certain fact or recollection does not mean that the Hearing Tribunal must reject all of their evidence. As such, attacks on credibility that are not germane to the central issues do not constitute a barrier to a finding of unprofessional conduct in relation to the allegations.

Closing Argument on Behalf of Dr. Vu

176. Ms. McMahon and Ms. Winn provided written submissions on behalf of Dr. Vu, and Ms. McMahon also made oral submissions when the hearing reconvened on May 9, 2022.

177. On behalf of Dr. Vu, it was submitted that the Complaints Director bears the burden of proving each allegation on the balance of probabilities. As such, a physician does not have to lead evidence that there was clinical justification for the impugned touching.

178. In order to make factual findings, the Hearing Tribunal must consider the credibility and the reliability of witness testimony. In the face of conflicting evidence, the Hearing Tribunal must determine, based on the totality of evidence whether the College has proven that it is more likely than not that Dr. Vu committed sexual abuse.

179. Counsel for Dr. Vu then reviewed the facts pertaining to [redacted] and outlined a number of inconsistencies in her evidence. For example, [redacted] testified that when she attended on February 4, 2020, she did not expect a complete physical examination, which was inconsistent with the [redacted] Complaint, which referenced a "physical examination." Similarly, there were inconsistencies with respect to [redacted]'s recollection about being offered a chaperone, and in the [redacted] Complaint, she stated that her previous vaginal exams had been completed by nurses, a contention that was clearly in error. Counsel alleged that [redacted] denied other facts that were uncontentious, including that she had attended with Dr. Vu on September 6, 2018 for vaginal bleeding.

180. Counsel for Dr. Vu also emphasized that in the [redacted] Complaint, she complained that Dr. Vu "began giving me sex advise positions that would be

suitable for a woman of my shape and build with his fingers showing me sexual positions that the penis should be moving for more *comfort*" (emphasis added), whereas in direct examination, [redacted] testified that Dr. Vu told her the position the penis needs to be to have the "most maximum pleasure of a woman your size." She specifically denied that Dr. Vu used language regarding ways that she could prevent pain during intercourse, and insisted that he used the language "maximum pleasure."

181. Further, counsel submitted that [redacted] had a selective and poor memory, and that she was argumentative and sarcastic.

182. With respect to [redacted], counsel submitted that [redacted] did not remember the sequence of Dr. Vu's internal examination on November 1, 2017. Further, she could not recall the exact words used by Dr. Vu, she only recalled general details.

183. Counsel also submitted that during the hearing [redacted] had concerns regarding not being properly offered a chaperone when this was not raised in the [redacted] Complaint.

184. Further, counsel submitted that given that [redacted] and [redacted] had a discussion about the events in question, there was the possibility of collusion, and [redacted]'s evidence was not independent because she only made her complaint after she spoke to [redacted]

185. Regarding the examination itself, [redacted] could not recall what sexual positions were demonstrated, but that it was maybe one, two or three movements.

186. In contrast, Dr. Vu never denied that he provided dyspareunia counselling or the reasons for doing so. He made several admissions on cross-examination, and was candid in acknowledging what he did and did not recall.

187. As such, where Dr. Vu's recollection of events differed from the evidence of [redacted] and [redacted], the information in Dr. Vu's chart or his testimony should be preferred.

188. Counsel submitted that Dr. Bell's evidence should be looked at cautiously, given his insistence that a chaperone was mandatory despite the information in the CMPA Article, the College's Standards of Practice and Advice to the Profession. They also indicated that Dr. Bell used the word "sexualized" because it had been used by the investigator. Finally, Dr. Bell's opinion that an examination that is not clinically indicated must be sexual in nature is not reasonable and requires physicians to practice to a

perfectionist standard. It is evident that Dr. Bell's opinion is not unbiased or fair, and is not reflective of the standard of care.

189. Counsel also reviewed Dr. Dalby's evidence, and emphasized Dr. Dalby's opinion that Dr. Vu has no mental pathology, mental disorder or sexual deviation. Dr. Dalby's evidence is helpful in assessing whether Dr. Vu's conduct was sexual in nature.

190. Counsel for Dr. Vu submitted that Bill 21 does not apply to allegation #1, which relates to the conduct involving [redacted] that occurred prior to April 1, 2019, and provided a number of legal authorities to support this submission.

191. To the extent that the Complaints Director alleges that Dr. Vu's conduct fell below the minimum standard of care, such that he should be found to have engaged in unprofessional conduct separate and apart from breaching the standards of practice referenced in the Notice of Hearing, Dr. Vu's Counsel submitted that it is not open to the Hearing Tribunal to find unprofessional conduct unless it related to sexual abuse/sexual misconduct, or a breach of the Standards of Practice referenced in the Notice of Hearing.

192. In determining whether or not the conduct regarding [redacted] constitutes "sexual abuse", the Hearing Tribunal must determine whether the examination was appropriate to the service being provided. If it was, then the conduct is not "sexual abuse" by virtue of the definition.

193. However, even if the Hearing Tribunal finds that the examination was not clinically appropriate, that is not the end of the matter. The Hearing Tribunal must still go on to consider whether the conduct was of a "sexual nature." Dr. Vu's Counsel agreed with the Complaints Director that the Supreme Court of Canada's decision in *R. v. Chase* is instructive, which establishes the following test: "viewed in light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer." Other factors to be considered have been outlined in cases decided in Ontario under provisions that are parallel to Bill 21, and include: the nature of the conduct, the accompanying words and gestures, the intent and purpose of the person committing the act, whether consent was provided, was there a clinical indication for the touching, whether the touch was accidental or incidental, was the physician under a misguided or clearly mistaken belief on the necessity of care, if there is any evidence of demonstrable arousal or sexual gratification.

194. Counsel reviewed a number of decisions where tribunals had found that although a physician may have inappropriately performed an examination,

and may have been misguided in doing so, this does not automatically mean that the exam was sexualized.

195. In all of the circumstances, Dr. Vu's Counsel submitted that his conduct was not of a sexual nature and does not constitute sexual abuse, because it was appropriate to the service provided, which was counselling to avoid dyspareunia. Such advice was clinically indicated as Dr. Vu had an indication for doing so. In the alternative, the conduct was not of a sexual nature. He had a clear reason to perform the exam, offered both patients a chaperone, respected their privacy while they disrobed, and maintained a running commentary throughout his examination. Although his comments were on a sexually related topic, they were not sexualized. Finally, there was no evidence of sexual intention, motivation or purpose.

196. Counsel submitted that the cases relied on by the Complaints Director (regarding Dr. Nqumayo, Dr. Litchfield and Dr. Delacruz) were distinguishable, because in those cases there was no appearance of clinical care, and there was no medical reason for the examinations that were conducted.

197. Regardless of whether or not sexual abuse is found, Counsel submitted that Dr. Vu's conduct was not otherwise unprofessional. The old standard broadly discusses steps to take to prevent against a boundary violation. Dr. Vu complied with required steps, including providing the patients with privacy to disrobe, using appropriate examination technique, and offering a chaperone. At most, Dr. Vu's dyspareunia advice was an error of judgment, and is not a significant departure from the standard of care so as to constitute unprofessional conduct.

Questions from Hearing Tribunal

198. Following each party's closing submission, the Hearing Tribunal asked the parties whether Dr. Vu's conduct regarding [redacted] could potentially be characterized as sexual misconduct rather than sexual abuse. Mr. Boyer indicated it could not because there is direct touching of the vagina. As such, if the conduct does not constitute sexual abuse, it cannot constitute sexual misconduct, by virtue of the way the provisions are drafted.

199. Ms. McMahon indicated that the Hearing Tribunal could make a finding of sexual misconduct if they found that the examination was not of a sexual nature, but the commentary that accompanied it was.

200. The Hearing Tribunal also asked for clarification with respect to what standard was breached in relation to [redacted], since the conduct occurred prior to Bill 21. Mr. Boyer submitted that the College's Standard of Practice that was in force prior to April 1, 2019 was breached, but the examination was

also clinically inappropriate and as such should be characterized as unprofessional conduct.

201. Ms. McMahon confirmed that the standard that applied to [redacted]'s conduct was the standard at **Exhibit 1, Tab 16**, which prohibits "sexualized" conduct. Dr. Vu's conduct was not sexualized, and as such the standard was not breached.

Advice from Independent Legal Counsel

202. Ms. Haymond, counsel to the Hearing Tribunal, then indicated on the record her advice to the Tribunal. Ms. Haymond stated that when looking at the evidence, the Hearing Tribunal is restricted to what is in the Notice of Hearing. In this case, the allegations reference a breach of two standards of practice, but there was not a broader allegation of unprofessional conduct that encompassed harm to the integrity of the profession or unskilled practice. When deliberating, the Hearing Tribunal must focus on wording in the Notice of Hearing.

203. Ms. Haymond also indicated that the Supreme Court of Canada's decision in *R. v. Chase* makes it clear that sexual motivation or intent is one factor to be considered in determining whether conduct is of a sexual nature, however, the absence of sexual motivation or intent is not determinative. Ms. Haymond indicated that courts in the criminal context have made findings of guilt in the absence of evidence of sexual gratification, and it was not a pre-requisite in the context of allegations of sexual abuse pursuant to the HPA.

204. Both parties were then provided an opportunity to comment on Ms. Haymond's advice, no comments were offered, and the hearing was then adjourned.

FINDINGS

205. The Hearing Tribunal's task is to review the allegations in the Notice of Hearing, and determine whether the allegations are factually proven, on a balance of probabilities.

206. In fulfilling its task, the Hearing Tribunal is confined to considering the allegations set out in the Notice of Hearing.

207. The allegations in this case relate to specific conduct by Dr. Vu while performing internal vaginal exams of [redacted] on November 1, 2017, and of [redacted] on February 4, 2020. It is then alleged that the conduct is contrary to the College of Physicians and Surgeons of Alberta Standards of Practice. However, the only standards specifically referenced in the Notice of Hearing are the Standard of Practice on Boundary Violations that was in force prior to April 1, 2019 ("the Pre-Bill 21 Standard of Practice") and the Standard of Practice on Boundary Violations that was in force after April 1, 2019, when Bill 21, *An Act to Protect Patients,* was proclaimed in force (the "Post-Bill 21 Standard of Practice"). The Notice of Hearing did not reference any other Standards of Practice, nor were there any other standards of practice put into evidence during the course of the hearing.

208. The Hearing Tribunal considered whether the allegations were factually proven, as alleged in the Notice of Hearing, and if so, whether Dr. Vu's conduct in relation to [redacted] contravened the Pre-Bill 21 Standard of Practice (**Exhibit 1, Tab 16, p. 205)**, and whether his conduct in relation to [redacted] contravened the Post-Bill 21 Standard of Practice (**Exhibit 1, Tab 17, p. 207).** The Hearing Tribunal then considered whether, if proven, the conduct rises to the level of unprofessional conduct.

Factual Findings Regarding Allegation #1

209. Allegation #1 relates to the exam performed on [redacted] and is as follows:

> On November 1, 2017, during an examination of your patient, [redacted], you did inappropriately provide commentary along with digital pressure inside the vagina to demonstrate to your patient the point of contact of a penis if the patient were having intercourse using different sexual positions when your patient had made no complaint about sexual difficulties and did not request advice from you on that subject.

210. The facts with respect to allegation #1 are largely undisputed as between [redacted] and Dr. Vu.

211. [redacted] and Dr. Vu agreed that she attended with Dr. Vu on November 1, 2017, because she was experiencing some bleeding from her cervix, and was concerned that her IUD had moved. Dr. Vu performed an internal

vaginal examination, without a chaperone present. While a chaperone was offered, [redacted] had the impression this created an inconvenience, and agreed to proceed without a chaperone since she had no previous issues with Dr. Vu.

212. [redacted] was not sure of the exact order in which the internal exam proceeded, however, at some point during the exam, Dr. Vu inserted his gloved fingers into her vagina and told her "this is how it would feel if you were in x sexual position." Dr. Vu also advised her if she had pain in the position he was demonstrating, a different position may be less painful. [redacted] believed that there were about three sexual positions that were demonstrated by Dr. Vu using his fingers, and one of the positions he referred to during the examination was "doggy style". During the exam, [redacted] didn't understand what was happening, and felt very unsafe. She advised Dr. Vu she did not have pain on intercourse, at which point the examination was terminated.

213. Dr. Vu indicated he had no independent recollection of the care provided to [redacted] However, he described his standard practice when there was a pelvic exam that indicated concerns about vaginal bleeding and placement of the IUD. He would have conducted an external visual inspection, then inserted the speculum and conducted swabs to rule out STIs and viewed the structures. Then he would have removed the speculum and conducted an internal exam at which time he would palpate the cervix, uterus and ovaries to check for abnormalities.

214. Dr. Vu indicated that it was after this portion of the exam, while his fingers were still inserted, that he would have followed his standard practice in relation to dyspareunia, which involved providing counselling on pelvic anatomy and sexual positions to prevent dyspareunia. He stated that he did so by explaining that if the cervix is hit during intercourse, it can cause pain, then utilizing his fingers identified areas to the left, right and anterior of the cervix that can be utilized. During this portion of the exam, he also advised [redacted] of the sexual positions that are most problematic, that is, male on top and that in that position the partner could point to the left or right or the patient can adjust their position. He explained that the better position is the male behind or the female on top.

215. Although there were some discrepancies with respect to [redacted]'s recollection of what occurred and Dr. Vu's testimony, the description provided by [redacted] was largely consistent with Dr. Vu's description of his usual practice.

216. The Hearing Tribunal finds that Dr. Vu did perform an internal vaginal exam on [redacted] on November 1, 2017, following her report of bleeding and concerns that her IUD had shifted. Dr. Vu performed a complete pelvic exam at that time. While [redacted] could not recall the exact sequence of events, the Hearing Tribunal finds that Dr. Vu would have followed his usual practice, which proceeded in three stages consisting of a visual inspection,

the insertion of a speculum and swabs, and then removal of the speculum and an internal exam using his digits to check for abnormalities.

217. Although the Hearing Tribunal finds that Dr. Vu's question "do you shave or wax?" is not really an appropriate question, and could be perceived as unnecessary, other than that comment, the initial portion of the exam proceeded as one would expect.

218. However, while Dr. Vu's fingers were still inserted in [redacted]'s vagina, he proceeded to provide her with what he referred to as "dyspareunia counselling". Although the Hearing Tribunal has referenced this portion of the exam as "dyspareunia counselling", the Hearing Tribunal notes that Dr. Vu did not merely provide verbal advice to [redacted] regarding pain on intercourse. Further, the dyspareunia counselling did not involve an examination to elicit whether digital pressure caused pain in specific locations or where [redacted] had pain on intercourse. [redacted] was not in fact having pain on intercourse at the time, nor was there any indication that she had complained of painful intercourse previously.

219. Rather, during the dyspareunia counselling, Dr. Vu provided digital pressure to three different areas of the vagina (to the left, to the right and to the anterior of the cervix). The Hearing Tribunal finds that his purpose in doing so was to demonstrate that these were the areas of the vagina where the penis could be directed or where the contact should be made, in order to avoid pain on intercourse.

220. While performing this demonstration with his digits inserted in [redacted]'s vagina, Dr. Vu also provided commentary with respect to various sexual positions that may exacerbate or alleviate painful intercourse. He advised [redacted] that it may be more painful for the male to be on top, and less painful for the woman to be on top, or for the man to enter from behind which in the evidence provided was colloquially referred to as "doggy style". The advice about sexual positions was provided contemporaneously while Dr. Vu was using his digits to demonstrate where the penis could be directed to avoid pain.

221. Further, the Hearing Tribunal finds that [redacted] had not reported any sexual difficulties, including pain on intercourse, to Dr. Vu on November 1, 2017, and there is no evidence that she had reported that she had experienced pain on intercourse at any time previously. The Hearing Tribunal accepts [redacted]'s evidence that during the exam, she advised Dr. Vu that she did not have pain on intercourse.

222. [redacted]'s description of events that occurred during the exam was largely consistent with Dr. Vu's description of his usual practice. Both agree that

the dyspareunia counselling occurred, and while [redacted] was not exactly certain of the order of events, her recollection of the portion of the exam where Dr. Vu provided his dyspareunia counselling was largely consistent with Dr. Vu's description of his standard practice.

223. Although there were extensive submissions with respect to [redacted]'s credibility, given that the evidence of Dr. Vu and [redacted] was largely consistent on key points, it is not necessary to resolve all of the inconsistencies, since they were not with respect to matters that were material or significant.

224. Overall, the Hearing Tribunal found [redacted] to be a credible witness, and accepted her description of what occurred during the portion of the exam when she received dyspareunia counselling. Although there were certain things that [redacted] could not remember, such as the exact order in which the internal examination proceeded, or the exact words used by Dr. Vu when providing advice about sexual positions, this is understandable given the passage of time, and the stress of her feeling unsafe at the time. The Hearing Tribunal found that this did not diminish her overall credibility or the reliability of her account of the dyspareunia counselling.

225. Further, the Hearing Tribunal did not agree with the suggestion on behalf of Dr. Vu that [redacted] appeared adversarial or evasive. While [redacted] was frustrated at certain points during her cross-examination, this is understandable given the personal and sensitive nature of her testimony, and the impact the incident had on her. Overall, [redacted] was forthright, clear, and had a sufficient recollection of what occurred during the internal portion of the vaginal exam such that her evidence on the key points was both credible and reliable. Further, [redacted] was candid in acknowledging areas where her memory may not be clear.

226. It was also suggested that [redacted]'s evidence should be given less weight as compared to Dr. Vu's testimony, given the possibility of collusion between [redacted] and [redacted] when they spoke about the incidents in February or March of 2020. The Hearing Tribunal finds that the conversation between [redacted] and [redacted] did not detract from the credibility or reliability of [redacted]'s evidence. There were some material differences between the evidence provided by [redacted] and [redacted]. [redacted] stated that Dr. Vu referred to the position of the penis in order to achieve "maximum pleasure", whereas [redacted] denied that he referred to "maximum pleasure" at any time. [redacted] stated that Dr. Vu referred to one of the sexual positions as "doggy style" whereas [redacted] did not testify that Dr. Vu used this terminology. While the overall description of what occurred was similar, there were some differences. If [redacted] and [redacted] had compared their stories and then tailored their evidence, then it would be expected that their evidence would be more similar. Further, although Dr. Vu's Counsel referred to [redacted] and [redacted] as "friends", in fact [redacted] had left employment on unfavorable terms and the two had not been in contact since then. Accordingly, the fact that there was a conversation between

[redacted] and [redacted] in 2020 did not impact the credibility or reliability of [redacted]'s evidence.

227. The Hearing Tribunal also considered Dr. Vu's testimony and the credibility and reliability of his evidence. The Hearing Tribunal found that Dr. Vu testified in a clear and straight forward manner. Dr. Vu attempted to be helpful, acknowledged where he had deficits in his memory, and responded to questions on cross-examination and from the Hearing Tribunal in a direct and forthright manner. Dr. Vu's evidence was largely internally consistent, although he did acknowledge that he made an error in his written response to the [redacted] Complaint, when he stated that he provides dyspareunia counselling "standardly with all patients" (**Exhibit 1, Tab 12, p. 115)**, since in fact he only provides dyspareunia counselling in the three specific circumstances noted (history of dyspareunia, short vaginal canal or low-lying cervix or prolapsed uterus).

228. He had no independent recollection of the events so much of his testimony was based on his usual practice. Dr. Vu did not record his dyspareunia counselling in [redacted]'s chart, and as such the Hearing Tribunal relied on his description of his usual practice in assessing whether it accepted his evidence regarding what occurred on November 1, 2017. As indicated above, Dr. Vu's evidence is largely consistent with [redacted]'s evidence and there was no real dispute on key material points.

229. The Hearing Tribunal specifically considered whether it accepted Dr. Vu's evidence that it is his standard practice to provide dyspareunia counselling in the three situations where he felt it was indicated. Although Dr. Vu stated in his written response to the [redacted] Complaint (**Exhibit 1, Tab 6, p. 10)** that he provides this advice standardly "with all patients", he clarified in his testimony that this was an error and he only provides dyspareunia counselling in the three circumstances noted. The Hearing Tribunal noted this discrepancy, but accepted Dr. Vu's testimony that he does not provide dyspareunia counselling to all patients, but only provides it in the three circumstances referenced in his testimony. While Dr. Vu did indicate that he provided this advice standardly to all patients, at page 12 of his response, he indicated that "I provided my usual advice regarding avoiding trauma to the cervix during sexual intercourse (see below) because I noted the patient had a history of dyspareunia." Accordingly, although Dr. Vu did not explain in his initial response the three circumstances in which he provides dyspareunia counselling, his response does clarify that he felt he had a reason to perform the dyspareunia counselling, and in that respect is consistent with his later response to the [redacted] Complaint and with his testimony at the hearing.

230. The Hearing Tribunal also considered whether it accepted Dr. Vu's testimony that he genuinely believed that the dyspareunia counselling he provided was helpful and that he was doing so in the best interests of his patients.

The Hearing Tribunal found that Dr. Vu's testimony in this regard appeared to be sincere, and accepted that Dr. Vu engaged in the dyspareunia counselling based on a genuine (but misguided) belief that he was providing helpful advice to his female patients. Despite the fact that the Hearing Tribunal accepted Dr. Vu's testimony that he genuinely believed the dyspareunia counselling was helpful and clinically indicated, this does not excuse Dr. Vu's actions nor does it serve to justify the examination he performed. Set out below is a further discussion with respect to the impact of this factual finding with respect to the analysis of whether Dr. Vu's conduct constitutes "sexual abuse."

231. Although Dr. Vu denied that he would have used the terminology "doggy style" (unless the patient used that terminology), the Hearing Tribunal prefers the testimony of [redacted] on this point. Although the incident occurred in 2017, [redacted] was clear in her testimony that Dr. Vu referred to one of the sexual positions as "doggy style." In fact, Dr. Vu himself acknowledges that one of the positions he recommends to alleviate pain on intercourse is the man entering from behind. This supports [redacted]'s recollection that this position was discussed. [redacted]'s testimony on this point was clear and her recollection of this portion of her encounter with Dr. Vu was consistent with the information provided in the [redacted] Complaint. In contrast, Dr. Vu had no independent recollection of the events and relied only on his usual practice. Further, Dr. Vu conceded that he might have used the term "doggy style" if the patient had asked about it. The Hearing Tribunal finds that [redacted] did not ask Dr. Vu any questions and did not utilize the term "doggy style" herself. Instead, the Hearing Tribunal finds that while Dr. Vu was providing commentary during the dyspareunia counselling, he used the more colloquial term "doggy style".

232. In light of the foregoing, the Hearing Tribunal finds that Dr. Vu provided commentary to [redacted], along with digital pressure, to demonstrate the point of contact of a penis during intercourse using different sexual positions. The Hearing Tribunal further finds that the patient had not made any complaints about sexual difficulties, including pain on intercourse. The purpose of her attendance with Dr. Vu on November 1, 2017 was to determine the cause of the cervical bleeding, and determine whether her IUD was in place.

233. Allegation #1 also alleges that the commentary provided by Dr. Vu during the dyspareunia counselling, along with the digital pressure, was *inappropriate.* Accordingly, in order to find the allegation is factually proven, the Hearing Tribunal must also consider whether the commentary and digital pressure were inappropriate in all of the circumstances.

234. The Hearing Tribunal carefully considered the evidence of Dr. Bell regarding the standard of care that applies to family physicians performing exams of

this nature. The Hearing Tribunal also considered Dr. Vu's evidence regarding his rationale for proceeding with dyspareunia counselling in this case.

235. Dr. Vu testified that he developed a practice of providing dyspareunia counselling in three circumstances: where the patient has a history of dyspareunia, a short vaginal canal or a low-lying cervix, or those with a uterine prolapse. Dr. Vu indicated that although he had no special training in sexual health, dyspareunia is an issue for many patients, and he began to include the dyspareunia counselling for all patients who fell into one of these categories, in order to proactively prevent future potential incidences of dyspareunia.

236. The Hearing Tribunal finds that the dyspareunia counselling, including the use of his digits to demonstrate the point of contact of the penis, while at the same time discussing sexual positions that the patient could be in to avoid pain, was inappropriate. Regardless of whether [redacted] was at risk of developing dyspareunia at some point in the future (due to a short vaginal canal or low-lying cervix) she was not having pain on intercourse at the time she came to see Dr. Vu on November 1, 2017. Nor did she have any history of dyspareunia. It was inappropriate for Dr. Vu to assume that [redacted] was interested in dyspareunia counselling, particularly given the invasive nature of the counselling, which included a digital demonstration and advice about sexual positions, while his fingers were inserted in her vagina.

237. The Hearing Tribunal carefully considered the expert opinion provided by Dr. Bell with respect to chaperones. During the hearing there was a considerable amount of testimony and focus on the issue of chaperones, and whether Dr. Vu should have proceeded with the patient examinations of both [redacted] and [redacted] in the absence of a chaperone. The Hearing Tribunal notes that there is no allegation against Dr. Vu alleging that it was inappropriate to proceed in the absence of a chaperone. However, the fact that examinations were conducted in the absence of a chaperone does have a bearing on whether Dr. Vu's conduct was of a "sexual nature", and is discussed in further detail below.

238. Although there is no allegation that Dr. Vu inappropriately proceeded with the examinations in the absence of a chaperone, the Hearing Tribunal did consider Dr. Bell's evidence on this point, and disagrees that it is mandatory to have a chaperone present for sensitive examinations. While it is strongly advisable, and the Hearing Tribunal accepts Dr. Bell's opinion that family medicine residents are taught not to proceed without a chaperone present, proceeding in the absence of a chaperone is not contrary to the College's standards of practice. The Advice to the Profession on Boundary Violations: Sexual, states that the College "strongly recommends the use of a chaperone if requested by a patient" during sensitive personal or intimate

examinations, however this is not a mandatory requirement (**Exhibit 1, Tab 18, p. 218).** Nor is proceeding with an examination in the absence of a chaperone contrary to the advice provided by the CMPA (**Exhibit 1, Tab 6, p. 20).** Accordingly, while the Hearing Tribunal agrees that it is strongly advisable, as long as a chaperone is offered, proceeding without a chaperone does not contravene the College's standards of practice.

239. While the Hearing Tribunal did not agree with Dr. Bell's opinion that a chaperone was mandatory for a sensitive examination, the Hearing Tribunal accepted Dr. Bell's opinion that Dr. Vu's comments and clinical exam during which he discusses various sexual positions and how they impact upon pain during intercourse were unacceptable, and would only be appropriate if the patient had specifically indicated that she was having pain with intercourse and that she wanted advice about it.

240. Although Dr. Bell stated in cross-examination that the examination that Dr. Vu conducted was appropriate, but he had no indication for it, on re-direct, Dr. Bell clarified his response, stating that a digital vaginal exam could be appropriate to explore various parts of the vagina to see where the pain may be arising, if appropriate consent had been obtained. However, providing a description of various sexual positions is not something he would do. The Hearing Tribunal agreed with Dr. Bell that with a complaint of pelvic pain a digital vaginal exam could be clinically indicated and could be appropriate. However, in this case the dyspareunia counselling was not appropriate to the service being provided, nor was it undertaken appropriately.

241. Patients who attend for sensitive examinations are in an extremely vulnerable position. A patient who consents to an internal vaginal exam does not provide the physician with carte blanche to undertake other assessments or procedures, or to provide advice on matters not directly relevant to the reason for the patient's attendance. Dr. Vu, in providing dyspareunia counselling, chose to expand the services he was asked to provide, and give extra advice and perform additional procedures on matters that were neither requested nor specifically indicated, as there was no complaint of dyspareunia (nor did Dr. Vu even ask about this). By providing extra advice and engaging in extra procedures, Dr. Vu effectively prolonged the duration of time his fingers were inserted in D.D's vagina. [redacted] understandably felt shocked and scared. The Hearing Tribunal agrees with Dr. Bell that the dyspareunia counselling was an unnecessary invasion of the patient of a personal and sensitive nature.

242. Although Dr. Vu suggested that he was trying to be helpful, the dyspareunia counselling, which involved touching intended to demonstrate the point of contact of a penis within [redacted]'s vagina, along with advice about different sexual positions that could alleviate painful intercourse, was not requested

by [redacted] and was something that she did not expect. The dyspareunia counselling was not warranted, and in the circumstances was inappropriate.

243. In light of the foregoing, all of the elements of allegation #1 are factually proven on a balance of probabilities.

Factual Findings Regarding Allegation #2

244. Allegation #2 related to [redacted] and is as follows:

> On February 4, 2020, during an examination of your patient, [redacted], you did inappropriately provide commentary along with digital pressure inside the vagina to demonstrate to your patient the point of contact of a penis if the patient were having intercourse using different sexual positions when your patient had made no complaint about sexual difficulties and did not request advice from you on that subject.

245. As was the case with [redacted] much of what occurred was not in dispute regarding the examination that Dr. Vu conducted of [redacted] on February 4, 2020.

246. [redacted] testified that she attended with Dr. Vu on February 4, 2020 as she had a cyst in her armpit. She also wanted to be checked for STIs. She stated that she had no other concerns at the time. [redacted] testified that during the internal portion of the exam, Dr. Vu inserted his hand inside of her and said "this is the position that the penis needs to be to have the most maximum pleasure of a woman your size." [redacted] could not recall the number of positions demonstrated, but believes it could have been one, two or three. At the time, [redacted] was not experiencing any pain on intercourse and if Dr. Vu had asked her if she was, she would have said "no." [redacted] felt violated and reported the incident to the CPS and then to the College.

247. Dr. Vu stated that when examining [redacted] on February 4, 2020, he followed his standard practice regarding dyspareunia counselling, which would have been indicated as she had complained of intermittent dyspareunia at a previous appointment on January 17, 2019. Dr. Vu said he would not have inserted his hand into [redacted]'s vagina, but would have inserted his gloved digits. Further, he denied advising of her of the position the penis needs to be in for "maximum pleasure" or of advising [redacted] of sexual positions suitable for a woman of her shape and build.

248. The Hearing Tribunal finds that the examination of [redacted] proceeded in the same manner as the examination that Dr. Vu conducted of [redacted], in accordance with Dr. Vu's standard practice. That is, following the speculum portion of the exam, he conducted an internal exam involving palpation of

the cervix, uterus and ovaries. However, because of [redacted]'s previous history of dyspareunia, he proceeded to perform dyspareunia counselling, in the same manner as described above for [redacted]

249. There were several discrepancies between the evidence of [redacted] and Dr. Vu. [redacted] stated that a nurse was present at the beginning of the exam, but left with [redacted]'s permission because the room was too crowded. This was denied by Dr. Vu, who explained that discussions about having a chaperone always occur prior to the sensitive examination beginning. If a chaperone is requested, the nurse will be invited and the examination will be delayed until the nurse is available.

250. The Hearing Tribunal believes that [redacted]'s recollection that a nurse was originally present and then left the examination room is unlikely, as this would be inconsistent with Dr. Vu's usual practice. Further, it is inconsistent with the more plausible scenario, which is that a chaperone was initially offered, but declined by [redacted]. Dr. Vu indicated that there are occasions where the nurse sees the patient to obtain information before he attends with the patient, and that is possibly what occurred here.

251. Further, [redacted] stated in the [redacted] Complaint that previous vaginal exams performed at the Clinic had been performed by nurses. Dr. Vu denied this was the case the case and confirmed that vaginal exams are only performed by physicians at the Clinic. A vaginal exam is a restricted activity, and the Hearing Tribunal finds that it is unlikely that any of [redacted]'s previous vaginal exams were conducted by nurses. Further, this is inconsistent with [redacted]'s patient chart.

252. While [redacted]'s recollection regarding the nurse being present initially then leaving, and her recollection that previous exams were conducted by nurses, is not in and of itself, material to the Hearing Tribunal's decision with respect to allegation #2, the Hearing Tribunal did consider these inconsistencies when considering the more important inconsistency with respect to [redacted]'s evidence, which is whether Dr. Vu used the words "maximum pleasure", or whether [redacted] could have been mistaken in that regard.

253. As noted above at paragraph 226, the Hearing Tribunal did not find that the discussion that [redacted] and [redacted] demonstrated collusion, or that it impacted [redacted]'s credibility. That discussion occurred <u>after</u> [redacted] had already submitted her Complaint to the CPS. There was nothing to indicate that [redacted] changed or tailored her version of events to make it more similar to [redacted]'s description of what occurred.

254. When considering [redacted]'s evidence that Dr. Vu used the words "maximum pleasure", the Hearing Tribunal carefully reviewed the [redacted] Complaint that she submitted to CPS, which was written on February 5, 2020, the day after she attended with Dr. Vu. In the [redacted] Complaint, she stated the following:

> "When finally, with his fingers moving inside of me began giving me sex advise positions that would be suitable for a woman of my shape and build and physically with his fingers showing me positions the penis should be moving for more comfort." Nowhere in the [redacted] Complaint does she indicate that Dr. Vu used the words "maximum pleasure."

255. While the Hearing Tribunal accepts [redacted]'s evidence that she was in shock and not in the best mental state at the time she prepared the [redacted] Complaint, her omission of the words "maximum pleasure" is significant. The Hearing Tribunal finds that it is unlikely that Dr. Vu advised [redacted] how to achieve "maximum pleasure", and rejects [redacted]'s testimony in this regard.

256. The Hearing Tribunal's findings on this point are further reinforced as a result of its findings on the more minor discrepancies referred to above. Although [redacted] did her best to recall what occurred, her testimony that a chaperone was initially present and then left, and that a nurse had performed her vaginal exam previously, was not plausible and was not accepted. This impacted the reliability of her evidence that Dr. Vu referred to "maximum pleasure", and as such the Hearing Tribunal rejected her testimony on that point.

257. While the Hearing Tribunal rejected [redacted]'s evidence that Dr. Vu told her about sexual positions to achieve "maximum pleasure", the Hearing Tribunal did not agree with the submission on behalf of Dr. Vu that [redacted]'s credibility was impacted because she was sarcastic or argumentative. [redacted] was testifying about an event that was clearly traumatic for her. It is expected that a patient who feels she has been sexually violated may appear emotional or angry. The tone and manner of [redacted]'s testimony did not diminish her credibility, and the Hearing Tribunal's findings with respect to the reference to "maximum pleasure" were based primarily on the discrepancy between [redacted]'s testimony and the language used in the [redacted] Complaint.

258. The Hearing Tribunal finds that the appointment on February 4, 2020 unfolded in a similar manner as the appointment with [redacted] on November 1, 2017, and that Dr. Vu followed his standard practice in providing dyspareunia counselling to [redacted].

259. As was the case with [redacted], while Dr. Vu's fingers were still inserted in [redacted]'s vagina, he provided digital pressure to three different areas of the vagina

(to the left, to the right and to the anterior of the cervix). His purpose in doing so was to demonstrate that there were areas of the vagina where the penis could be directed or where contact should be made by the penis, in order to avoid pain on intercourse.

260. At the same time, while performing this demonstration with his digits inserted in [redacted]'s vagina, Dr. Vu also provided commentary with respect to various sexual positions that may exacerbate or alleviate painful intercourse. He advised [redacted] that it may be more painful for the male to be on top, and less painful for the woman to be on top, or for the man to enter from behind. The advice about sexual positions was provided contemporaneously while Dr. Vu was using his digits to demonstrate where the penis could be directed to avoid pain.

261. For the same reasons as set out above in relation to allegation #1, the Hearing Tribunal finds that allegation #2 against Dr. Vu regarding [redacted] is factually proven on a balance of probabilities.

262. In considering allegation #2, the Hearing Tribunal specifically considered whether [redacted]'s report of intermittent dyspareunia on January 17, 2019 provided Dr. Vu with any additional clinical indication to perform the dyspareunia counselling, as compared with [redacted] The Hearing Tribunal accepted Dr. Bell's opinion and found that there was no clinical indication for the dyspareunia counselling, notwithstanding that [redacted] had reported intermittent dyspareunia previously. The purpose of [redacted]'s attendance with Dr. Vu on February 4, 2020, almost a year later, had nothing to do with dyspareunia. Nor is there any evidence that Dr. Vu asked [redacted] whether she had experienced dyspareunia since then. Further, at the time she had complained about dyspareunia, a relevant examination and counselling was not undertaken by Dr. Vu, making it harder to justify such an examination and counselling, unexpected by the patient, at a point in which this symptom was not present. Dr. Vu's decision to provide dyspareunia counselling was not clinically indicated. Even if Dr. Vu had a genuine belief that he was helping [redacted] due to her previous report of intermittent dyspareunia the previous year, the provision of dyspareunia counselling was not appropriate in this circumstance, and nor was the manner in which it was provided appropriate.

263. In light of the foregoing, all of the elements of allegation #2 are factually proven on a balance of probabilities.

Whether the Conduct Constitutes "Unprofessional Conduct"

264. Although the Hearing Tribunal has found that the elements of allegation #1 and #2 are factually proven, the Hearing Tribunal must go on to consider whether the conduct constitutes "unprofessional conduct".

265. "Unprofessional conduct" is defined in s. 1(1)(pp) of the HPA to include a variety of conduct. As indicated above, the only potential unprofessional conduct referenced in the Notice of Hearing are breaches of the Standards of Practice relating to boundary violations.

266. Accordingly, the Hearing Tribunal must consider whether Dr. Vu's conduct constitutes a breach of the relevant standards of practice that were in force at the time of his examination of each patient.

267. Although the allegation relating to [redacted] is the first allegation, the parties first turned their attention to the allegation relating to [redacted], which occurred in February of 2020. This is because the Standard of Practice changed effective April 1, 2019, as did the applicable provisions in the HPA. Effective April 1, 2019, the HPA was amended to require mandatory cancellation of a regulated member's registration and practice permit following a finding of "sexual abuse."

268. Because the parties focused their submissions considerably on whether the conduct in issue constitutes "sexual abuse", the Hearing Tribunal will address allegation #2 relating to [redacted] first, and will then address allegation #1 relating to [redacted]

Framework for Determining Whether the Conduct Referred to in Allegation #2 Constitutes "Sexual Abuse" Pursuant to the HPA

269. As indicated above, the Hearing Tribunal finds that the elements of allegation #2 are factually proven, on a balance of probabilities.

270. However, the Hearing Tribunal must go on to determine whether the conduct constitutes "sexual abuse" as defined in the HPA, and as set out in the Post-Bill 21 Standard of Practice.

271. The definition of sexual abuse is set out in s. 1(1)(nn.1) of the HPA as follows:

> (nn.1) "sexual abuse" means the threatened, attempted or actual conduct of a regulated member towards a patient that is of a sexual nature and includes any of the following conduct:

(i) sexual intercourse between a regulated member and a patient of that regulated member;

(ii) genital to genital, genital to anal, oral to genital, or oral to anal contact between a regulated member and a patient of that regulated member;

(iii) masturbation of a regulated member by, or in the presence of, a patient of that regulated member;

(iv) masturbation of a regulated member's patient by that regulated member;

(v) encouraging a regulated member's patient to masturbate in the presence of that regulated member.

(vi) touching of a sexual nature of a patient's genitals, anus, breasts or buttocks by a regulated member.

272. The definition of "sexual nature" is set out in section 1(1)(nn.3) as follows:

> "sexual nature" does not include any conduct, behaviour or remarks that are appropriate to the services provided.

273. These definitions are repeated in the Post-Bill 21 Standard of Practice, which provides further clarification regarding the definition of "sexual nature":

> "In other words, touching of the patient's body by a regulated member does not constitute Sexual Abuse if the touching is appropriate to the health care service being provided. However, regulated members are reminded of the obligation to obtain a patient's informed consent prior to an examination, assessment, treatment or procedure. (See the College's standard of practice on *Informed Consent* and its Advice to the Profession on "Informed Consent for Adults" and "Informed Consent for Minors".)

274. Because Dr. Vu touched [redacted]'s genitals while providing the dyspareunia counselling, it falls within the list of activities described in s. 1(1)(nn.1)(vi). However, such touching only constitutes "sexual abuse" if the touching was of a "sexual nature."

275. Section 1(1)(nn.3) and the Post-Bill 21 Standard of Practice make it clear that if the touching of the [redacted]'s genitals was "appropriate to the service provided", the touching will not constitute "sexual abuse".

276. Given that [redacted] indicated she wanted to be checked for an STI, it was appropriate for Dr. Vu to conduct a pelvic exam and test her for STIs, and

to touch her genitals for that purpose. This was the service sought by [redacted] and the service that ought to have been provided by Dr. Vu. For the reasons already noted above, it was not appropriate for Dr. Vu to extend his examination to continue touching [redacted]'s genitals in order to provide dyspareunia counselling. [redacted] did not attend with complaints of dyspareunia, nor did Dr. Vu ask if she was experiencing dyspareunia. Dr. Vu's decision to proceed with dyspareunia counselling resulted in more prolonged touching of [redacted]'s genitals when such touching was not clinically indicated, not consented to, and was not appropriate to the service being provided.

277. The fact that Dr. Vu already had his fingers inserted into [redacted]'s vagina did not mean that he was authorized to continue with an additional procedure that was not indicated or requested, particularly given the sensitive nature of the touching and the accompanying commentary regarding sexual positions, which occurred while Dr. Vu's fingers were still inserted in [redacted]'s vagina.

278. As such, the Hearing Tribunal finds that this portion of the exam was not appropriate to the health care service being provided, which was an internal exam, including swabs for an STI.

279. Although by virtue of s. 1(1)(nn.1) of the HPA, touching of the genitals that is appropriate to the services being provided cannot constitute "sexual abuse", the HPA does not state that touching that is <u>not</u> appropriate to the health care service being provided automatically constitutes "sexual abuse".

280. Dr. Bell opined that if a sensitive examination is not clinically indicated, then the touching is automatically sexual abuse, and there is no middle ground. The Hearing Tribunal does not agree with Dr. Bell's interpretation. When there is touching of the nature described in s. 1(1)(nn.1) that is not clinically indicated or appropriate to the service provided, that may be a factor that suggests that the conduct constitutes sexual abuse. However, this is only one of the factors to be considered and is not determinative.

281. Even where the touching is not appropriate to the service provided, pursuant to s. 1(1)(nn.1) of the HPA, such touching will still only constitute "sexual abuse" if the touching is of a "sexual nature." Accordingly, even though the touching was not appropriate to the internal exam which was the reason for [redacted]'s attendance on February 4, 2020, the Hearing Tribunal must still go on to assess whether the touching of [redacted] was of a "sexual nature" as contemplated in the HPA.

282. Unfortunately, neither the HPA nor the Post-Bill 21 Standard of Practice provides any further guidance regarding what constitutes touching of a

"sexual nature". Accordingly, the Hearing Tribunal must determine what that term means.

283. Although "sexual nature" is not defined, the modern approach to statutory interpretation requires that the words of an Act be read in their entire context and in their grammatical and ordinary sense, harmoniously with the scheme of the Act, the object of the Act, and the intention of the legislature.

284. Although there are a variety of dictionary definitions of the word "sexual", generally the word "sexual" is defined as relating to sex or sexual activity.[2]

285. Although clearly the dyspareunia counselling provided by Dr. Vu related to sexual activity, both parties referred to case law to assist the Hearing Tribunal in determining whether Dr. Vu's conduct was of a "sexual nature" such that his conduct in relation to [redacted] constituted "sexual abuse". Given that physicians may be required to engage in discussions about sex or sexual activity and/or to touch a patient's genitals or sensitive body parts while providing care, the mere fact that an exam or counselling relates to sex or sexual activity is not necessarily determinative. Accordingly, in addition to considering the plain and ordinary meaning of the word "sexual", the Hearing Tribunal determined that it was appropriate to consider the cases presented by the parties.

286. Both parties referred to the Supreme Court of Canada's decision in *R. v. Chase,* a criminal case involving an allegation of sexual assault*,* where the complainant alleged that the accused seized her around the shoulders and grabbed her breasts. In order to determine whether the charge was proven, the Court had to determine whether the assault was of a "sexual nature", which is not a defined term in the *Criminal Code.* The Court held that the test to determine whether an assault is sexual is an objective test, and is whether "viewed in the light of all of the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer"?

287. Although *R. v. Chase* is a criminal case, it has been utilized in the professional discipline context. The Hearing Tribunal agrees with both parties that, in the absence of a specific definition of "sexual nature", the test articulated in *Chase* is helpful. It has been applied in similar proceedings involving health professionals charged with sexual abuse. See for example: *CPSO v. Peirovy,* 2018 ONCA 420; *CPSO v. Phipps*, 2018 ONCPSD 48; and *CPSO v. Islam*, 2020 ONSPSD 5. The test applies equally to professional conduct proceedings under the HPA.

[2] See, for example, the definition at Dictionary.com which defines "sexual" as "occurring between or involving the sexes". See also the definition in merriam-webster.com where it is defined as "of, relating to, or associated with sex or the sexes."

288. In *Chase*, the Court set out a number of factors that may be considered in order to determine whether there is a sexual or carnal context to the assault. These factors include:

- The part of the body touched;
- The nature of the contact;
- The situation in which the contact occurred;
- The accompanying words and gestures;
- The intent and purpose of the person committing the act;
- Whether the accused's motive is sexual gratification; and
- Any other relevant factors.

289. Counsel for Dr. Vu referenced a number of additional factors that have been considered by tribunals pursuant to Ontario's *Regulated Health Professions Act* when considering whether touching by a health professional is of a "sexual nature" and therefore constitutes "sexual abuse".[3] The Hearing Tribunal agrees that although the factors set out in *Chase* are a good starting point, there are additional factors that should be considered in the context of a professional conduct hearing involving a regulated health professional. It is necessary to consider factors, in addition to those referred to in *Chase,* because health professionals may be required to touch sensitive parts of the body in order to effectively provide health services to their patients. As such, the entire context in which the services were provided must be taken into account. The additional factors that may be relevant include:

- Whether the touching was appropriate to the service provided;
- The patient's perception regarding what occurred;
- Whether care was taken to respect to the privacy and integrity of the patient during the exam (e.g. appropriate draping and presence of a chaperone if appropriate);
- Whether consent was provided for the examination or treatment;
- Whether the touching was accidental or incidental;
- Whether the physician was under a misguided or clearly mistaken belief in the necessity of care; and
- Whether the touching was unrelated to a medical purpose.

[3] See, for example: *CMTO v Gudov*, 2020 ONCMTO 29; *CMTO v. Bennett*, 2021 ONCMTO 14; *CPSO v. Kunyetz*, 2019 ONSC 4300; *CPSO v. Mallette,* 2020 ONCSPSD 2; *and Re Chung*, 2014 ONCPSD 7.

290. The above list is not intended to be exhaustive, and there may be other factors that are relevant depending on the circumstances. No single factor is determinative. Instead, each of the relevant factors should be considered as part of the analysis to assist in determining whether the sexual or carnal nature of the act is apparent to a reasonable observer.

Does Dr. Vu's Touching of [redacted]'s Vagina as Alleged in Allegation #2 Constitute Sexual Abuse and a Breach of the Post-Bill 21 Standard of Practice?

291. The Hearing Tribunal carefully considered each of the factors referenced above, in order to determine whether Dr. Vu's touching of [redacted]'s vagina was of a "sexual nature":

- **Whether the touching was appropriate to the service provided:** [redacted] attended with Dr. Vu in relation to a cyst under her arm, and requested a swab for STIs. While it was appropriate for Dr. Vu to conduct an internal pelvic examination in conjunction with testing for STIs, it was not appropriate for Dr. Vu to extend the services and provide unwanted advice regarding dyspareunia, which included a digital demonstration of where the penis should be directed.

- **The nature of the contact:** Dr. Vu provided dyspareunia counselling that consisted of using his fingers to touch [redacted]'s vagina to demonstrate the point of contact of the penis. At the same time, he provided advice to [redacted] about sexual positions that she could engage in to minimize pain on intercourse. Dr. Vu's commentary and actions clearly pertained to sexual activity between [redacted] and her sexual partners, was not clinically indicated, and was not appropriate to the service being provided.

- **Situation in which the contact occurred:** The situation here differed from some of the cases referred to by the Complaints Director, such as the decision in *Litchfield v. CPSA,* 20018 ABCA 164 (and related discipline proceedings), where Dr. Litchfield was found to have engaged in a pelvic exam that was not medically necessary at all. In contrast, this was not a situation where there was no clinical indication for Dr. Vu to conduct an internal pelvic examination of [redacted] at all. While the routine portion of the pelvic examination was clinically indicated, Dr. Vu prolonged the touching of [redacted]'s vagina by providing dyspareunia counselling, which was not indicated or requested by [redacted]. The fact that there was a legitimate medical purpose for the initial examination did not authorize Dr. Vu to continue to keep his fingers inserted into [redacted]'s vagina for purposes that were not warranted.

- **Intent and purpose:** The Hearing Tribunal accepted that Dr. Vu's intent in providing dyspareunia counselling was to assist [redacted] in avoiding pain on intercourse, a common problem reported by his patients and one which [redacted] had experienced previously.

- **Sexual gratification:** There was no evidence that Dr. Vu derived sexual gratification as a result of providing dyspareunia counselling. Although the Court in *Chase* held that whether the accused's motive was sexual gratification was one factor that could be considered, the Court confirmed that sexual assault is not a crime requiring evidence of specific intent. As such, in the criminal context, the accused can be convicted of sexual assault, even when there is no evidence of sexual gratification:

  > "The factors that could motivate sexual assault are said to be many and varied….To put upon the Crown the burden of proving a specific intent would go a long way toward defeating the obvious purpose of the enactment. Moreover, there are strong reasons in social policy which would support this view. To import an added element of specific intent in such offences, would be to hamper unreasonably the enforcement process."

  While *Chase* is a criminal case, a finding of sexual intent or gratification is similarly not a pre-requisite to a finding sexual abuse under the HPA. While evidence of sexual gratification will make the carnal or sexual nature of the conduct more likely, the absence of sexual gratification is not determinative. Requiring the Complaints Director to prove sexual gratification would place an impossible burden on the Complaints Director, since in many instances the patient will not be in a position to observe whether the physician experienced sexual gratification. Sexual gratification is therefore only one factor to be considered; it is not a required element in order to find that conduct is of a "sexual nature."

- **Whether care was taken to respect the patient's privacy and integrity:** Dr. Vu left the room so that [redacted] could change into a gown, and engaged in appropriate draping. Although some steps were taken to respect [redacted]'s privacy and integrity, these actions were insufficient to mitigate the harmful impact caused by the dyspareunia counselling he provided. Despite the fact that [redacted] was properly draped, Dr. Vu's actions violated [redacted]'s sexual integrity.

- **Whether consent was provided:** Although Dr. Vu testified that it is his practice to provide a "running commentary" while providing care, and this was not disputed by [redacted], Dr. Vu did not take adequate steps to obtain informed consent. Specifically:

- He did not discuss the dyspareunia counselling with [redacted] at any time prior to inserting the speculum into her vagina or conducting the examination of her internal structures. Dr. Vu proceeded with the dyspareunia counselling after this portion of the exam, without providing any prior warning to [redacted].

- He did not explain why he felt such counselling was warranted or would be helpful, nor did he provide [redacted] with the opportunity to refuse. [redacted] was understandably shocked and surprised. While physicians are entitled to rely on implied consent for some forms of examinations, in situations where a physician engages in a sensitive examination, greater care must be taken to ensure that specific and explicit consent is obtained.

- The requirement for explicit consent for sensitive examinations is detailed in the Advice to the Professions, Boundary Violations: Sexual **(Exhibit 1, Tab 18, p. 217).** Although Dr. Vu obtained consent to perform an internal exam, and although [redacted] consented to proceed without a chaperone, once the exam delved into different territory - sexual counselling without request for such counselling, including digital touching as an unexpected physical action – further consent was required. The fact that [redacted] consented to a routine pelvic exam does not mean that she consented to the dyspareunia counselling.

- Although [redacted] agreed to proceed with the internal exam without having a chaperone present, at the time she agreed she was not aware that Dr. Vu intended to perform dyspareunia counselling. While it was not inappropriate for Dr. Vu to proceed without the presence of a chaperone, he did not explain what he intended to do during the internal exam. Had he explained it to [redacted], she could have consented or refused, or could have agreed to proceed but only with a chaperone present.

- [redacted] was not aware in advance of what the touching would consist of, or the purpose of the touching. As such, she cannot be said to have provided implied consent. Further, Dr. Vu himself recognized that it would have been appropriate to obtain consent in advance before he commenced the pelvic examination.

- In all of the circumstances, Dr. Vu did not obtain adequate informed consent prior to providing dyspareunia counselling.

- **Whether the touching was accidental or incidental:** This was not a situation where Dr. Vu inadvertently touched or brushed up against [redacted]'s vagina while providing care. Dr. Vu intentionally

touched [redacted]'s vagina, utilizing his fingers to demonstrate points within the vagina where the penis could be directed to minimize painful intercourse.

- **Misguided or Mistaken Belief in the Necessity of Care:** The Hearing Tribunal found that Dr. Vu was sincere that his dyspareunia counselling had been helpful to other patients and would be helpful to [redacted]. The Hearing Tribunal however found that there was no evidence that Dr. Vu believed that the dyspareunia counselling was "necessary". Rather he adopted the practice because some patients had reported that they found it to be helpful. Regardless of the reason for engaging in the conduct, the Hearing Tribunal found that the dyspareunia counselling was unwarranted, and that Dr. Vu's ignorance or naivety did not serve to justify his actions. [redacted] did not report pain on intercourse when she attended with Dr. Vu in February of 2020, and in fact she was not asked by Dr. Vu whether she was continuing to have intermittent dyspareunia. Importantly, Dr. Vu had no specific training in treating sexual health disorders, including dyspareunia. Even if Dr. Vu naively believed that he was providing helpful assistance, his beliefs were misguided and demonstrated a complete lack of understanding regarding the sensitive and personal nature of the services he was providing.

- **Whether the conduct was unrelated to a medical purpose:** Although Dr. Vu's purpose in providing the dyspareunia counselling was to assist in the event of future episodes of dyspareunia, and in that sense he had a medical purpose for engaging in dyspareunia counselling, as noted above, the dyspareunia counselling was not clinically indicated nor was it appropriate to the service being provided.

- **The patient's perception regarding what occurred:** [redacted] noted in the [redacted] Complaint that Dr. Vu's actions were "wildly inappropriate", and she testified that she felt violated as a result of Dr. Vu's actions, which prompted her to report her concerns to CPS. Although the patient's perceptions of what occurred are not any more determinative than the physician's intent, whether or not the patient perceived the conduct as being sexual in nature is one factor that may be considered.

- **Other factors:** Although Dr. Vu was not charged with proceeding with the dyspareunia counselling in the absence of a chaperone, and in any event the Hearing Tribunal rejects Dr. Bell's opinion that a chaperone was required, the fact that Dr. Vu proceeded to provide dyspareunia counselling when there was no chaperone present is nevertheless a contextual factor that is relevant in this case. Dr. Vu proceeded with dyspareunia counselling when there was no third party present. This was extremely unwise, but is also relevant when

assessing whether the carnal or sexual nature of the conduct is visible to a reasonable observer.

292. As indicated above, the Hearing Tribunal does not agree with Dr. Bell that if a physician touches a patient's vagina and the touching is not appropriate to the service being provided, it automatically constitutes "sexual abuse." However, where a physician touches a part of the body referred to in s. 1(1)(nn.1) (including a patient's genitals), and the touching is not appropriate to the service being provided, the touching should be scrutinized very carefully. Careful scrutiny is required in order to ensure that physicians are diligent in carrying out examinations and procedures involving sensitive body parts when clinically appropriate. While careful scrutiny is required, this is still only one of the many factors to be considered, and is not, in and of itself, determinative.

293. As such, even though the touching of [redacted]'s vagina was not appropriate to the service being provided, the Hearing Tribunal went on to consider whether the touching was of a "sexual nature", and more particularly, whether the sexual or carnal nature of the touching would be visible to a reasonable observer.

294. The Hearing Tribunal finds that the Complaints Director has proven, on a balance of probabilities, that Dr. Vu's conduct constitutes "sexual abuse" as defined in the HPA. Although there is no evidence that Dr. Vu experienced any sexual gratification as a result of the dyspareunia counselling he provided to [redacted], the sexual or carnal nature of the touching would nevertheless be visible to a reasonable observer. Dr. Vu used his fingers to demonstrate the point of contact of the penis in [redacted]'s vagina, while at the same time providing [redacted] with advice about different sexual positions she (and her partner) could use to minimize pain on intercourse. Both the touching and the contemporaneous commentary provided by Dr. Vu pertained to the act of having sex, and in this sense the dyspareunia counselling was clearly of a "sexual nature".

295. Further, a reasonable observer would consider the conduct to be of a sexual or carnal nature, given the purposeful nature of the touching when there was no clinical indication for Dr. Vu to provide dyspareunia counselling on the date in question. The sexual or carnal nature of the conduct is also apparent given that Dr. Vu did not take any steps to obtain informed consent, and instead proceeded to touch [redacted] in a manner that violated her sexual integrity and caused her harm. [redacted] was not warned in advance of what Dr. Vu proposed to do, and had no opportunity to refuse.

296. Notably, there was no chaperone present. While a chaperone was not necessary, the fact that the dyspareunia counselling was provided in the

absence of a third party chaperone is another factor that would cause a reasonable observer to believe that the touching was of a sexual nature.

297. The Hearing Tribunal specifically considered that there was no evidence of sexual intent or sexual gratification. As noted above, this is not a requirement for a finding of sexual abuse. Even without carnal intent or evidence of sexual gratification on the part of Dr. Vu, the dyspareunia counselling would be viewed by a reasonable observer to be an invasion of the sexual integrity of the patient, and based on a consideration of the relevant factors constitutes sexual abuse.

298. Further, the Hearing Tribunal also carefully considered Dr. Vu's stated purpose in carrying out the dyspareunia counselling. Although the Hearing Tribunal found that Dr. Vu believed that his actions benefitted [redacted], ignorance or naivety is no excuse. Further, the fact that Dr. Vu had a genuine belief that his dyspareunia counselling was warranted and helpful does not diminish the sexual or carnal nature of the touching, when viewed objectively and considered in conjunction with the other relevant factors. The amendments to the HPA were made in recognition of the power imbalance that exists between physicians and their patients. Physicians have a tremendous amount of knowledge that patients do not have, and patients are required to trust that their physician will take care to only touch them when such touching is warranted. Physicians must take appropriate steps to touch sensitive parts of the body only for purposes that are clinically indicated, and even then only when they have obtained adequate informed consent. The manner in which Dr. Vu touched [redacted] would be perceived by a reasonable observer as being in sexual in nature. Dr. Vu's conduct was invasive, and had a negative impact on [redacted]. It was not a technical or minor breach of his obligations. Further, Dr. Vu's conduct occurred less than one year after Bill 21 was proclaimed in force, at a time when Dr. Vu ought to have known that his actions were inappropriate. Dr. Vu's ignorance does not serve as a defence.

299. Physicians must continue to provide appropriate care to their patients, and should not be reluctant to examine patients in sensitive areas when clinically indicated. However, they should take care to ensure that the touching is appropriate to the service being provided. Further, care should be taken to obtain and document informed consent. This also ensures that patients have an opportunity to refuse treatment, and avoids potential misperceptions. A discussion about the presence of a chaperone should include full disclosure of the nature and breadth of the examination and actions being undertaken so that the patient can make a proper determination about whether they would feel more safe and comfortable with a chaperone present. Diligent assessment about the patient's comfort with the procedure is advisable in order to avoid any misunderstanding.

300. Although the Hearing Tribunal found that Dr. Vu believed that his dyspareunia counselling was of benefit to his patients, his actions were nevertheless misguided and inappropriate. The fact that he believed he was helping does not diminish the impact of his actions, which were detrimental to [redacted]. In the circumstances, Dr. Vu's conduct rises to the level of "unprofessional conduct".

301. The Hearing Tribunal finds that the Complaints Director has proven allegation #2 on a balance of probabilities, and that Dr. Vu's conduct constitutes "sexual abuse" as defined in the HPA.

Does the conduct in relation to [redacted] referenced in allegation #1 constitute a breach of the Pre-Bill 21 Standard of Practice?

302. The allegations concerning [redacted] arise from her attendance with Dr. Vu on November 1, 2017. If Dr. Vu's conduct was governed by the Post-Bill 21 Standard of Practice, the Hearing Tribunal would have found that Dr. Vu's conduct in relation to allegation #1 also constitutes "sexual abuse" for the same reasons set out above in connection with the prior findings on allegation #2. However, the events referenced in allegation #1 occurred prior to the date Bill 21 was in force. Both parties submitted that the allegation pertaining to [redacted] is governed by the Pre-Bill 21 Standard of Practice. The Hearing Tribunal agrees that Bill 21 was not intended to be applied retroactively. As such, Dr. Vu's conduct in relation to [redacted] must be assessed in light of the Pre-Bill 21 Standard of Practice.

303. The Pre-Bill 21 Standard of Practice differs significantly from the Post-Bill 21 Standard of Practice, as it does not define any particular physical act that constitutes a sexual boundary violation, nor does it mandate any specific consequence for being found to have engaged in a boundary violation.

304. The Pre-Bill 21 Standard of Practice states (in part) the following:

> (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:
>
> a. Providing inadequate draping,
>
> b. Failing to provide privacy while the patient is dressing or undressing,
>
> c. Being judgmental of a patient's sexual orientation or activities,
>
> d. Sexualizing comments, gesture or tone of voices,
>
> e. Requesting details of a sexual history when not medically indicated,

f. Failing to obtain informed consent for intimate or sensitive examinations,

g. Using unorthodox examination techniques including inappropriate touching of the breasts, genitalia or anus,

h. Sexualizing body contact including frotteurism, kissing, hugging or fondling,

i. Socializing with a patient in the context of developing an intimate relationship, or

j. Making physician-patient sexual contact.

305. The Pre-Bill 21 Standard of Practice does not reference "sexual abuse", nor does it refer to the requirement for the conduct to be of a "sexual nature" in order for a physician's actions to constitute a boundary violation.

305. The Pre-Bill 21 Standard of Practice requires physicians to maintain professional boundaries, and to refrain from "sexualizing" any interaction with a patient. It then provides a list of specific activities that are intended to exemplify the circumstances in which a physician may be found to have breached professional boundaries and where an interaction may become "sexualized" as a result.

306. Based on the wording of the Pre-Bill 21 Standard of Practice, it is clear that a physician may be convicted of a Sexual Boundary Violation, even though the physician had no sexual motive or intent. Put another way, by performing any of the activities listed in (1), the relationship could become "sexualized" (as that term is used in the Standard), and this could occur regardless of the physician's intent or motive.

307. The reference to "sexualize" in the Pre-Bill 21 Standard of Practice is not specifically defined. However, given the manner in which the standard is drafted, if a physician engages in any of the activities listed, it could "sexualize" the conduct by endowing the physician's conduct with a sexual character.

308. As such, a physician could be guilty of a boundary violation even where they derive no sexual gratification. For example, a physician who is judgmental of a patient's sexual orientation or activities could be guilty of breaching the standard. A boundary violation of this nature has nothing to do with whether a physician derives sexual gratification, nor does it require sexual intent on the part of the physician. A physician who engages in such conduct may inadvertently sexualize, or make sexual, the treatment they are providing by being judgmental of a patient's sexual orientation or activities.

309. Further, a boundary violation could occur where the physician's actions are inadvertent. A physician who mistakenly provides inadequate draping or inadvertently fails to obtain informed consent could be guilty of a boundary violation, notwithstanding that their conduct was not purposeful. However, the Pre-Bill 21 Standard of Practice suggests that performing a sensitive exam without adequate draping could sexualize the examination by unnecessarily exposing the patient and breaching the patient's privacy.

310. In this case, Dr. Vu sexualized his interaction with [redacted] by making sexualized comments, failing to obtain informed consent, and using unorthodox examination techniques including inappropriate touching of her genitalia.

311. The sexualized comments made by Dr. Vu included providing advice about where the penis should be positioned in the vagina to avoid painful intercourse, and advice about sexual positions that could minimize pain, including sex from behind. If sexual advice had been requested or sought by [redacted], or if it was clinically indicated, Dr. Vu's sexual counselling commentary would not constitute a boundary violation. However, for the reasons already discussed, the dyspareunia counselling was not appropriate to the service being provided.

312. Dr. Vu also asked [redacted] whether she shaved or waxed. Dr. Vu's explanation for asking was to encourage [redacted] to continue with her grooming habits as he noted no ingrown hairs. The comment understandably made [redacted] uncomfortable, since she had not complained about ingrown hairs. While Dr. Vu's comment would not in and of itself constitute unprofessional conduct, making an unnecessary comment regarding a patient's genitalia further reinforces the finding that Dr. Vu's conduct in performing the dyspareunia counselling was "sexualized" as contemplated by the Pre-Bill 21 Standard of Practice.

313. Dr. Vu also provided [redacted] with dyspareunia counselling, without obtaining adequate informed consent. The findings regarding informed consent referenced in relation to [redacted] at paragraph 291 are equally applicable to [redacted]

314. Further, the dyspareunia counselling provided by Dr. Vu, which included a digital demonstration utilizing his fingers in [redacted]'s vagina, was an unorthodox examination technique. While Dr. Bell indicated that if a patient reported painful intercourse, he may try to exert pressure on various points within the vagina to locate the source of the pain; that is not what Dr. Vu did. Instead, Dr. Vu utilized his digits to provide advice about where the penis should be directed. Dr. Vu did not have any specific training in regard

to dyspareunia, nor did he identify any specific articles or literature that supported his unorthodox practice.

315. Although there was no evidence that Dr. Vu derived sexual gratification from his actions, and the Hearing Tribunal found that Dr. Vu believed that his dyspareunia counselling was helpful to his patients, Dr. Vu's conduct was nevertheless "sexualized" as contemplated in the Pre-Bill 21 Standard of Practice. Dr. Vu's ignorance or naivety does not excuse his conduct, nor does it diminish the fact that his conduct was sexualized and therefore constitute a boundary violation.

316. The Hearing Tribunal finds that Dr. Vu sexualized his interactions with [redacted] by making comments of a sexualized nature, failing to obtain adequate informed consent, and engaging in unorthodox examination techniques. Dr. Vu's actions constitute a boundary violation, and a breach of the Pre-Bill 21 Standard of Practice.

317. The Pre-Bill 21 Standard of Practice does not utilize the same terminology as that referenced in the HPA. The term "sexual nature" does not appear, and the standard itself defines what type of conduct may constitute the type of "sexualized conduct" that constitutes a prohibited boundary violation. As such, it is not necessary to refer to the test set out in *Chase,* in order to determine whether the conduct is of a "sexual nature."

318. While it is not necessary to review and apply the factors listed above at paragraphs 288-289 if they were relevant in assessing whether Dr. Vu's actions in relation to [redacted] constituted a boundary violation, the Hearing Tribunal would make the same findings with respect to [redacted] that it did in relation to [redacted] (see paragraphs 291-299.) The treatment provided was largely the same, except that in [redacted]'s case one of the positions she testified was referred to by Dr. Vu was "doggy style". The colloquial reference was inappropriate. The reference to "doggy style" in conjunction with his question whether [redacted] shaves or waxes makes it even more clear that a reasonably observer would believe that Dr. Vu's conduct was of a sexual nature.

CONCLUSION

319. For the reasons set out above, the Hearing Tribunal finds that the Complaints Director has proven allegations #1 and #2 on a balance of probabilities. The Hearing Tribunal further finds that the conduct in relation to allegation #1 constitutes a breach of the Pre-Bill 21 Standard of Practice, and the conduct in relation to allegation #2 constitutes a breach of the Post-Bill 21 Standard of Practice. Further, the breaches committed by Dr. Vu were not merely technical or trivial; they are sufficient to rise to the level of unprofessional conduct.

320. The Hearing Tribunal is aware of the serious consequences to Dr. Vu as a result of its finding with respect to allegation #2, and has carefully scrutinized all of the evidence and considered the arguments presented on behalf of the parties. Although Dr. Vu did not derive any sexual gratification as a result of the dyspareunia counselling providing to [redacted], and the Hearing Tribunal accepted that Dr. Vu genuinely believed his actions were reasonable, given the definition of "sexual abuse" in the HPA, this is not determinative. Despite Dr. Vu's intentions, a reasonable observer would perceive that the dyspareunia counselling was of a "sexual nature". The factors that support such a finding are set out above, and include: that the touching was not appropriate to the service provided, the touching involved a sensitive body part, and was accompanied by commentary about sexual activity involving [redacted] and others, the lack of informed consent, and the fact that the conduct occurred in the absence of a chaperone.

321. In the circumstances, the Complaints Director has discharged the burden of proof on a balance of probabilities, and the evidence is sufficiently clear, cogent and convincing such that both allegations are proven.

322. Given the Hearing Tribunal's findings with respect to allegation #2 regarding [redacted], in accordance with section 81.1(1) of the HPA, Dr. Vu's practice permit is immediately suspended until an order under section 82 is made. The Hearing Tribunal will await confirmation from the parties whether they wish to address sanction in writing or wish to reconvene to make submissions with respect to what orders should be made pursuant to section 82.

Signed on behalf of the Hearing Tribunal by the Chair:

Dr. Douglas Faulder
Dated this 29th day of August, 2022.