

COLLEGE OF PHYSICIANS & SURGEONS OF
ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. ANIKE ATIGARI

**DECISION OF THE HEARING TRIBUNAL OF
THE COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA
September 8, 2025**

I. INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Anike Atigari on March 3-7 and May 16, 2025. The members of the Hearing Tribunal were:

Mr. Glen Buick (Chair and public member);
Dr. Don Yee;
Dr. Adam Oster;
Ms. Barbara Rocchio (public member).
2. Appearances:

Mr. Craig Boyer, legal counsel for the Complaints Director;
Dr. Gordon Giddings, Complaints Director; Britney Whitson, Associate Complaints Director; Dean Blue, Director of Professional Conduct; Clark Maul, professional conduct staff member; Nazrina Umarji, Acting Hearings Director;
Dr. Anike Atigari (the "Respondent");
Ms. Barbara Stratton KC, Helen Ross, Safar Mahmood, Belal Zaher, Brynne Harding, legal counsel for the Respondent; and
Mr. Matthew Woodley, RMRF LLP, independent legal counsel for the Hearing Tribunal.

II. PRELIMINARY MATTERS

3. There were no objections to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing.
4. The Complaints Director applied to have the hearing closed to the public pursuant to section 78 of the *Health Professions Act*, RSA 2000, c H-7 (the "HPA"). The basis for the request was that the expected evidence related to personal health information relating to the psychiatric assessments undertaken on the complainants by the Respondent. Counsel for the Respondent raised no objection to the application in general, but sought to have their expert witness, Dr. [REDACTED], and the Respondent's spouse, Dr. [REDACTED], exempted from the exclusion of the public in general (for reasons set out below).
5. Section 78(1) of the HPA creates a presumption that a hearing before a hearing tribunal will be open to the public, but it contemplates that an exception to that presumption can be made in particular circumstances, including where "not disclosing a person's confidential personal, health, property or financial information outweighs the desirability of having the hearing open to the public" (HPA, s 78(1)(a)(3)). The Hearing Tribunal has reviewed the proposed Exhibit 1 which contained a significant amount of confidential health information about several of the complainants treated by

the Respondent. Given that much of the information related to psychiatric assessments, it dealt with very private information which would not normally be shared by a person in a public setting. The Hearing Tribunal concluded that the interests of justice clearly required that the hearing be closed to the public to ensure that the confidential personal and health information relating to the complainants was not disclosed. The Hearing Tribunal also notes that members of the public might be reluctant to make a complaint about a physician if the complaint process would necessarily involve the disclosure of such confidential health information.

6. Further, in terms of the benefits of transparency, the Hearing Tribunal notes that its decision will be available to the public, with any identifying information relating to the complainants removed. The public interest in transparency and an open administrative justice system will be preserved while the identities of the complainants will be anonymized. The Hearing Tribunal therefore closed the hearing to the public pursuant to section 78(1) of the HPA.
7. As a result of the closure of the hearing to the public, and to ensure transparency in relation to the release of this decision, the Hearing Tribunal refers to the complainants and lay witnesses by their initials in this decision.
 - For CPSA complaint file 200281, [REDACTED] was a patient of the Respondent, and [REDACTED] was her common law spouse. Both were complainants.
 - For CPSA complaint file 210494, [REDACTED] was a patient of the Respondent and was also a complainant.
 - For CPSA complaint file 220137, [REDACTED] was a patient of the Respondent and was also a complainant.
 - For CPSA complaint file 220138, [REDACTED] was a patient of the Respondent and was also a complainant.
 - For CPSA complaint file 220581, [REDACTED] was a patient of the Respondent and was also a complainant. [REDACTED]'s mother, [REDACTED], was a witness in the proceeding.
 - For CPSA complaint file 230262, [REDACTED] was a patient of the Respondent and was also a complainant.
 - For CPSA complaint file 230639, [REDACTED] was a patient of the Respondent and was also a complainant.
8. In relation to the Respondent's requests that Dr. [REDACTED] and Dr. [REDACTED] be permitted to remain in the hearing despite the fact that the hearing was closed, the Hearing Tribunal considered submissions from the parties on these issues and ruled as follows.

9. First, in relation to Dr. [REDACTED], the Hearing Tribunal noted that it was not common for expert witnesses to attend a hearing during the evidence of lay witnesses in the CPSA hearing context, and that because the hearing was closed to the public, it would not be appropriate for her to do so here. While the Hearing Tribunal accepted the submission from counsel for the Respondent that an expert witness is often asked to provide an opinion on the testimony of lay witnesses, the Hearing Tribunal noted that legal counsel would be in a position to put the facts as testified to by the lay witnesses to the expert in order to elicit a more exact opinion. Further, the expert witnesses of the Complaints Director were not in attendance, and there would be a measure of unfairness arising from allowing one party's expert to attend while the other party's experts would not attend.
10. Second, in relation to Dr. [REDACTED], the Hearing Tribunal accepted the Respondent's submission that his presence might be helpful for emotional support. However, a consequence of the decision to close the hearing is that members of the public are necessarily excluded. While Dr. [REDACTED] is a regulated member and would be aware of obligations of confidentiality in a general sense, he was not a treating physician for any of the complainants, and his presence would necessarily mean the disclosure to another individual not directly involved in the hearing. This presents the very risk which caused the Hearing Tribunal to close the hearing. The Hearing Tribunal therefore directed that he be excluded, noting that he could provide emotional support to the Respondent during breaks.

III. ALLEGATION

11. The Notice of Hearing lists the following allegations (the "Allegations"):
- Allegation 1: During the period of March 2019 to April 2020, you did fail to treat your patient, [REDACTED], and her partner, [REDACTED], with courtesy and respect.
 - Allegation 2: On March 6, 2019, you did inappropriately bill the Alberta Health Care plan for eleven units of health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created, did not justify a claim for eleven units of that health service code.
 - Allegation 3: [Withdrawn]
 - Allegation 4: [Withdrawn]
 - Allegation 5: [Withdrawn]
 - Allegation 6: On April 14, 2021, you did inappropriately bill the Alberta Health Care plan for eleven units of health service code 08.19A, when your time spent with the patient, [REDACTED], and

the record you created, did not justify a claim for eleven units of that health service code.

- Allegation 7: On January 11, 2022, you did display a lack of knowledge or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician and the patient's presenting history and complaints.
- Allegation 8: On January 11, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services in failing to provide adequate advice for further treatment options for your patient, [REDACTED].
- Allegation 9: On January 11, 2022, you did inappropriately bill the Alberta Health Care plan for eleven units of health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created, did not justify a claim for eleven units of that health service code.
- Allegation 10: On January 19, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, [REDACTED], given the reason for referral by the patient's family physician, and the patient's presenting history and complaints.
- Allegation 11: On January 19, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services in failing to provide adequate advice for further treatment options for your patient, [REDACTED].
- Allegation 12: On January 19, 2022, you did inappropriately bill the Alberta Health Care plan for eleven units of the health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created did not justify a claim for eleven units of that health service code.
- Allegation 13: On April 25, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services to your patient, [REDACTED], particulars of which include one or more of the following:
- a. You failed to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician, and the patient's presenting history and complaints;

- b. Your diagnosis of [REDACTED] was based on inadequate consideration of relevant information;
- c. You dismissed your patient's established diagnosis of having [REDACTED] without adequate reason for doing so;
- d. You failed to prepare an adequate record of assessment by failing to include documentation of an evaluation of the patient's work history and family history;
- e. You provided an inadequate consultation report to the patient's referring family physician.

Allegation 14: On April 25, 2022, you did fail to treat your patient, [REDACTED], with courtesy and respect.

Allegation 15: On April 25, 2022, you did inappropriately bill the Alberta Health Care plan for eleven units of the health service code 08.19A, when the time spent with the patient, [REDACTED] did not justify a claim for eleven units of that health service code.

Allegation 16: On August 16, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician, and the patient's presenting history and complaints.

Allegation 17: On August 16, 2022, you did fail to treat your patient, [REDACTED], with courtesy and respect.

Allegation 18: On August 16, 2022, you did inappropriately bill the Alberta Health Care plan for eleven units of the health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created did not justify a claim for eleven units of that health service code.

Allegation 19: On May 12, 2023, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician, and the patient's presenting history and complaints.

Allegation 20: On or about May 12, 2023, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services regarding your patient [REDACTED] by preparing a consultation report to your patient's family

physician that was inadequate and failed to accurately report the history provided by your patient.

Allegation 21: On May 12, 2023, you did fail to treat your patient, [REDACTED], with courtesy and respect.

Allegation 22: On May 12, 2023, you did inappropriately bill the Alberta Health Care plan for eleven units of the health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created did not justify a claim for eleven units of that health service code.

IV. EVIDENCE

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

Exhibit 1 – Agreed Exhibit Book

Exhibit 2 – Treatment records of Dr. [REDACTED]

Exhibit 3 – Email from [REDACTED], dated February 18, 2025

Exhibit 4 – Investigation Interview Transcript with [REDACTED]

Exhibit 5 – Rebuttal Comments by Dr. [REDACTED] to Dr. [REDACTED]'s Opinion

Exhibit 6 – Email re [REDACTED] Consult Report

Exhibit 7 – Rebuttal Comments by Dr. [REDACTED] to Dr. [REDACTED]'s Opinion

Exhibit 8 – Email from [REDACTED] re Errors in Consult Report

Exhibit 9 – Curriculum Vitae of Dr. [REDACTED]

Exhibit 10 – Rebuttal Comments by Dr. [REDACTED] to Dr. [REDACTED]'s Opinion

Exhibit 11 – [REDACTED] Appointment Recording

Exhibit 12 – Rebuttal by Dr. [REDACTED] to Dr. [REDACTED]'s Opinion

Exhibit 13 – Letters and Emails between counsel re Transcript and Audio Recordings

Exhibit 14 – Letter dated February 2, 2021 re Memorandum of Understanding

Exhibit 15 – Letter dated August 27, 2022

Exhibit 16 – Records re Respondent's Continuing Medical Education

Exhibit 17 – CMA *Code of Ethics and Professionalism* – 2018

Exhibit 18 – Global Assessment of Functioning Scale

13. The Hearing Tribunal heard evidence from 11 lay witnesses (including the Respondent) and from five expert witnesses during the course of the hearing. The specific evidence heard and considered by the Hearing Tribunal is set out under each of the relevant allegations set out below. In summary form, however, the nature of the allegations made against the Respondent relate to

three general categories: (a) whether the Respondent treated the patients with courtesy and respect; (b) whether the Respondent engaged in inappropriate billing practices in relation to those patients; and (c) whether the Respondent displayed a lack of knowledge, skill or judgment in her assessment of the patients relating to [REDACTED].

14. In considering these issues, the Hearing Tribunal recognizes that it heard evidence relating to several complaints with similar allegations in the context of a single hearing. The Hearing Tribunal has considered each allegation based on the evidence led by the parties relating to it; that is, the Hearing Tribunal has remained alive to the need to avoid allowing evidence relating to one complainant's experience with the Respondent to influence its consideration of the evidence relating to other complainants. That approach is consistent with the positions articulated by both legal counsel when the issue was raised by the Hearing Tribunal during the course of oral submissions.

V. ANALYSIS OF ALLEGATIONS AND DECISION WITH REASONS

Allegation 1: During the period of March 2019 to April 2020 you did fail to treat your patient, [REDACTED], and her partner, [REDACTED], with courtesy and respect.

15. Allegation 1 relates to professional services provided by the Respondent to [REDACTED] and her common law spouse, [REDACTED], during appointments occurring between March 6, 2019 and April 1, 2020 with [REDACTED], and on September 24, 2019 with [REDACTED].
16. In her evidence, [REDACTED] indicated that she originally attended for an appointment with the Respondent and was made to wait for approximately half an hour.
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
17. [REDACTED] saw the Respondent again on July 17, 2019; [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

18. [REDACTED]'s final appointment with the Respondent was on April 1, 2020, [REDACTED]
[REDACTED] She testified that she decided to return to see the Respondent instead of trying to find a new psychiatrist because it was easier to resume treatment with her than trying to find a new provider. [REDACTED]

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

19. [REDACTED] testified that during the April 1, 2020 appointment, the Respondent was "angry", while during previous appointments she was "just condescending and rude, and belittling a little bit" (Transcript at 35). [REDACTED] stated that the Respondent told her that she would no longer see her as a patient unless she was referred to her again by her physician.

20. [REDACTED] testified that she had a significant experience with other [REDACTED] professionals, and that they had been kind, even when they did not understand what was happening with her. She stated that she felt that they treated her with kindness and respect. By comparison, she testified that she did not have that experience with the Respondent, and instead the Respondent reflected no interest in hearing what [REDACTED] had to say [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

21. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] She also acknowledged that her memories of the appointments with the Respondent were imperfect given the passage of time, and that she had to refer to her complaint to refresh her memory about what occurred (Transcript at 47-48). Counsel reviewed aspects of the Respondent's chart notes with her, and she agreed that they reflected much of what was discussed during her first appointment; she disagreed with certain statements, indicated that while they appeared in the chart notes, she did not provide the information to the Respondent. She agreed that the Respondent covered a "broad range of topics" during the first appointment, including exploring her physical and mental health (Transcript at 54, lines 19-24). She confirmed that the Respondent was "friendly" at the first appointment (Transcript at 57, lines 2-4).
22. [REDACTED] also acknowledged that she had not included an April 18, 2019 appointment in her complaint, and she did not testify about it in her examination in chief. When questioned about that appointment, she acknowledged that her recollection was fuzzy, and that in relation to whether the Respondent listened to her concerns and took steps to help [REDACTED] [REDACTED] she could not recall, although the Respondent did provide her with a prescription [REDACTED] (Transcript at 62, lines 17-27). [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] [REDACTED] was shown a letter from the Respondent to her family physician following that appointment where the Respondent requests that the family physician address the physical symptoms reported to her; [REDACTED] denied knowing about that letter (Transcript at 72, line 13 to 73, line 13). She agreed that the Respondent listened to her concerns and acted on them in following up with her family physician (Transcript at 74, lines 17-27). She denied that it was the Respondent who asked to meet with [REDACTED], and that she was the one who suggested it (Transcript at 97, lines 2-5).
23. [REDACTED] acknowledged that she skipped an appointment with the Respondent scheduled for August 8, 2019 [REDACTED]
[REDACTED] She acknowledged continuing to see her family physician around that time, and

that she had been referred to a second psychiatrist, but she believed that ultimately she did not attend that appointment. She later acknowledged that she had seen the second psychiatrist, but that she simply didn't recall it (Transcript at 84).

24. In relation to the April 1, 2020 appointment, [REDACTED] acknowledged that it was the first time that the Respondent had learned about [REDACTED], [REDACTED] [REDACTED] In terms of how the appointment ended, [REDACTED] testified as follows (Transcript at 91, line 24 to 92, line 21):

Q Okay. She explained that she recommended this because of the gap in the care between when she previously saw you and when she saw you that day; is that right?

A Not to my recollection, no.

Q She explained that she was concerned about the state of your therapeutic relationship with her, correct?

A Yes. She aggressively stated that to me.

Q [REDACTED]
[REDACTED]

A [REDACTED]
[REDACTED]

Q And she said she thought it was in your best interest to see a different psychiatrist, correct?

A Correct.

Q And this very much upset you, didn't it?

A It upset me because it was -- she was angry while saying these things, and she didn't suggest anything. She told me, which is a big difference.

Q You felt like you were giving her another chance, but she ended up cutting off that relationship, didn't she?

A Yes, she did cut it off.

Q And that's even though you were giving her another chance, right?

A Yeah.

25. Finally, ■ acknowledged that the Complaints Director had proposed an informal resolution to the complaint, which she agreed to. However, ■ had filed a separate complaint, and he refused to consent to an informal resolution.
26. ■ provided testimony to the Hearing Tribunal about the basis for his separate complaint about the Respondent. He stated that ■ was coming home from her appointments very upset, stating that the Respondent didn't believe what she was saying, ■. ■
 ■
 ■ He testified that ■ told him that the Respondent had asked to speak with ■ because she likes to meet with her patients' spouses (Transcript at 106-107). ■ described the September 24, 2019 appointment as being "bizarre". He testified that his initial impression was that there was a possible "cultural language barrier" going on, and that the Respondent was "bringing parts of her culture, wherever she came from" (Transcript at 107, lines 5-15). ■
 ■
 ■ He noted that the Respondent had a "thick accent" and that he does not do well with thick accents; he stated that it took him time to understand what the Respondent was saying. He testified that at the end of the meeting, he did not feel that the Respondent had received and acknowledged what he had told her.
27. In cross-examination, he confirmed that all of the information he had about ■'s appointments with the Respondent came from ■ herself, ■
 ■
 ■ He acknowledged that when he was interviewed by the CPSA investigator in 2021, he stated that his memory was "fuzzy" (Transcript at 134-35). ■ denied any problems with his memory, blaming the fact that the events occurred six years ago on the CPSA process rather than any concerns with his memory (Transcript at 136-37). To a significant degree, ■ agreed with the contents of the Respondent's medical records relating to what was discussed when pressed (Transcript at 138-48). ■ stated that what the Respondent told him about ■'s presentation at her appointments was inconsistent with what ■ herself had told him but also acknowledged that he said to the Respondent that ■ must have been downplaying her issues (Transcript at 144, line 5 to 145, line 11).
28. At times, ■'s evidence was combative, and he refused to acknowledge facts which appeared self-evident. For example, ■ refused to acknowledge that his statement that the Respondent was "eager" to hand ■ off to someone

else was inconsistent with the fact that ■ had seen the Respondent four times and had asked to meet with him to get a better understanding of ■ (Transcript at 145-46). He refused to provide responsive answers to aspects of his complaint (see e.g., Transcript at 150-51). He acknowledged that the meeting with the Respondent ended respectfully but refused to acknowledge (as reflected in the chart note) that he agreed with the Respondent to continue to share information about ■. ■ also acknowledged that he was aware that the Complaints Director proposed to resolve the complaint informally and that ■ had agreed to that resolution, and that he insisted that the matter proceed to a hearing.

29. The Respondent provided evidence in relation to her interactions with both ■ and ■. She testified that she had "clear and specific" recollections of those interactions despite the passage of time (Transcript at 695). She testified about the appointments with ■, and her decision-making process regarding treatment. In relation to the allegation of inappropriate comments, she testified as follows:

Q Okay. And I have some specific questions about ■ and ■. You heard evidence this week that ■ alleged that you made some inappropriate comments to her. What is your response?

A I didn't make those comments. ■
 ■
 ■
 ■
 ■ I obtain high professionalism with my patients.

30. Regarding the April 1, 2020 meeting, the Respondent denied having made any comments to ■ that were inappropriate, ■
 ■
 ■ In response to the allegation that the Respondent berated ■ during the appointment, the Respondent stated (Transcript at 704, lines 9-27):

No, I wouldn't describe our interaction as berating, ■
 ■
 ■
 ■

So I would have thought that I was pleading and trying to make her understand that part of the risk assessment is to assess past risk as well as future risk. I can't be well informed about the future risk if I'm not aware about the past risk. ■
 ■
 ■

■ If I'm not aware of those

information, then I will be blind-sided, and it could place a patient at risk if I don't do -- if I don't carry out due diligence.

So we didn't -- she didn't provide a lot of information. So I did most of the talking and in terms of trying to -- to get information from her.

31. In relation to the meeting with ■■■, the Respondent confirmed that she requested to meet with him given the information provided to her by ■■■, and her determination that the collection of collateral information would be helpful. She indicated that the meeting went well and that he provided helpful information to her (Transcript at 700). She testified that when the meeting ended, she and ■■■ shook hands.
32. The Respondent also referred to the fact that the Complaints Director had sought and received an expert report in the course of the investigation of the complaint which determined that the Respondent had met the standard of care for a psychiatrist in Alberta relating to her interactions with ■■■ and ■■■, and that ■■■ had agreed to an informal resolution of her complaint.
33. Allegation 1 relates to whether or not the Respondent failed to treat ■■■ and ■■■ with "courtesy and respect" in her interactions with them. The Complaints Director refers to the principles articulated in sections A and B in the CMA *Code of Ethics and Professionalism* ("Code of Ethics"), which contemplates certain core expectations for physicians. Specifically, the Complaints Director refers to the following "virtues" in Section A:

COMPASSION. A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient's suffering, and accompanies the suffering and vulnerable patient. ...

HUMILITY. A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient's knowledge of their own circumstances.

INTEGRITY. A physician who acts with integrity demonstrates consistency in their intentions and actions and acts in a truthful manner in accordance with professional expectations, even in the face of adversity.

34. In relation to Section B of the Code of Ethics, the Hearing Tribunal understands the following to be relevant to its consideration of Allegation 1:

Commitment to respect for persons

Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.

Always respect the autonomy of the patient.

35. As a starting point (and as with all of the allegations considered below), the Hearing Tribunal notes that the Complaints Director bears the onus of proving the factual basis for the allegation on a balance of probabilities. The Hearing Tribunal has considered the totality of the evidence in relation to Allegation 1, including the relevant medical records and the testimony of the witnesses.
36. The factual basis for Allegation 1 is contested: the evidence of the Respondent is, in many respects, diametrically opposed to the evidence of both [REDACTED] and [REDACTED]. The Hearing Tribunal has therefore considered what evidence in relation to what occurred during the relevant appointments is more credible. While the Hearing Tribunal accepts that both [REDACTED] and [REDACTED] made their complaints and testified to the Hearing Tribunal honestly, it has concluded for the reasons that follow that the Respondent's evidence must be accepted to the extent that it differs from the complainant's evidence.
37. First, [REDACTED] candidly acknowledged that her recollection of the events in question was imperfect given the passage of time. There were events which occurred in the same timeframe relating to medical care that she simply did not recall, including, for example, her appointment with Dr. [REDACTED]. Although [REDACTED] strenuously objected to any suggestion that his memory might have been affected by the passage of time, he acknowledged that he told the CPSA investigator when he was interviewed approximately two years after the events that his recollection was "fuzzy"; despite his protestations, the Hearing Tribunal is not able to accept that his memory of the relevant events would have improved over the intervening four years. Both [REDACTED] and [REDACTED] were referring to aspects of their written complaints while providing their testimony. The Respondent, on the other hand, testified that she had a clear and specific memory of the interactions (Transcript at 695, lines 20-23). Nothing in her evidence in chief or cross-examination suggested that this statement was hyperbole.
38. Second, to the extent that [REDACTED] testified about [REDACTED]'s interactions with the Respondent, he had no ability to directly observe them. He relied exclusively on what he was told by [REDACTED]. [REDACTED] stated that she was not "a big person to share my personal and private medical information, even the people closest with me, because there is a stigma and embarrassment attached to it. So what people know of my experience is often limited a little bit" (Transcript at 47, lines 6-10). [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

39. Third, [REDACTED]'s recollection of certain events was inconsistent with the medical records, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Further, she suggested that she was the one who recommended that the Respondent meet with [REDACTED], while [REDACTED] testified that she told him that the Respondent made the request; that is consistent with the Respondent's evidence on that issue.
40. Fourth, both [REDACTED] and [REDACTED]'s testimony appeared at times to be exaggerated. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] at times answered questions in a combative tone and obfuscated on aspects of his original complaint. [REDACTED] also appeared to have an interest in the outcome which exceeded reasonable expectations, and he insisted that the matter be pursued even when [REDACTED], the patient, had agreed to an informal resolution of the complaint.
41. For those reasons, the Hearing Tribunal finds that the Respondent's evidence in relation to what occurred during the relevant appointments must be accepted. [REDACTED]
[REDACTED] based on the chart notes and the testimony of the Respondent, it finds that she did not fail to treat [REDACTED] and [REDACTED] with courtesy and respect.
42. While the Hearing Tribunal accepts that [REDACTED] did not feel that the Respondent adequately listened to her concerns, the chart notes indicate that the Respondent did gather relevant information from [REDACTED] as part of her assessment; further, she agreed to continue to meet with [REDACTED] for the purpose of assisting her in working towards a diagnosis. [REDACTED] acknowledged that she did not include one visit with the Respondent at all in her complaint and did not suggest any concerns with professionalism during that appointment. She acknowledged in cross-examination that the Respondent did follow-up with her family physician relating to her concerns although she was not aware of that at the time.
43. The balance of the evidence also does not support the conclusion that the Respondent told [REDACTED] [REDACTED]. The records reflect the fact that while a formal diagnosis was not made, the Respondent agreed to continue to treat [REDACTED] in an effort to assist. [REDACTED]

also testified that this was his understanding of the Respondent's statements.

44. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] While [REDACTED] perceived the interaction as being dismissive, it is clear from the evidence and the medical records that the Respondent had a valid basis for proposing a termination of the therapeutic relationship: [REDACTED]
[REDACTED]
[REDACTED] In any event, it is also clear that the Respondent offered to continue to treat [REDACTED] if a new referral was sent by [REDACTED]'s family physician. This reflected a sensitivity to the preservation of the relationship and a willingness to assist despite those concerns.

45. For those reasons, the Hearing Tribunal is not able to conclude that the Respondent failed to treat [REDACTED] and [REDACTED] with courtesy and respect in her interactions with them. While the interactions with the Respondent were clearly not satisfactory to the complainants, they do not reflect a breach of the relevant portion of the Code of Ethics and are therefore not unprofessional conduct as defined in the HPA. As noted above, the Hearing Tribunal accepts that [REDACTED] gave her evidence in good faith, based on her honest recollection of the events in question; the task of the Hearing Tribunal, however, is to determine whether the evidence before it satisfies the burden of proof on the Complaints Director. It is not able to conclude that the burden has been discharged in relation to this allegation.
46. The Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 1.

Allegation 2: On March 6, 2019, you did inappropriately bill the Alberta Health Care plan for eleven units of health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created, did not justify a claim for eleven units of that health service code.

47. Allegation 2 is based on the fact that a psychiatrist is able to bill for a maximum of 11 units under code 08.19A for the kind of assessment undertaken by the Respondent on March 6, 2019. The evidence about this code and its limitations was not introduced through a lay expert called by the Complaints Director. The Complaints Director attempted to elicit this evidence through Dr. [REDACTED], an expert retained by the Complaints Director to speak to the standard of care in the [REDACTED] and [REDACTED] complaints. Dr. [REDACTED] was qualified (without objection) to give expert evidence as a practicing psychiatrist with experience in assessing and treating [REDACTED]. In his

examination in chief of Dr. [REDACTED] relating to [REDACTED], legal counsel for the Complaints Director sought to ask questions relating to billing practices and the use of code 08.19A. Legal counsel for the Respondent objected to that line of questions on the basis that Dr. [REDACTED] had not been qualified to give any evidence relating to billing, and such evidence was not included in her expert report in any event. Following submissions from the parties, the Hearing Tribunal directed that Dr. [REDACTED] would not be permitted to give evidence in relation to billing given the specific qualification which was sought by the Complaints Director, and that the evidence was unanticipated and not included in her expert report. It would have been unfair to permit Dr. [REDACTED] to testify about that issue without being appropriately qualified, and without sufficient advance notice of the expected evidence to the Respondent.

48. In any event, the Respondent in her evidence confirmed that 11 units was the maximum for such an appointment, with the first unit being for 30 minutes, and each subsequent unit being for an additional 15 minutes (Transcript at 739, line 28 to 740, line 1).
49. The evidence in relation to Allegation 2 is also contested. [REDACTED] testified that she spent approximately 20 minutes with the Respondent on March 6, 2019 (Transcript at 35, lines 14-17). The Respondent testified that she "dedicated 1 hour in terms of direct patient contact" for the first appointment with [REDACTED] (Transcript at 698, line 22 to 699, line 6). [REDACTED] testified that she waited for just over 30 minutes to see the Respondent, and that the appointment ended given the fact that the Respondent had another patient immediately following her appointment. While the Hearing Tribunal has concerns with respect to the amount of time that [REDACTED] was directly interacting with the Respondent, for the reasons above it accepts the evidence of the Respondent as being more reliable. Specifically, given the breadth of topics covered by the Respondent during that initial appointment, it would have been very difficult to do so in approximately 20 minutes. As noted above, [REDACTED] agreed that the Respondent covered a "broad range of topics" during the first appointment, including exploring her physical and mental health (Transcript at 54, lines 19-24). This suggests an appointment lasting longer than 20 minutes.
50. Finally, the only evidence that the Hearing Tribunal has about the amount of time dedicated to the appointment other than direct interactions with [REDACTED] comes from the Respondent (Transcript at 698, line 19 to 699, line 6):

Q Before you go to May, can I just go back to that March appointment?

A Yes.

Q On that first appointment, how long did you spend working on that appointment with her in total before, during and after? How much time did you dedicate to that appointment?

A So my initial appointment I would have dedicated 1 hour in terms of direct patient contact. But my indirect patient contact, where I look at files, the jottings, write a letter to the family physician, write my notes, type my notes myself, I usually would need about 30 minutes to 1 hour preparing for the assessment, and as much as that time or more writing my notes or preparing my notes and faxing it to the family physician.

51. While the Hearing Tribunal has some degree of skepticism in relation to the amount of time spent on the steps described by the Respondent, there is a lack of evidence which would allow it to conclude on a balance of probabilities that the Respondent inappropriately billed the Alberta Health Care plan. That is, the evidence is that the Respondent devoted sufficient time to justify 11 units for the initial appointment with ■■■, regardless of whether or not that time was reasonably spent in the circumstances. The Hearing Tribunal was not provided with any expert evidence suggesting that it could not have taken three hours for the work which the Respondent says that she undertook for the assessment of ■■■, and it is unable to come to that conclusion on the facts relating to this complaint.
52. For those reasons, the Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 2.
53. The Hearing Tribunal notes that allegations 3, 4 and 5 were withdrawn by the Complaints Director prior to the commencement of the hearing.

Allegation 6: On April 14, 2021, you did inappropriately bill the Alberta Health Care plan for eleven units of health service code 08.19A, when your time spent with the patient, [REDACTED], and the record you created, did not justify a claim for eleven units of that health service code.

54. [REDACTED] attended at an appointment with the Respondent on April 14, 2021 [REDACTED]
[REDACTED]. She testified that her father dropped her at the appointment, and that she waited to be seen for approximately 15 minutes. She stated that she was brought into the appointment by the Respondent, and that it was "one of the most terrifying appointments" that she has had with a physician (Transcript at 178). She testified that the entirety of the appointment was 36 minutes and that it was her father that made the calculation based on when she was dropped off and when she came out of the appointment. This would suggest that she spent no longer than 20 minutes with the Respondent during the assessment.
55. The Respondent's evidence was as follows:

A It's unlikely when I looked at the assessment. That's usually an assessment that would take me time to prepare, time to meet the patient directly and time to do my notes, write my notes. So she -- her recollection of the appointment is not my recollection of the appointment. And I can't get that notes done within the time -- all the information I collected from her -- within the time frame that she said she attended.

Q How long did you spend on her appointment before, during and after?

A Before the appointment I always estimate that I will need about 30 minutes to 1 hour preparing for the assessment. And then the assessment will take me roughly about an hour. That's when the -- the time I book for patients. But most appointments will run over 1 hour. And then I take more time after the assessment reflecting on the assessment, looking at documents, going through my assessment, and wondering if there might be some diagnosis I might be missing, and that usually takes me about 1 hour to 1 hour, 30 minutes as well. So roughly I would expect I spent the maximum time available, which is 3 hours for the appointment or more.

56. The Respondent also testified that the Complaints Director had retained an expert who provided an opinion that she had met the standard of care in her assessment of ■■■, and that "the length of time for this case was typical for a limited psychiatric history" (Exhibit 15).
57. As noted above, the Hearing Tribunal was not provided with any expert opinion from a practicing psychiatrist on whether billing 11 units for the assessment of ■■■ was clearly not possible or was so unreasonable as to be "inappropriate". The Hearing Tribunal was asked to infer given the very limited information on the patient's file and the templated nature of the consult report that the billing was inappropriate. For the same reason as those set out in Allegation 2, the Hearing Tribunal is not prepared to do so given the evidence of the Respondent on how much time she spent in total on ■■■'s assessment. While it might be skeptical that three hours were spent, the Hearing Tribunal is not able to conclude that the Complaints Director has discharged his burden of establishing that fact based on the evidence before it.
58. The Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 6.

Allegation 7: On January 11, 2022, you did display a lack of knowledge or lack of skill or judgment in the provision of professional

services by failing to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician and the patient's presenting history and complaints.

59. Allegation 7 focusses on the adequacy of the assessment of [REDACTED] that was undertaken by the Respondent [REDACTED]. Unlike the previous allegations, this allegation includes both factual discrepancies relating to the nature of the information sought and received by the Respondent in undertaking the assessment, but also expert evidence about whether the Respondent met the standard of care for such an assessment in Alberta at the relevant time.
60. In terms of the facts, [REDACTED] testified that he saw the Respondent [REDACTED]. He had been taking a particular medication, and his physician wanted him to see a specialist about his symptoms. [REDACTED]
[REDACTED]
[REDACTED]
61. He testified that the appointment with the Respondent was "very short", that the Respondent was not attentive and was not listening to him, and that he left the meeting feeling "very belittled" (Transcript at 187). He testified that he did not keep a record of the exact length of the appointment, but that it was around 15 minutes, although he stated that it was 20 minutes in his complaint (Transcript at 188). In relation to the nature of the information that he discussed with the Respondent, he stated (Transcript at 190, line 12 to 191, line 1):

Well, I went in and explained how I ended up going to see her, and we started with some very basic questions. She asked me about, like, my education and why I was there in the first place. I had told her that I did not have a current prescription and I was trying to see if I could get something more official, so to speak, to go to the doctor with, and she started to ask me questions about my education.

And I felt like right there was where we kind of got to a misunderstanding and the communication -- the questions she was asking me, I was trying my best to answer, and she seemed just short and frustrated with me. But from there it just -- it slowly devolved I feel like. I'm not sure if we were just both being cranky or what, but I felt that she stopped listening to me under the impression that I was just there for medication, not for help.

62. [REDACTED] testified that he was not asked to take any ratings or tests during the appointment. He stated that at the end of the appointment he was not provided with any advice or any diagnosis; rather, he stated that "[s]he said

that she felt as if I was pushing for medication, that I was just there pushing for that, which is not true" (Transcript at 191, lines 19-21). He reviewed the consult letter that was sent by the Respondent to his physician, and had concerns about its accuracy (Transcript at 192, lines 6-20):

Well, there was a few. To start, because usually it starts with family history, she wrote that the family history is not contributory. [REDACTED]

[REDACTED] We -- we do have issues that are worth noting, and I did bring those up. And those are marked as nil or not contributory. We have -- I mean, there's, in my opinion, a -- what's the term I would use -- contradictory message with her stating [REDACTED]

[REDACTED] That was the reason I was there and so -- and that was in the bottom of the report, I believe.

63. Exhibit 3 was entered into evidence, which was an email from [REDACTED] relating to the various errors that he believed were included in the Respondent's consult letter.

64. In cross-examination, [REDACTED] reviewed his education history [REDACTED]. [REDACTED] At the time that he saw the Respondent, he was not aware that she was a psychiatrist, [REDACTED]. Although [REDACTED] acknowledged that memories generally fade with time, he testified that he remembered some things about the appointment quite clearly (Transcript at 211, lines 1-4). When challenged with his memory of the length of the meeting, he acknowledged that he was estimating the length of the meeting but stated that "it wasn't longer than 20 minutes" (Transcript at 212, line 24).

65. [REDACTED] He acknowledged that questions relating to other issues were asked and accurately recorded by the Respondent. [REDACTED] He confirmed that the only information that the Respondent would have had about his previous diagnosis [REDACTED] was what he provided to her. He confirmed that he told the Respondent that medication [REDACTED] would be a

"quick solution" although he stated that it did not have to be a narcotic. He testified that at the end of the appointment, the Respondent told him that he did not need medication, and that he disagreed with that assessment (Transcript at 221). He acknowledged being frustrated and offended after the appointment, and that he believed the Respondent was not listening to him. When asked whether he "stopped trying to explain himself" towards the end of the appointment, he stated: "By the time we had reached the conclusion that the appointment wasn't going anywhere, there wasn't much explaining going on" (Transcript at 223, lines 3-5). He agreed that the Respondent likely attempted to provide him with a leaflet at the conclusion of the appointment, and that he did not believe that the Respondent had any ill intentions during the appointment.

66. The Respondent's recollection of the appointment with [REDACTED] was different in many respects. She testified as follows in relation to the nature of the assessment undertaken (Transcript at 714, line 17 to 715, line 15):

[REDACTED] was referred -- I think sometime in January, and I saw him at the same -- in January. [REDACTED] And I gathered information. [REDACTED] [REDACTED] I think there was also somewhere -- I'm not sure if he was the one that said something about -- his other concern. So he provided information about some of the symptoms he has, [REDACTED] and why he believed he suffered with it. And I took a history about childhood and his achievements so far, and I made a clinical determination [REDACTED], but, however, I provided a pamphlet or information on how he can -- [REDACTED] -- how he can -- how it can help with some of the difficulties he reported. But the leaflet was unaccepted. And there were no concerns with the assessment. It's concluded -- it went on successfully. There was just a difference in opinion. He was not happy with the conclusion, which was my opinion [REDACTED]. I included in my assessment to the family physician that he was overtly disgruntled about the absence and that he mentioned he didn't think I listened to him.

67. The Respondent testified that she did consider the previous diagnosis [REDACTED], but that she was making her assessment based on the information available to her in the context of the assessment. She determined that while [REDACTED] had reported certain symptoms [REDACTED], he did not meet the clinical criteria in the DSM-5 (Transcript at 714).
68. In cross-examination, the Respondent acknowledged that she used a template for her consult reports, including for the report created for [REDACTED]. She

confirmed that she still held the opinion reflected in her original response to the CPSA regarding the [REDACTED] complaint that she did not believe it was necessary to "spend additional needless time that [she] could not credibly or in good faith fill with anything more than questionably relevant areas of assessment" (Transcript at 792-93). Regarding the prior diagnosis [REDACTED], she testified as follows (Transcript at 802, line 14 to 803, line 5):

Q Now, I heard you say in relation to [REDACTED] that you were aware of his report of a prior diagnosis, but that you based your diagnosis on the realtime assessment?

A Yes.

Q So really what you are saying is that your diagnosis is based on what is being told to you by the patient, correct?

A Yes.

Q And because the patient did not bring any third-party information, you would effectively ignore the report of a prior diagnosis?

A I appraise the information verbally mentioned or discussed with the patient in terms of when the diagnosis was made and who made the diagnosis. And I used that information to inform my opinion at that time, as well as the clinical presentation, [REDACTED].

69. The Hearing Tribunal was provided with two expert reports and testimony in relation to the assessment of [REDACTED] by the Respondent. Dr. [REDACTED] was qualified by the Hearing Tribunal (without objection) to provide opinion evidence "as a practicing psychiatrist with experience in assessing and treating [REDACTED]". Dr. [REDACTED] provided evidence that the Respondent had failed to meet the standard of care for a psychiatrist practicing in Alberta regarding the assessment of [REDACTED]. In relation to the specific aspects of the care provided which she believed did not meet the standard of care, she identified the following categories:

- a. The brevity of the assessment, and the fact that a 20 minute assessment could not have represented the kind of comprehensive assessment contemplated in relevant guidelines;
- b. Standard assessment elements were not undertaken, including the previous diagnosis [REDACTED] and the effectiveness of treatments for it;
- c. The lack of any notation relating to the dosage of the medication taken by [REDACTED] or its effectiveness;

- d. The fact that family history is noted as non-contributory while [REDACTED] clearly indicated in his complaint that there was a family history [REDACTED];
 - e. The lack of any record of a review of lab work or the ordering of lab work;
 - f. The lack of any record of the taking of developmental history which is important in assessing [REDACTED];
 - g. The lack of other sources of information or the use of rating scales or attempts to gather collateral information from [REDACTED]'s partner or individuals who knew [REDACTED] in adolescence;
 - h. The lack of a full review of relevant symptoms from the DSM-5 list of relevant symptoms;
 - i. Given the fact that [REDACTED] reported [REDACTED];
 - j. Aspects of the report suggest that [REDACTED] did not report certain symptoms, while other aspects of the report suggest that concerns were raised by him;
 - k. The fact that a lack of inattention during a first appointment might not be conclusive of an absence of that symptom.
70. She concluded that the Respondent's assessment of [REDACTED] was (Transcript at 259, line 27 to 260, line 7):
- brief and not comprehensive, didn't include a developmental history, included an incomplete review of his presenting symptoms [REDACTED], an incomplete review of additional mental health symptoms -- psychiatric history, medical history, and family history -- there wasn't an attempt to review or obtain lab work, no review of information from other collateral sources or rating scales.
71. Dr. [REDACTED] also provided her comments on the response that the Respondent had provided to the Complaints Director in the course of the investigation. In relation to the Respondent's statement that once she was able to rule out [REDACTED], it was not necessary to spend additional time with the patient, she noted that while it is possible to form a clinical opinion before one has completed a lengthy assessment, part of the practice of medicine is ruling out other disorders that may have similar symptoms which requires additional information, and the need to document evidence for the clinical decision that was made. She noted that because [REDACTED] was using [REDACTED] medication at the time of the appointment, it was possible that the medication ameliorated some symptoms and that there was no indication that this was considered. She noted that even though [REDACTED] had been successful in school, that did not mean that he did not have [REDACTED] because he might have been using other compensatory strategies to manage his

symptoms. Ultimately, she concluded that her opinion remained that the Respondent's assessment of [REDACTED] was brief and incomplete, and that it failed to meet the standard of care.

72. Dr. [REDACTED] also commented on the expert report written by Dr. [REDACTED] on behalf of the Respondent. She highlighted the areas where Dr. [REDACTED] was critical of her report and explained that some of her comments were mischaracterized by Dr. [REDACTED]. Most of her practice relates to general assessments, rather than to a specific request for a determination of whether a particular patient has [REDACTED] (Transcript at 296). She rejected the assertion that a psychiatrist is not required to note all of the relevant factual information elicited during an assessment, even negative findings; however, she agreed that it would not be necessary for the specific questions posed by the psychiatrist to be included in the medical records. She agreed that if the diagnostic criteria in the DSM-5 were not met, no diagnosis of [REDACTED] could be made, and that the physician undertaking the assessment is in the best position to make those determinations (Transcript at 302). She also agreed that a physician is required to conduct his or her own assessment and cannot defer to the patient's wishes. She also agreed that once a physician gathered enough information to determine that key criteria for a diagnosis were not present, the physician has the answer for that particular diagnosis, but that "you may need to continue to explore symptoms because this may represent a different diagnosis with a different symptom set" (Transcript at 306, line 26 to 307, line 2).
73. In cross-examination, Dr. [REDACTED] acknowledged that the majority of her clinical work was hospital based, but that she has an office practice which is a general adult office practice (Transcript at 292). She does not specialize specifically in [REDACTED] assessments.
74. Dr. [REDACTED] gave evidence in relation to the standard of care applicable to the kind of assessment undertaken by the Respondent regarding [REDACTED]. She was qualified (without objection) to give opinion evidence on the standard of care expected of a psychiatrist in 2019 and 2023 in respect of the issues set out in the Notice of Hearing (Transcript at 819). She testified that she has noticed an increase in individuals seeking [REDACTED] diagnosis [REDACTED], and that patients can become angry and combative when they do not receive the diagnosis they are seeking (Transcript at 821). Her evidence was that the standard of care of a physician assessing and diagnosing [REDACTED] is set by the DSM-5 criteria, and that the [REDACTED] Guidelines can be helpful, but that they do not set the standard of care, and it is not necessary for a physician to follow all of the recommendations in the [REDACTED] Guidelines when assessing and diagnosing [REDACTED] (Transcript at 823).
75. Dr. [REDACTED] also testified that the general length of an assessment [REDACTED] was difficult to determine. In some cases, [REDACTED] can be ruled out in two questions, but in other instances a person with "an extremely complex history" might require a very long assessment in the three-hour range, and

potentially over more than one appointment (Transcript at 824). She also testified about the risks of overdiagnosis, and situations where a patient provides only very limited information in the course of an assessment. She testified that it was important to conduct a mental status exam in the context of any assessment (Transcript at 828).

76. In relation to ■■■, Dr. ■■■ testified that the Respondent met the standard of care both in relation to her assessment of ■■■ and the diagnosis that he did not have ■■■. She stated that ■■■ did not meet the "B" or "D" criteria for ■■■ (Transcript at 831-32). She rejected the criticisms of Dr. ■■■ in relation to the lack of assessment tools, noting that she prefers to speak directly to the patient in order to undertake the assessments. She also testified that lab work was not required in the circumstances. She did not consider the length of the appointment with ■■■, but that she did determine that "all of the aspects required of a psychiatrist in a psychiatric consultation was present in the report" (Transcript at 835, lines 15-18). ■■■
■■■
■■■

77. ■■■
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78. The Hearing Tribunal accepts the evidence of ■■■ in relation to the length and content of the appointment with the Respondent. His recollection of the length of the appointment was clear and consistent with his previous statements; while he acknowledged that he was not timing the appointment, he indicated that it could not have lasted longer than 20 minutes. The Respondent's recollection was based on her usual practice rather than on a specific memory of the appointment with ■■■ (Transcript at 719). Further, ■■■ testified that he remembered aspects of the appointment very clearly. Given the importance of the appointment for ■■■, and that he had been anticipating an assessment for some time, the Hearing Tribunal finds that his recollection of the appointment was reliable.

79. It is clear that the Respondent formed an opinion about ■■■ and the reason for his seeking an assessment early in the appointment. The interaction between the Respondent and ■■■ was characterized by the Respondent seeking very specific pieces of information from ■■■, rather than allowing ■■■ to provide all of the background that he thought might be important. The Hearing Tribunal finds that from the perspective of ■■■, the appointment with the Respondent would have seemed belittling and upsetting.
80. Despite those findings, the Hearing Tribunal's task is to determine whether or not the Respondent engaged in unprofessional conduct by displaying a lack of knowledge, skill or judgment in her assessment of ■■■. While the Hearing Tribunal readily accepts that the assessment was not done in accordance with best practice, it is not able to conclude that the Respondent's conduct

fell below the accepted standard of care. The Hearing Tribunal accepts the evidence of Dr. [REDACTED] (supported by other experts relating to other matters) that the [REDACTED] Guidelines do not establish the standard of care; on the contrary, the standard of care is set by the diagnostic criteria in the DSM-5. The evidence of Dr. [REDACTED] was clear that where the purpose for the assessment is a determination about whether or not a patient has [REDACTED], it is possible in some circumstances for that diagnosis to be ruled out in relatively short order. [REDACTED] was not seen by the Respondent for a general assessment where other diagnosis would need to be considered (which appears to have been the focus of Dr. [REDACTED]'s evidence and experience); rather, the question that the Respondent was asked to answer was specifically in relation to whether [REDACTED] had [REDACTED]. On these particular facts, the Hearing Tribunal finds that the assessment of [REDACTED] did not reflect a lack of knowledge, skill or judgment. The assessment was imperfect, would have left [REDACTED] with a negative impression of the Respondent and the care he received, but it met the minimum standard of care required of a psychiatrist undertaking a specific assessment for [REDACTED].

81. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 7.

Allegation 8: On January 11, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services in failing to provide adequate advice for further treatment options for your patient, [REDACTED].

82. The balance of the evidence suggests that the Respondent provided [REDACTED] with a pamphlet at the conclusion of the appointment on January 22, 2022. Although the Hearing Tribunal is concerned with the evidence of the Respondent relying heavily on templates for consult letters that are not appropriately updated for each assessment, the consult report does refer to "helpful tips" being discussed, and an offered pamphlet that was not accepted.
83. [REDACTED]'s evidence on this issue was equivocal. While he stated that he did not recall a leaflet being provided to him, he ultimately agreed that the Respondent offered a leaflet and that he refused to take it based on the chart notes (Transcript at 226, lines 24-27). Importantly, when the appointment was ending and [REDACTED] was upset with the approach having been taken by the Respondent, he indicated to her that he intended to find another doctor who would listen to him (Transcript at 223). That is, the Respondent had some reason to believe that he intended to seek a second opinion in relation to the [REDACTED] diagnosis.
84. On balance, the Hearing Tribunal is not able to conclude that the Respondent failed to provide "adequate advice" for further treatment options. Again, her approach does not reflect best practice, but it met the minimum standard of care in the particular circumstances relating to [REDACTED]'s assessment.

85. The Hearing Tribunal therefore finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 8.

Allegation 9: On January 11, 2022, you did inappropriately bill the AHCIP eleven units of the health service code 08.19A, when your time spent with the patient, ■■■■■, and the record you created did not justify a claim for eleven units of that health service code.

86. As noted above, the Hearing Tribunal accepts the evidence of ■■■■■ relating to the length of the appointment being no longer than 20 minutes. His evidence was clear on that issue while the Respondent's was based on her assumption given her general practice. While it has a great deal of skepticism about the amount of time that the Respondent billed to the assessment of ■■■■■, it notes that the only evidence regarding the total amount of time that the Respondent spent on the assessment came from the Respondent herself. Her evidence in cross-examination was that she spent three hours on the assessment for ■■■■■ (Transcript at 799); the Hearing Tribunal heard no evidence from any witness that it was impossible or even highly improbable that this could be the case given the nature of the pre- and post-assessment work involved.
87. Again, the Hearing Tribunal has a significant degree of skepticism in relation to this Allegation, but it finds that the facts have not been proven on a balance of probabilities. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 9.

Allegation 10: On January 19, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, ■■■■■, given the reason for referral by the patient's family physician, and the patient's presenting history and complaints.

88. ■■■■■ testified about her experience in an assessment with the Respondent on January 19, 2022. While many of the complaints were similar to those expressed by other complainants, ■■■■■ made a surreptitious recording of her interaction with the Respondent. Although there were some concerns regarding a suggested late disclosure of the audio recording, it was eventually admitted into evidence on consent, along with a transcript of the recording. The recoding of the interaction resolved clearly one of the issues of contention in the hearing: the length of the assessment undertaken by the Respondent. The audio recording demonstrated that the assessment scheduled for one hour lasted approximately 21 minutes.
89. ■■■■■ testified that she made the complaint because she felt that she had not been heard by the Respondent, and her struggles had been dismissed (Transcript at 592). In cross-examination, ■■■■■ acknowledged that she did not

seek the Respondent's consent to record the assessment, and that she did so because she had looked up reviews of the Respondent online and had some concerns about her. She testified that she felt that the Respondent was shutting down her ability to respond and disagreed that the Respondent acted in a professional manner towards her during the appointment. She denied that there was any substantive part of the assessment that was not recorded by her.

90. The Respondent testified that she undertook her regular [REDACTED] assessment with [REDACTED] where she discusses "all the pertinent information required to make a diagnosis of [REDACTED]" (Transcript at 719, lines 15-16). She stated that [REDACTED] provided her very limited information and that she felt [REDACTED] was not willing to engage in the assessment. She states that she formed the opinion that [REDACTED] did not have [REDACTED], and she provided her with [REDACTED] relating to the concerns she had expressed (Transcript at 720). In cross-examination, the Respondent acknowledged that her consult report was based heavily on pre-populated templates (Transcript at 772-86), and that it referred to outdated diagnostic information regarding multi-axial diagnosis formulae and the global assessment of functioning. She also acknowledged that there is no indication in the chart materials provided to the CPSA that she obtained or attempted to obtain the [REDACTED] questionnaire that [REDACTED] had completed with her family physician, nor any record of her stated attempts to locate information on Netcare (Transcript at 800-801).

91. Dr. [REDACTED] provided an expert report and testimony about the assessment undertaken by the Respondent on [REDACTED]. She testified that (Transcript at 610, lines 4-14):

And that I noted that from the transcript, [the Respondent] hadn't inquired about several of the symptoms of [REDACTED], a number of the things potentially relevant to the diagnosis of [REDACTED], [REDACTED]
[REDACTED]. And some of the aspects of [REDACTED]'s history that [the Respondent] did inquire about were discussed quite briefly, such as the patient's developmental history and early life history.

92. She noted that her conclusion was that the assessment did not meet the standard of care, particularly in relation to the failure by the Respondent to consider [REDACTED]'s experience of her symptoms, and that certain symptoms set out in the DSM-5 were not questioned (Transcript at 613-14). She found that the failure by the Respondent to look to other assessment tools or collateral information suggests an incomplete assessment inconsistent with the standard of care. She addressed her addendum report which responded to the expert report of Dr. [REDACTED], and that her opinion remained that the standard of care was not met. In relation to the self-assessment form, she noted that had the Respondent reviewed it prior to the assessment, it would

be expected that she would have reviewed the positive report of symptoms in some depth (Transcript at 620-21).

93. In cross-examination, Dr. [REDACTED] confirmed her previous evidence that the [REDACTED] Guidelines do not define the standard of care, but they do inform the standard of care for the diagnosis of [REDACTED] (Transcript at 625-26). She acknowledged that the assessment is a collaborative process, and that if [REDACTED] had come into the meeting thinking that there would be a "fight", it could impact the development of the therapeutic relationship required for a successful assessment (Transcript at 634). However, she did not have the impression from her review of the transcript that [REDACTED] was being non-responsive or was avoiding answering questions (Transcript at 635, lines 6-16). She acknowledged that she had not been provided an opportunity to listen to the audio recording of the assessment, and was not able to consider issues like tone, pauses and timing.
94. No expert evidence was adduced by the Respondent in relation to the assessment of [REDACTED].
95. The Hearing Tribunal has reviewed both the audio recording and the transcript of the interaction. It had no hesitation in finding that the nature of the interaction between the Respondent and [REDACTED] was inadequate, and it does not reflect an appropriate clinical interaction with a patient. The Respondent did not engage in a nuanced interview style, and interrupted answers being provided by [REDACTED]. Many questions were "closed" and did not encourage elaboration. While it is clear from the audio recording that [REDACTED] ultimately did not provide detailed responses, that followed from her being interrupted or a rapid change in focus of the questions.
96. However, in terms of the adequacy of the assessment, the Hearing Tribunal notes that [REDACTED] was referred to the Respondent for an assessment of whether or not she had [REDACTED]. The information elicited from [REDACTED] related to the diagnostic criteria set out in the DSM-5, and while a more complete assessment might have involved drilling down on negative responses, the evidence before the Hearing Tribunal suggests that the Respondent gathered enough information to assess that [REDACTED] did not have [REDACTED].
97. As a result, the Hearing Tribunal finds that while the assessment was borderline, it does not reflect unprofessional conduct and the Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct.

Allegation 11: On January 19, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services in failing to provide adequate advice for further treatment options for your patient, [REDACTED].

98. The evidence in relation to this allegation centred on the audio recording and transcript. After advising [REDACTED] that she could not diagnose her with a disorder,

_____ was not asked specific questions about this in her examination in chief or cross-examination.

99. The Respondent testified that she concluded that the diagnostic criteria for [REDACTED] had not been met, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
100. Dr. [REDACTED] testified that in her opinion, the Respondent did not appropriately provide adequate advice to [REDACTED] regarding further treatment options. She stated that the Respondent did not “provide an alternate explanation for her symptoms or explain a reason why she doesn’t think the symptoms, for example, difficulties with focus, rise to the level of [REDACTED]” (Transcript at 611, lines 13-16). She testified (Transcript at 611, line 17 to 612, line 4):

I will note -- and I won't go through all of this -- but in the report that [the Respondent] certainly does offer [REDACTED] some recommendations [REDACTED]. I will note that I thought some additional recommendations could have been made that [REDACTED] may have found helpful. And, in summary, some relevant interventions were discussed by [the Respondent] and more may have been contained in the leaflet that's referenced. But perhaps this advice could have been discussed more thoroughly with [REDACTED] and [REDACTED] could have been engaged in the discussion. It didn't appear from the review of the documents that [the Respondent] had conveyed a sense of hope for improvement or positive change, and that may also have had some bearing on the rapport in the appointment.

101. Again, the Respondent's approach to the assessment and recommendations for further treatment options for ■ do not represent best practice. The nature of the interaction was clipped, unclear and unsympathetic. However, the Hearing Tribunal notes that the Respondent did acknowledge that the symptoms ■ were valid and provided some (limited) information about strategies to overcome them. It is clear that some literature relating to these strategies was provided to ■. At that stage, it was not realistic to expect that ■ would engage in a discussion about further treatment options with the Respondent given the fact that the therapeutic

relationship was harmed by the manner in which the assessment was undertaken. The Respondent also referred to the fact that ■ could seek a second opinion if she did not agree with the Respondent's diagnosis. Despite the evidence provided by Dr. ■, the Hearing Tribunal finds that while her approach did not reflect best practice, it met the minimum standard of care applicable for a specific assessment for ■ in Alberta at the time. It does not reflect a lack of knowledge, skill or judgment in the practice of psychiatric medicine.

102. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 11.

Allegation 12: On January 19, 2022, you did inappropriately bill the ACHIP eleven units of the health service code 08.19A, when your time spent with the patient, ■, and the record you created did not justify a claim for eleven units of that health service code.

103. The Hearing Tribunal finds that the in-person assessment of ■ took approximately 21 minutes based on the recording. The Hearing Tribunal does not accept that there were any substantive aspects of the interaction between ■ and the Respondent that were not captured in the recording. It is left to determine whether the Respondent inappropriately billed eleven units for the entire assessment process given the fact that the in-person portion was approximately 21 minutes long.
104. As noted above, the Hearing Tribunal's only evidence on this comes from the Respondent. Although aspects of her testimony relating specifically to ■ were confusing, and related at times to her general practice, she confirmed on cross-examination that she spent three hours on the ■ assessment in total. Her reference to researching on Netcare is not credible given the fact that there was no indication in her chart notes about having done so, but while the Hearing Tribunal is skeptical that she spent three hours on the ■ assessment, it is not able to conclude on a balance of probabilities that the Complaints Director has proven this to be the case. The Hearing Tribunal has no clear evidence from any practitioner suggesting that it is impossible or highly improbable that such an assessment could take that amount of time. This is not an inference that the Hearing Tribunal is prepared to draw in these circumstances.
105. As a result, the Hearing Tribunal finds the Respondent **not guilty** of unprofessional conduct in relation to Allegation 12.

Allegation 13: On April 25, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services to your patient, ■, particulars of which include one or more of the following:

- a. You failed to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician, and the patient's presenting history and complaints;
- b. [REDACTED]
[REDACTED]
[REDACTED]
- c. [REDACTED]
[REDACTED]
- d. You failed to prepare an adequate record of assessment by failing to include documentation of an evaluation of the patient's work history and family history;
- e. You provided an inadequate consultation report to the patient's referring family physician.

106. [REDACTED] gave evidence about her assessment with the Respondent. She testified that the beginning of the assessment was professional and that the Respondent asked questions about her history; however, once [REDACTED] told the Respondent that she was having difficulty with [REDACTED], "the tone of the appointment seemed to take a turn where [the Respondent] didn't seem to believe [REDACTED] about ... this claim, and seemed to be seeking to, like, kind of tear down the diagnosis that [REDACTED] had of [REDACTED]" (Transcript at 269, lines 24-27). [REDACTED] noted that she had a previous diagnosis of [REDACTED] from a Dr. [REDACTED], and that she mentioned it to the Respondent. She discussed her medication use as a result of the diagnosis of [REDACTED] under the care of her family physician and the fact that [REDACTED] in advance of her appointment with the Respondent. She testified that the Respondent told her [REDACTED] and that unless [REDACTED] permitted her to speak with her parents to gain collateral information, she would not be willing to see her again (Transcript at 373). She was very shaken as a result of the appointment with the Respondent, and she eventually saw another psychiatrist who confirmed her diagnosis of [REDACTED]. [REDACTED]
[REDACTED]. She testified that her appointment with the Respondent was "no more than one hour" (Transcript at 375, line 1), and that she noted a number of inaccuracies included in the Respondent's consult letter to her family physician. [REDACTED] reviewed those inaccuracies, including [REDACTED], a lack of a reference to [REDACTED] and inconsistency with other aspects of the consult letter (Exhibit 6).
107. In cross-examination, [REDACTED] acknowledged that given the passage of time she might not have a strong recollection of what exactly was discussed during the appointment. She agreed that the Respondent asked her about a range of topics, and that she covered a "pretty broad range of topics" (Transcript at 382, line 1). She confirmed that she specifically declined the Respondent's

request to speak with her parents. She also confirmed that although the Respondent did not make a diagnosis, she provided some guidance in relation to "sleep habits, diet, daily routine, [and] healthy living type of things" (Transcript at 386, lines 12-14).

108. Although [REDACTED] testified that there was some confusion at the start of the assessment in relation to the purpose for it, the Respondent did not discuss with [REDACTED] the contents of the referral letter from her physician (Transcript at 393-94), nor did the Respondent explain the rationale for why she wished to speak with [REDACTED]'s parents (Transcript at 394).
109. [REDACTED]'s mother, [REDACTED] also testified. She confirmed [REDACTED]'s history [REDACTED]
[REDACTED] She also confirmed that [REDACTED] received a subsequent diagnosis [REDACTED] from a psychiatrist following her appointment with the Respondent. In cross-examination, she confirmed that she had no medical training and did not attend the appointment with [REDACTED] and the Respondent.
110. Dr [REDACTED] was qualified to provide expert evidence in relation to the assessment undertaken by the Respondent on [REDACTED]. She provided an expert report setting out her conclusions and noted that the report was based on an assumption that the Respondent had access to previous medical records relating to [REDACTED], which she now understands is incorrect. However, she testified that this did not change her ultimate conclusion that the Respondent failed to meet the standard of care expected of a psychiatrist in relation to the assessment of [REDACTED]. She testified (Transcript at 407, line 16 to 408, line 14):

And although I accept that [the Respondent] did not have access to the records that clearly documented [REDACTED] all the steps that were taken to make that diagnosis, it was listed in the referral from the family physician that there was a diagnosis of [REDACTED], and the patient herself also provided that diagnosis, which means that we're working under the assumption that there is an existing diagnosis, and you are being asked to provide an opinion now as to further treatment and management of this condition.

So in order to get rid of or eliminate a previous diagnosis, it's much more difficult than to make a diagnosis because, in psychiatry, you know, everything is treated as a working diagnosis or a hypothesis. And I would note that when you talk to somebody at one point in time, you get a snapshot of what their mental status is and what their symptoms are at that particular point in time.

So that absence of symptoms at that particular point in time does not necessarily mean that the diagnosis was never present or should be disregarded. Particularly in the case where the patient has been treated and has been managed for this condition for many years, it could potentially reflect that it was adequately treated for a period of time.

111. She testified that given the existing diagnosis and the reasons for referral, the standard of care required a very careful assessment of the diagnostic criteria for [REDACTED] to ensure that if there is no diagnosis of [REDACTED], it is very clear how the diagnosis was arrived at. She highlighted the discrepancies between the consult letter and the diagnostic criteria and the lack of evidence that certain topics, including [REDACTED], were canvassed with [REDACTED]. She acknowledged that the Respondent did a very good job of exploring lifestyle choices. However, although the Respondent did record medication history, there was no evidence of any consideration of dosage and whether it had been adjusted, which are important when the patient reports that the medication is no longer helpful. In relation to the fact that the Respondent did not have access to the previous medical information, Dr. [REDACTED] notes that given the fact of a previous diagnosis, [REDACTED] and the lack of that information at the time of assessment, it was incumbent upon the Respondent to conduct a further investigation before coming to a conclusion. In response to the expert report by Dr. [REDACTED], she reiterated her conclusion and noted that evidence of [REDACTED] might not exist in a first clinical encounter, and that the Respondent was required to gather more information prior to coming to a conclusion.
112. In cross-examination, Dr. [REDACTED] agreed that the diagnosis of [REDACTED] is based on the DSM-5 criteria, and that the [REDACTED] guidelines are helpful but do not equate to the standard of care (Transcript at 425). She disagreed that the Respondent was not aware of the previous diagnosis of [REDACTED], and although it might be important to consider who gave the previous diagnosis, it was something that still required investigation.
113. The Respondent also provided her recollection about the assessment of [REDACTED]. She stated that she specifically remembered discussing [REDACTED], but she did not recall if she inquired with [REDACTED] about previous medications she had used (Transcript at 723, lines 21-25). She testified that she "was looking at the situation where at this time [she was] not seeing [REDACTED]" (Transcript at 724, lines 11-13). She stated that she "[d]efinitely would have told her the reason" she asked to see her parents (Transcript at 724, lines 19-20). She confirmed that she was aware of the previous diagnosis of [REDACTED], but that the records were "not made available to me" (Transcript at 725, lines 6-7).
114. Dr. [REDACTED] provided an expert opinion in relation to the assessment undertaken of [REDACTED] by the Respondent. She concluded that the standard of care was met. She specifically noted that [REDACTED] did not provide "much

information to work with" (Transcript at 839, lines 2-3), including who made the previous diagnosis or whether that person was "credible" and what kind of information went into making the diagnosis. She also noted that it was reasonable for the Respondent to conclude based on the information provided that [REDACTED]

[REDACTED]. She stated that it would have been "very difficult for [the Respondent] to actually get [records relating to her previous diagnosis] in a timely manner for this specific assessment" (Transcript at 840, lines 10-12).

115. In cross-examination, Dr. [REDACTED] agreed that there was nothing in the chart that indicated that the Respondent made any attempt to gather information about the previous diagnosis, and that it would not be difficult to simply call the referring physician to request a copy of the previous records, although she stated that "trying to manage overall patient flow when you're the only person in the office does actually end up then making it a much more onerous task" (Transcript at 873, lines 18-20).
116. The Hearing Tribunal concludes that the Respondent's assessment of [REDACTED] fell below the standard of care expected for a psychiatrist practicing in Alberta. It finds that the nature of the inquiries made—as with the previous complainants—was limited and perfunctory, although that standing alone did not breach the standard of care. However, with [REDACTED], there was a clear previous diagnosis of [REDACTED]; this heightened the requirement on the Respondent to conduct a thorough investigation prior to coming to a conclusion [REDACTED]. It accepts Dr. [REDACTED]'s evidence on this point as reflecting the standard of care. Although the referral letter did not identify the person having made the previous diagnosis, it referred to that person as a "specialist" which required further investigation. The Hearing Tribunal rejects Dr. [REDACTED]'s evidence that all that was required was to undertake a fresh examination; it is evident that some symptoms of [REDACTED] might not be manifest during a first appointment with a patient where the patient might be particularly focused on the interaction due to nerves or uncertainty. Given the previous diagnosis, more was required to assess [REDACTED].
117. The Hearing Tribunal is mindful of the Respondent's repeated evidence that she spent approximately 30 minutes reviewing materials in preparation for an assessment. It is impossible that reviewing the referral letter could have taken that long; the Respondent had ample opportunity to at least attempt to request the previous (and clearly relevant) information; even if that information came to her following the assessment, it ought to have been considered prior to her coming to a conclusion.
118. Further, the Hearing Tribunal rejects Dr. [REDACTED]'s suggestion that managing "overall patient flow" can excuse a psychiatrist from making an inquiry with the referring physician to obtain the records relating to the previous diagnosis. The Respondent, in effect, simply disregarded the previous

diagnosis as being irrelevant to the assessment. It is entirely possible that those records would have provided information that would have assisted in understanding the symptoms [REDACTED], how the assessment was carried out, and important collateral information underlying the previous diagnosis. Although the Respondent was not able to gather current collateral information from [REDACTED]'s parents—and she cannot be faulted for that given [REDACTED]'s clear position on the issue—the limitation on that specific collateral information made the gathering of other potential information even more important. In any event, the Hearing Tribunal finds that the Respondent did not explain the rationale for wanting to speak with M[REDACTED]'s parents; [REDACTED]'s evidence on that issue was unequivocal while the Respondent's evidence was conditional (she "would have" explained the rationale). In the absence of an explanation for the request, [REDACTED] cannot be faulted for refusing the request.

119. The Hearing Tribunal is therefore satisfied that the Respondent fell below the standard of care in relation to her assessment of [REDACTED]; that failure was material, and it therefore reflects a lack of skill or judgment in the practice of medicine. The Hearing Tribunal's conclusion supports a finding of unprofessional conduct in relation to particulars (a) and (c) of Allegation 13.
120. In relation to particulars (b) and (d), the Hearing Tribunal is not prepared to conclude that those are clearly proven on a balance of probabilities. Aspects of the Respondent's questioning of those topics leave much to be desired, but they do not (standing alone) constitute unprofessional conduct.
121. In relation to particular (e), however, the Hearing Tribunal finds that the Respondent provided an inadequate consultation report to [REDACTED]'s referring physician. The Respondent failed to undertake a complete assessment, essentially ignoring material and apparently available evidence. Her consult report was, as a consequence, materially deficient. The evidence also suggests that the Respondent's failure to undertake an adequate assessment was a misdiagnosis given the subsequent confirmation of [REDACTED]'s [REDACTED], although the Hearing Tribunal is not required to make a specific finding in relation to that issue.
122. For those reasons, the Hearing Tribunal finds the Respondent **guilty** of unprofessional conduct in relation to Allegation 13.

Allegation 14: On April 25, 2022, you did fail to treat your patient, [REDACTED], with courtesy and respect.

123. [REDACTED]'s evidence in relation to this allegation changed from the time of her original complaint to the time of her testimony at the hearing. She very candidly stepped back from the specific allegation that the conduct of the Respondent was akin to the development of an abusive relationship (Transcript at 390, line 5 to 391, line 21):

Q Just a few more questions for you. In your written complaint, you had wrote down that the appointment felt like an attempt to begin an abusive patient-provider relationship; do you recall that?

A I recall that.

Q Do you recall attending an interview with the College investigator, [REDACTED], on January 31st, 2023?

A I do.

Q And we can pull up the transcript of that if you would like to see it. I'm just going to read a comment that you made to [REDACTED]. This would be at page 5 of the transcript. So [REDACTED] asked you about this comment in your complaint, and you said:

...I'm not entirely sure if I stand by that now. That's one possible interpretation of events, that that's -- that that could be perhaps why she wanted to keep treating me even though she said that she -- there was nothing wrong with me. It could have also been that she thought that whatever issues I had were subclinical, didn't require a diagnosis but might still require professional help. So I don't necessarily stand by that earlier statement.

Do you remember telling [REDACTED] that?

A I do.

Q So fair to say that at the time of this interview, you had changed your mind a little bit from what you wrote in your complaint?

A That's correct.

Q And then one more comment in your complaint, you had written that you felt that [the Respondent] was specifically trying to upset you during the appointment?

A That's correct.

Q But, again, in your interview with [REDACTED], you walked that back a little bit and said that's:

...probably not what she was doing. That's not -- it's not really a reasonable way to think about other people's motives?

A That's correct.

Q So that's another part of the complaint that you changed your mind about by the time you got to the interview; is that fair?

A Yes.

124. While it is clear that ■ was upset during the appointment and with the manner in which the Respondent asked questions of her, she confirmed in cross-examination that the interactions remained professional (Transcript at 387, line 13-27):

Q And the way [the Respondent] carried herself through the appointment, her tone of voice, she remained professional, correct?

A Yes.

Q And she didn't raise her voice or make inappropriate gestures?

A No.

Q Now, after leaving the appointment, it's fair to say that you were upset, correct?

A Yes.

Q And I understand that you texted a few of your friends about the appointment?

A Yes. Yes.

Q And you provided those messages with your complaint?

A Yes

125. The Hearing Tribunal cannot conclude that this evidence reflects conduct inconsistent with the provisions of the Code of Ethics noted above. For those reasons, the Hearing Tribunal finds that it has not been proven on a balance of probabilities that the Respondent failed to treat ■ with courtesy and respect in her assessment. The Respondent is therefore **not guilty** of Allegation 14.

Allegation 15: On April 25, 2022, you did inappropriately bill the Alberta Health Care plan for eleven units of the health service code 08.19G, when the time spent with the patient, [REDACTED] did not justify a claim for eleven units of that health service code.

126. For the same reasons as those noted above relating to Allegations 2, 9 and 12, the Hearing Tribunal is not able to conclude on a balance of probabilities that the Respondent did not spend less than three hours on the entirety of the assessment for [REDACTED] (see Transcript at 725, line 26 to 726, line 7).
127. The Hearing Tribunal therefore finds the Respondent **not guilty** of Allegation 15.

Allegation 16: On August 16, 2022, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, [REDACTED], given the reason for the referral by the patient's family physician, and the patient's presenting history and complaints.

128. [REDACTED] gave evidence in relation to his assessment by the Respondent. He had been referred by his physician for an urgent assessment relating to [REDACTED]. He testified that he had become concerned about [REDACTED]. [REDACTED] He testified that when he met with the Respondent, he did his best to be "as forthcoming and clear as possible" and to put his best foot forward in the assessment (Transcript at 442, lines 12-16). He described the Respondent as "no-nonsense" and that he appreciated that (Transcript at 444 at lines 1-3). He described the nature of the conversation and areas that were covered, although he noted that there was no real connection, and that it appeared as if the Respondent had a "destination in mind and, like, they were going to get there no matter what" (Transcript at 445, lines 2-7). He was shown the consult letter from the Respondent and reviewed the inaccuracies that he believes it contains (see Exhibit 8). [REDACTED]

129. In cross-examination, while [REDACTED] acknowledged that there were gaps in his memory of the assessment, he had "strong recollections of portions of the appointment" (Transcript at 462, lines 21-22). He agreed that the Respondent reviewed various areas in her assessment of him, and that he had expected that the assessment would have been more similar to his previous experience with therapy.
130. Dr. [REDACTED] was qualified to provide expert evidence in relation to the Respondent's assessment of [REDACTED]. She expressed the opinion based on the information she had reviewed that the Respondent had not met the standard of care in relation to the assessment undertaken of [REDACTED]. She noted various failings including: the lack of a detailed developmental history, perinatal history, development milestones, temperament as a child, history of trauma, abuse or losses, commentary about academic functioning, nor a full screen for childhood symptoms of [REDACTED]. She also noted that [REDACTED] had mentioned a number of things that were potential "red flags" for [REDACTED] and which ought to have been explored. She testified that the Respondent did not appear to have screened for anger management problems, safe driving issues or financial troubles (Transcript at 475-77). [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
She also provided her reasons for her disagreement with the expert report by Dr. [REDACTED]. She confirmed that nothing in Dr. [REDACTED]'s expert opinion changed her opinion that the Respondent failed to meet the standard of care in relation to her assessment of [REDACTED].
131. In cross-examination, Dr. [REDACTED] agreed that where a patient continues to provide information that is not pertinent to an assessment, it may be necessary to redirect the patient, and that a patient in that circumstance can feel like they were not listened to (Transcript at 487). She agreed that in some circumstances, it might be possible to rule out an [REDACTED] diagnosis where the diagnostic criteria are clearly not met. She disagreed that psychological testing done in the 1980s would have necessarily ruled out [REDACTED] given the state of medicine relating to [REDACTED] at that time. She also agreed that the "red flag" symptoms referred to in her report were not specific to [REDACTED]. In re-direct, Dr. [REDACTED] confirmed that nothing in the cross-examination changed her opinion that the standard of care had not been met; she also indicated that there is a "duty to explore other possibilities for the presenting symptoms" during a one-time consultation even where the specific reason for the referral was not present.
132. The Respondent gave evidence in relation to her assessment of [REDACTED] and noted that his symptoms were reported to start [REDACTED], and she determined that [REDACTED] (Transcript at 727, lines 3-4).

In

relation to the recording in her records [REDACTED], the Respondent stated (Transcript at 727, line 27 to 728, line 18):

I've reflected on this. Sometimes templates, typographical -- typo errors. Which is common. We type a lot. I do my typing myself. I don't give it to someone else. So when it's a typo error, sometimes it will be in this context.

[REDACTED] So my template will have a drop-down of alcohol +, plus. Recreational use +, plus. It's left for me to remove the plus if the patient says no. And if the patient says yes, I use recreational drugs, it's left for me to leave the plus and put cannabis, ecstasy. So that's -- I have to put down what the patient has said. So my templates don't come down with cannabis and ecstasy. [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

133. The Respondent also set out how she determined that [REDACTED] did not have [REDACTED], stating that he reported symptoms [REDACTED], when he was an adult. That fact alone meant that he did not meet the diagnostic criteria for [REDACTED] (Transcript at 729).
134. In cross-examination, the Respondent maintained her position that [REDACTED] had reported [REDACTED]. She stated that she would "ensure in future for [her] notes to be clearer than it is right now. This was in 2021. Sorry, 2022. And since then there has been a lot of improvement on [her] templates and [her] notes" (Transcript at 798, lines 14-17).
135. Dr. [REDACTED] also provided an expert opinion about the assessment undertaken by the Respondent for [REDACTED]. She stated that the Respondent met the standard of care because she determined that the diagnostic criterial for [REDACTED] were not met, including criteria "C" and "E" were not met. She noted that [REDACTED] first expressed concerns about symptoms [REDACTED], when he was an adult. That meant that the diagnosis could not be [REDACTED]. She expressed the opinion that the developmental history reviewed by the Respondent was adequate and met the standard. [REDACTED]
[REDACTED]
[REDACTED] She also noted that in some assessments, patients need to be redirected to relevant issues and some can find that process "invalidating" (Transcript at 844, line 27).

136. [REDACTED]
137. The Hearing Tribunal has no difficulty in finding that the assessment undertaken by the Respondent in relation to [REDACTED] was inadequate, and in a material way. The approach taken by the Respondent came down to making a determination that the first reported symptom by [REDACTED] was [REDACTED], and that this standing alone was sufficient to allow her to conclude that the diagnostic criteria were not met. This does not meet the standard of care. [REDACTED] reported symptoms, [REDACTED] [REDACTED] Although he was not diagnosed with [REDACTED] at that time, the assessment was [REDACTED], and the diagnostic criteria and practice relating to [REDACTED] had certainly evolved since that time. It was unacceptable for the Respondent to refrain from exploring those issues in much greater detail than is reflected in her assessment. Even in the absence of a diagnosis of [REDACTED], the Respondent herself acknowledged that [REDACTED] had "difficulties", but there was no exploration of what might be causing them beyond [REDACTED]. The Hearing Tribunal agrees with Dr. [REDACTED] that these "red flags" warranted further and more specific inquiries by the Respondent. It disagrees with Dr. [REDACTED] that the assessment was acceptable for those same reasons.
138. The Hearing Tribunal is particularly concerned with the Respondent's evidence relating to her record [REDACTED]. To the extent that the evidence of [REDACTED] and the Respondent differ on that issue, the Hearing Tribunal prefers the evidence of [REDACTED]. [REDACTED] gave his evidence in a forthright manner, entirely without guile or pretense. He was clearly doing his best to fairly recall the events at issue, and the Hearing Tribunal finds it highly improbable that he would not have provided honest responses to questions from the Respondent [REDACTED]. It is clear that [REDACTED] reported [REDACTED], but the Respondent either asked no questions about frequency and timing or recorded inaccurate information. Had [REDACTED] been asked, it is clear to the Hearing Tribunal that he would have provided honest and accurate responses. The Respondent's evidence about the use of templates was also concerning and confused. Her insistence that she accurately recorded in the medical record what she was told by [REDACTED] is not credible and the Hearing Tribunal rejects that evidence.
139. The assessment of [REDACTED] was inadequate, and it reflected a lack of knowledge, skill or judgment in the practice of medicine. It represents a material departure from the standard of care expected of a psychiatrist and is

therefore unprofessional conduct. For those reasons, the Hearing Tribunal finds the Respondent **guilty** of Allegation 16.

Allegation 17: On August 16, 2022, you did fail to treat your patient, ■■■■■, with courtesy and respect.

140. Again, ■■■■■ gave evidence in a forthright and honest manner. Although in cross-examination he maintained his evidence that the Respondent lacked empathy and was very focused on the specific aim that she had (Transcript at 459), his evidence did not reflect the language used in his original complaint, which stated that the Respondent had been "adversarial, curt, brusque, rude, impatient, aggressive and combative and dismissive" (Transcript at 474, lines 25-27).
141. Accepting ■■■■■'s evidence, the Hearing Tribunal is not able to find that the Respondent's interaction with ■■■■■ was sufficiently negative to amount to a lack of courtesy and respect. It is undoubtedly accurate to say that the Respondent was focused on some of the criteria necessary for an assessment and may have been dismissive of other information offered by ■■■■■, but it does not reflect a breach of the Code of Ethics and does not rise to the level of unprofessional conduct.
142. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of Allegation 17.

Allegation 18: On August 16, 2022, you did inappropriately bill the Alberta Health Care plan for eleven units of the health service code 08.19A, when your time spent with the patient, ■■■■■, and the record you created did not justify a claim for eleven units of that health service code.

143. For the same reasons as those noted above relating to Allegations 2, 9, 12 and 15, the Hearing Tribunal is not able to conclude on a balance of probabilities that the Respondent did not spend less than three hours on the entirety of the assessment for ■■■■■. In fact, ■■■■■'s own evidence was that the assessment was approximately 90 minutes.
144. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of Allegation 18.

Allegation 19: On May 12, 2023, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to undertake an adequate assessment of your patient, ■■■■■, given the reason for the referral by the patient's family physician, and the patient's presenting history and complaints.

145. ■ testified about his experience with the Respondent during his assessment on May 12, 2023. He described his interaction with the Respondent as follows (Transcript at 502, line 22 to 503, line 15):

Yeah, I guess, to summarize, I found [the Respondent], like, very dismissive, and often, like, cutting me off during kind of major details of my life and sharing. I think it took a lot of courage for me to be able to come to a professional and seek help and be able to talk about [REDACTED]

And I often found myself being cut off or hearing things that seemed very dismissive to what my family had been through and what I had experienced. She seemed, like, really rushed in -- in -- through the appointment. I came out, like, fairly tense and didn't really feel heard. And -- and, yeah, it gave me a lot of stress, and, like, self-doubt coming out of it. Luckily I kind of had a fairly supportive family and things like that to be able to, like, help me through that after that, supportive family and friends and stuff, that were able to, like, take me through and get -- allow me to get a second opinion.

146. ■ testified that he subsequently received a second opinion from another psychiatrist and was diagnosed with ■. He stated that the diagnosis and subsequent treatment assisted him in having a lot of success since that time (Transcript at 504-505). Importantly, the assessment with the Respondent was recorded by her with ■'s consent. The recording of the interview indicated to ■ that the entire appointment was approximately 30-32 minutes in length. He testified that the transcript was accurate in terms of the contents of the assessment.

147. In cross-examination, [REDACTED] confirmed [REDACTED]
[REDACTED]
[REDACTED]

Although he agreed that the "main reason" for his assessment by the Respondent related to [REDACTED] he was "there to share family history and things that had affected [him] in the past, hoping that I could get the best possible help and support" (Transcript at 514, lines 18-26). He agreed that his statement that the meeting with the Respondent was "heated", and that he had not had an opportunity to listen to the actual recording of the meeting.

148. Dr. [REDACTED] was qualified to give expert evidence about whether the assessment of [REDACTED] by the Respondent met the standard of care expected for a psychiatrist in Alberta. Her expert report and testimony focused on two areas: the nature of the communication style and manner used by the Respondent in conducting the assessment, and the adequacy of the assessment itself. In relation to the first issue, she was of the view that [REDACTED]'s experience of being "discredited and not fully heard" was reflected in the transcript (Transcript at 530, lines 16-17) and that the use of closed, leading

questions—often expressed in the negative—did not provide [REDACTED] with an opportunity to be heard. She noted that the expression [REDACTED] by [REDACTED] “was not handled in a compassionate and empathic manner and would have contributed to the patient feeling that he hadn’t been heard” (Transcript at 530, line 27 to 531, line 7). In relation to the adequacy of the assessment, she testified as follows (Transcript at 532, line 8 to 533, line 22:

There were some parts of the assessment that I felt would meet standard of care and sort of overall screening of certain things. There were certain parts of the assessment that I did not feel were ideal. I think I described it as suboptimal. [REDACTED]

[REDACTED] I did not think that was done in a very supportive and appropriate manner.

And then there were several parts of the assessment that I thought just did not meet the standard of care for an assessment of [REDACTED]. [REDACTED]

There was -- that was not followed up on. [REDACTED]

[REDACTED] And then in terms of the actual [REDACTED] assessment itself, from what I could see on the transcript, [REDACTED] presented a whole series of questions -- or of symptoms where he had concerns [REDACTED]. And [the Respondent] did not do a full assessment of DSM criteria to guide -- you know -- to guide ruling in or ruling out that diagnosis. She focussed on the adult portion of his life and reviewed some of his experiences in -- [REDACTED] school. And he would bring up a series of different symptoms, and what I noticed is she wouldn't continue to pursue and follow up on those symptoms. She would describe suggestions for cognitive therapy or ways of helping with procrastination, but the actual exploration of [REDACTED] symptoms was not sufficient, in my opinion.

149. Dr. [REDACTED] also noted that the assessment of functionality was limited and appeared to be based solely on how he had done in [REDACTED] school. This was not sufficient without examining what his experience in school actually looked like (Transcript at 534). She also indicated that it is not unreasonable

731, lines 12-13). In response to a question noting discrepancies between the recording and the chart notes, the Respondent stated (Transcript at 734, line 23 to 735, line 24):

Thank you. Yeah, I apologize for that. Like I said, I use templates and my templates, I -- that's -- for every patient encounter, the -- the template is populated by the information I get from the patient. So in the case of alcohol, it could have plus, 1 and -- it could have the plus sign, and in discussing with the patient, they know -- drug -- recreational drug would have plus and some other things. But in the direct encounter with the patient, these things would be taken off because the patient reported nil to all of this, did not report at all, did not report recreational drugs. Also, when I read the expert's opinion, the report, she mentioned that the tape had no -- there was nowhere in the tape where I asked for hyperactive symptoms or impulsive symptoms. So psychiatry can be quite subjective and we should -- we should be careful not to lead our patients on with very direct questions. So it would be very unlikely for me to ask a patient, do you interrupt, are you impulsive, are you fidgety, I will -- those are things I will observe. So in the reporting, even if they were not asked and they were recorded in the -- reported in my consult note to the family physician, it will state that the patients did not report it. So did not report, I would like to state again, means that that was screened for directly and indirectly, and it was not reported, neither elicited maybe on mental status examination, when it is in the negative.

153. In response to the criticism that she did not adequately respond to the disclosure [REDACTED] by [REDACTED], she stated: "So that's another area I'll need to work on" and explained her rationale for not asking further questions of him in relation to it (Transcript at 736, line 8ff).

154. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] However, she agreed that she did not explore that issue at all with [REDACTED] (Transcript at 795, line 20 to 796, line 24):

Q ... But you recognize in [REDACTED]'s transcript you didn't explore that at all, did you?

A No, I didn't.

Q You didn't ask a single question about [REDACTED]
[REDACTED]

██████████ asked none of those questions, correct?

A Correct.

Q And yet you found it acceptable to put ██████████ in a formal consult report going to the family physician?

A Yes, and that's one of the improvements I'm making in terms of the use of the templates, on such errors that would arise with using templates.

Q Well, Doctor, we heard one of the experts say this it quite concerning because this becomes part of a patient's record. The family physician has on the chart of a patient a consult report from a psychiatrist that has an indication ██████████ and that could be the subject of information that's used by an insurance company or anything. Do you understand the gravity of that?

A Yes, I do. And I was happy to provide the recording to the College. And the patient is aware they can assess the recording I made at any time.

Q You really don't recognize the significance of that piece of information being put in a formal consult report without any basis in the information from the patient -- do you understand that?

A Yes, I do.

155. Dr. ██████████ was also qualified as an expert in relation to the assessment of ██████████. She testified that the Respondent met the standard of care in relation to her assessment because she was able to assess that ██████████ did not meet the DSM-5 "D" criterion relating to ██████████. She reviewed ██████████'s academic history and stated (Transcript at 846, line 23 to 847, line 1):

And so -- and so I think it's reasonable that, like, in looking at ██████████ that the overall functioning, especially from, like, an ██████████ perspective, is actually not -- like, it doesn't meet clinical standards.

156. She disagreed with Dr. ██████████'s statement that ██████████ should be assessed along with other symptoms and stated that she found the Respondent's questions to be "efficient and pragmatic" (Transcript at 17). In

relation to the disclosure of trauma, she stated that she would have handled it in the same way given that it could have overwhelmed the [REDACTED] assessment (Transcript at 849, lines 7-15):

Yeah, I would have handled the disclosure in the same way, which is to quickly redirect [REDACTED] [REDACTED]

[REDACTED] [REDACTED]
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]
[REDACTED] [REDACTED]

157. [REDACTED]
[REDACTED] [REDACTED], [REDACTED]
[REDACTED]
[REDACTED]

158. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

159. The assessment undertaken by the Respondent was inadequate, and materially so. The Hearing Tribunal had the benefit not only of the transcript of the assessment but also the audio recording. The audio recording reflects rapid-fire, closed questioning of [REDACTED]. It did not create an environment where he was able to explain or expand upon questions in a meaningful way. Most concerning, however, was the fact that the assessment did not adequately screen for issues relating to [REDACTED]. While the Respondent asked questions which were relevant to the issue of [REDACTED], including in relation to academics and employment, the questions did not appropriately elicit sufficient information to rule out criterion "D". The Hearing Tribunal accepts Dr. [REDACTED]'s evidence on this issue: the simple fact of academic or employment success does not provide sufficient information to rule out issues with [REDACTED]. It is necessary to understand how those successes were achieved, and to explore whether they resulted from some particular effort on the part of the patient to overcome the limitations arising from [REDACTED]. To use Dr. [REDACTED]'s example, if an employee is successful in keeping a job, but it is because the employee works much longer hours to accomplish tasks or has significant technological or other supports, what appears to be [REDACTED] on the surface may not be. The Respondent's assessment of [REDACTED] was perfunctory and lacking appropriate depth. The Hearing Tribunal rejects Dr. [REDACTED]'s evidence on these issues. While functionality might be assessed early in the process, it is incumbent upon a reasonable practitioner to explore those issues throughout the assessment of other relevant symptoms and criteria.

160. The Hearing Tribunal also finds that the interview style used by the Respondent lacked empathy and compassion, including with respect to the disclosure of trauma. While it might be appropriate to “encapsulate” such a disclosure in order to complete the assessment, a reasonable psychiatrist would be required to in some way return to that topic and address the disclosure, even if it was a referral or recommendation for further exploration.
161. The tempo of the questions suggested an interrogation rather than a physician-patient relationship. Further, the audio recording includes the sound of the Respondent typing on her computer, presumably to record [REDACTED]’s answers. This does not assist in developing a welcoming or open atmosphere. It is not surprising that [REDACTED] felt unheard as a result of the interaction. The fact that the Respondent adopted this approach after she had been making efforts to improve her approach to assessments only deepens this concern.
162. Further, the Hearing Tribunal rejects the suggestion that [REDACTED] was seeking a diagnosis for the purpose of obtaining medication [REDACTED]. His evidence is inconsistent with that; [REDACTED]. While the Hearing Tribunal accepts that there are instances of patients seeking [REDACTED] medication for such purposes, an assessment cannot be based on such an assumption.
163. For those reasons, the Hearing Tribunal finds that the Respondent displayed a lack of knowledge, skill and judgment by failing to undertake an adequate assessment of [REDACTED]. The failure to do so in this circumstance—particularly given the disclosures made by [REDACTED] during the assessment and the lack of depth in relation to the functionality assessment—was a significant departure from the expected standard of care.
164. As a result, the Hearing Tribunal finds the Respondent **guilty** of unprofessional conduct in relation to Allegation 19.

Allegation 20: On or about May 12, 2023, you did display a lack of knowledge of or lack of skill or judgment in the provision of professional services regarding your patient [REDACTED] by preparing a consultation report to your patient's family physician that was inadequate and failed to accurately report the history provided by your patient.
165. Much of the relevant evidence on this issue was canvassed above and will not be repeated here. The Hearing Tribunal has no difficulty in concluding that the Respondent failed to prepare an adequate consultation report that

accurately reported the information provided by [REDACTED]. The failing on this allegation is particularly concerning to the Hearing Tribunal.

166. The discrepancy between what [REDACTED] reported [REDACTED] and the contents of the consultation report was egregious. It is clear that [REDACTED] did not report any information to the Respondent which could have conceivably allowed her to use the term [REDACTED]. The Respondent's evidence in relation to her use of templates was confusing, but it could not explain the problem in this circumstance in any event. While templates might be useful in terms of efficiency, a physician is solely responsible for ensuring that the contents of a template are modified to accurately and completely reflect the actual interaction which took place between the physician and her patient. All of the witnesses who gave evidence on this issue agreed that the inclusion of [REDACTED] in a consultation report where there was no basis for it could have a significant negative impact on a patient. There is a heightened level of responsibility on a physician to ensure that such information is recorded accurately. This issue standing alone is sufficient to ground a finding of guilt in relation to this allegation.
167. However, the Hearing Tribunal also accepts the evidence of Dr. [REDACTED] in relation to the overall quality of the consultation report. She testified as follows (Transcript at 540, lines 10-24):

Q ... So if that consult report that you saw, the one produced by [the Respondent], had been prepared for you by one of your residents, what would you say to that resident?

A I -- I do not think that that would be a report that I would consider meeting standard of care. It was almost like a bullet form, sort of a series of phrases. It was somewhat disorganized. It was inconsistent with certain parts of the thing -- of the report referencing a family history and other parts referencing a family history that wasn't present. I didn't think it looked professional because it was literally a series of -- of statements. But it wasn't sort of a thoughtful, comprehensive consolidation of an assessment that was done. So that would not be acceptable to me.

168. While Dr. [REDACTED]'s evidence on this issue is helpful, it simply confirms the views of the Hearing Tribunal that the consultation report created by the Respondent from her assessment of [REDACTED] was materially deficient. It reflects a lack of skill and judgment in the practice of medicine. While the Standard of Practice relating to Referral Consultation was not referred to by the parties, the Hearing Tribunal has reviewed it and determined that the consultation report did not accurately set out what was required in section 10(b); this conclusion is not required for the purpose of this finding, but the Hearing Tribunal notes the existence of the Standard of Practice.

169. Therefore, the Hearing Tribunal finds the Respondent **guilty** of unprofessional conduct in relation to Allegation 20.

Allegation 21: On May 12, 2023, you did fail to treat your patient, ■■■■■, with courtesy and respect.

170. While the Hearing Tribunal found above that the tone and approach taken by the Respondent did not provide an opportunity for a meaningful assessment, it is not able to conclude that the Respondent failed to treat ■■■■■ with courtesy and respect. ■■■■■'s evidence on this issue was fair and balanced; although he testified that he was not being heard and that he perceived that he was being talked down to, he acknowledged that she did not call him names or swear (Transcript at 511, line 23 to 512, line 1).
171. Further, the Hearing Tribunal had the benefit of the audio recording of the assessment. It concludes that while the Respondent's tone and manner does not reflect an empathetic approach, nor best practice, it was not discourteous or disrespectful. At times it approached a tempo which was akin to an interrogation, but it did not cross the line into what the Hearing Tribunal can conclude was unprofessional conduct. It does not reflect a violation of the provisions of the Code of Ethics noted above.
172. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of Allegation 21.

Allegation 22: On May 12, 2023, you did inappropriately bill the ACHIP eleven units of the health service code 08.19A, when your time spent with the patient, ■■■■■ and the record you created did not justify a claim for eleven units of that health service code.

173. For the same reasons as those noted above relating to Allegations 2, 9, 12, 15 and 18 the Hearing Tribunal is not able to conclude on a balance of probabilities that the Respondent did not spend less than three hours on the entirety of the assessment for ■■■■■ (see Transcript at 738, lines 10-14).
174. Therefore, the Hearing Tribunal finds the Respondent **not guilty** of Allegation 22.

VI. SUBMISSIONS ON SANCTION

175. For the reasons set out above, the Hearing Tribunal finds the Respondent guilty of unprofessional conduct in relation to allegations 13, 16, 19 and 20. The Hearing Tribunal therefore directs the parties to consult with each other and to coordinate with the Hearings Director's office in relation to written or oral submissions (or both) relating to appropriate orders under section 82 of the HPA. In the event that the parties are unable to agree, they may seek the direction of the Hearing Tribunal through the Hearings Director's office.

Signed on behalf of the Hearing Tribunal by the Chair:

A handwritten signature in black ink, appearing to read "Glen Buick". The signature is fluid and cursive, with the first name "Glen" and last name "Buick" clearly distinguishable.

Glen Buick

Dated this 8th day of September, 2025.