COLLEGE OF CHIROPRACTORS OF ALBERTA

Hearing Tribunal Written Decision and Orders for the Hearing of:

Dr. Timothy Sharp

On:

November 21, 2022

Posting expiration date:

December 12, 2032

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IN THE MATTER OF A HEARING OF THE HEARING TRIBUNAL
Into the Conduct of Dr. Timothy Sharp, a Regulated Member of the College of Chiropractors of Alberta (CCOA), pursuant to

THE HEALTH PROFESSIONS ACT, being
Chapter H-7 of the Revised Statutes of Alberta

DECISION OF THE HEARING TRIBUNAL

1. Hearing

The hearing was conducted virtually on November 21, 2022. The following individuals were present:

Shelly Flint, Public Member (Chair)
Dr. Alan Poytress, Regulated Member
Dr. Moe Gebera, Regulated Member
Anita Warnick, Public Member
Vivian Stevenson, KC, Independent Legal Counsel

Ms. Sheila Steger, Complaints Director
Blair Maxston, KC, Legal Counsel for the Complaints Director

Dr. Timothy Sharp, Investigated Person
Rose Carter, KC and J. Okerman, Legal Counsel for the Investigated Person

2. Preliminary Matters

Jurisdiction of the Hearing Tribunal was established. There were no objections to the jurisdiction or composition of the Hearing Tribunal to proceed with the hearing. There were no other preliminary matters raised by either party.

3. Allegation

The Notice of Hearing, Notice to Attend and Notice to Produce included three allegations which are reproduced below:

1. On, or about March 30, 2021, during an interaction with Patient C, Dr. Sharp failed in his professional duty to maintain professional boundaries and to obtain informed consent by adjusting Patient C's clothing without consent and/or touching her on the bare back to indicate when treatment was concluded, which breached College Standard of Practice 6.1 –"Professional Boundaries with Patients" and which breached College Standard of Practice

3.0 – "Provision of Information" and College Code of Ethics Article A5 – "Informed Choice and Consent of Treatment."

2. On, or about March 30, 2021, during an interaction with Patient C, Dr. Sharp failed in his professional duty to protect Patient C from harm by causing distress on Patient C that has had lasting implications for her, which breached College Code of Ethics Principle 2 – "Nonmaleficence."

3. On, or about March 30, 2021, during an interaction with Patient C, Dr. Sharp failed in his professional duty to ensure he treated his patient with dignity and respect and always maintain professional communication, which breached College Standard of Practice 1.2 – "Professional Communication."

4. Background

In a complaint dated June 14, 2021, Patient C (a patient of Dr. Sharp) made a complaint against Dr. Sharp arising from treatment she received from him, which was performed, in part on the knee chest Gonstad table at Dr. Sharp's clinic on March 30, 2021. Prior to the March 30, 2021 attendance, the Complainant had been treated by Dr. Sharp on two occasions.

In response to the complaint, the then Complaints Director of the College appointed an investigator to conduct an investigation pursuant to Part 4 of the Health Professions Act, RSA c H-7 (the "HPA"), and an investigation report was completed. The then Complaints Director then referred the matter to a hearing.

5. Evidence and Admission of Unprofessional Conduct

The hearing was conducted by way of an Agreed Statement of Facts (Exhibit 3), Admission of Unprofessional Conduct (Exhibit 2), Joint Submission Regarding Penalty (Exhibit 4), a copy of an apology letter written by Dr. Sharp (Exhibit 5), a letter from counsel for Dr. Sharp to counsel for the Complaints Director including attachments (Exhibit 6) and an email of November 20, 2022 from the CCOA with assessment results from the CCOA Trauma Informed Training Requirement (Exhibit 7). In addition to these Exhibits, the Tribunal heard oral evidence from two witnesses with respect to the sanction phase of the hearing.

Pursuant to the Agreed Statement of Facts, it was agreed that Dr. Sharp was a regulated member of the College and was the owner of "Liberty Chiropractic" in Edmonton (the "Clinic").

On March 30, 2021, Patient C attended the Clinic to receive chiropractic treatment from Dr. Sharp for acute lower back pain that occurred on Easter Sunday.

Following Patient C checking in at the front reception area of the Clinic and filling out the day sheet, a staff member escorted her to an open room for her to wait to see Dr. Sharp. Patient C was assessed for vestibular dysfunction and was asked to wait, seated on a table for her treatment.

When Dr. Sharp arrived, Patient C advised him that she had received a massage earlier that day and the massage therapist referred her to get chiropractic treatment. Dr. Sharp asked her where she had been and the importance to follow up with her balance dysfunction. Dr. Sharp asked Patient C to lay down and the assessment for Patient C's lower back pain commenced.

Treatment was given to Patient C in the open area. Cavitation and gas were released by Patient C when side posture was adjusted. Dr. Sharp communicated "I am going to wag your tail, in other words flex the sacrum" to describe the treatment. Confirmation of Patient C's understanding of treatment based on that communication was not confirmed.

Dr. Sharp determined Patient C required treatment on the knee chest chair. Patient C was directed to the knee chest room which is adjacent to the open area. Patient C was asked by Dr. Sharp to 'follow me' or 'come with me' and Dr. Sharp and Patient C proceeded to the knee chest room.

In the knee chest room, Dr. Sharp instructed Patient C on how to position herself on the knee chest chair - where knees, hands and head needed to be placed. Patient C knelt down on the knee chest chair and again asked Dr. Sharp 'What am I doing this for?' Dr. Sharp did explain this is an 'old school' technique to adjust the lower back. Dr. Sharp advised Patient C that he was putting on gloves in order to grip the tissue better. Patient C asked why. Dr. Sharp answered to adjust the spine. Dr. Sharp then advised Patient C that he needed to look at her x-rays in her file and left the room.

Dr. Sharp returned after reviewing Patient C's x-ray, communicated that he was going to pull down Patient C's pants to the top of the hips. Dr. Sharp did not request the consent of Patient C to lower her pants. Dr. Sharp also lifted the shirt of Patient C out of the way to perform adjustment. Dr. Sharp did not request the consent of Patient C to lift the shirt up.

Dr. Sharp proceeded to unhook Patient C's bra without requesting consent. When Patient C asked "What are you doing?" Dr. Sharp responded that he was going to adjust this area because of what the x-rays demonstrated. Palpation and movement assessments were performed.

Dr. Sharp advised that he was going to apply a joint lube (Motion Medicine) and after doing so with a glove on he clasped the bra closed and pulled her bottom clothing back up to the waistline. Dr. Sharp tapped Patient C on the back to advise treatment was completed and then left the room and went to her file to make notes.

Patient C came out and stood near the treatment table in the open area at which point Dr. Sharp asked her how she was doing. Patient C communicated she was better and was advised by Dr. Sharp to return to see him in a couple days.

In the Admission of Unprofessional Conduct (Exhibit 2), Dr. Sharp admitted that he is guilty of unprofessional conduct in relation to the three allegations.

6. Submissions

Mr. Maxston made submissions on behalf of the Complaints Director. He explained that the onus is on the Complaints Director to prove the facts that give rise to the allegations, and that the standard of proof is on a balance of probabilities. He advised that in this case, the parties have elected to proceed by way of Agreed Statement of Facts, and accordingly the facts are not in dispute and were proven.

Mr. Maxston then advised that the second onus on the Complaints Director is to prove that the acts which had been proven rise to a level of unprofessional conduct. He referred the Hearing Tribunal to the definition of "unprofessional conduct" in s. 1(1)(pp) of the HPA which includes conduct that breaches the Act or Standards of Practice, or conduct that harms the integrity of the profession. He also submitted that the Regulated Members on the Tribunal could use their knowledge and experience in assessing the conduct and that all Members of the Hearing Tribunal could also use their common sense and judgment in determining whether the acts admitted by Dr. Sharp rose to the level of unprofessional conduct.

Finally, Mr. Maxston advised the Tribunal that the parties had agreed that this case did not involve sexual misconduct or sexual abuse as defined in the HPA or the penalties applicable to that conduct. Again, he emphasized that this agreement did not in any way detract from the seriousness of the conduct but he wanted the Tribunal to understand that the case did not involve allegations of that nature.

Mr. Maxston then summarized the facts set out in the Agreed Statement of Facts, and the scope of the Admission of Unprofessional Conduct. He indicated that from the standpoint of the Complaints Director these were serious allegations and that the relatively brief nature of his comments was a reflection of the fact that the parties had agreed to proceed by way of the Agreed Statement of Facts and Admission of Unprofessional Conduct and was not to be taken as any suggestion that the conduct in question was not serious.

Ms. Carter then made submissions on behalf of Dr. Sharp. She asked the Tribunal to focus on the conduct involved and emphasized that this case did not involve the types of allegations that were frequently in the news recently relating to sexual impropriety. She submitted that what happened in this case fell at the lower end of the conduct scale. In doing so she made clear that she was not suggesting that the Complainant had not been significantly impacted. Ms. Carter submitted that this was a case of proper and accepted chiropractic treatment which involved Dr. Sharp explaining what he was doing while performing the treatment but failing to obtain consent before proceeding with the treatments. She submitted that ideally, and as recognized by Dr. Sharp, he should have explained the treatment fully and obtained the Complainant's informed consent before proceeding. Ms. Carter repeated the advice from Mr. Maxston that the case did not involve sexual abuse or sexual misconduct. She pointed out that Dr. Sharp had recognized his error and had admitted that his conduct constitutes unprofessional conduct in the circumstances.

7. Findings and Reasons

After hearing submissions from the parties, the Hearing Tribunal adjourned to deliberate on the liability portion of the hearing.

The Hearing Tribunal then advised the parties that it accepts Dr. Sharp's admission of unprofessional conduct based on the evidence set out in the Agreed Statement of Facts. Further, the Hearing Tribunal advised that it agrees that the conduct established by the Agreed Statement of Facts rises to the level of unprofessional conduct as defined in s. 1(1)(pp) of the HPA in relation to each of the three allegations.

In reaching this determination, the Hearing Tribunal carefully considered the scope of each of the allegations set out in the Notice of Hearing and the relevant Practice Standards and Articles of the Code of Ethics.

In relation to the first allegation, the Hearing Tribunal was satisfied that the facts admitted by Dr. Sharp demonstrated a breach of College Standard of Practice 6.1 –"Professional Boundaries with Patients", College Standard of Practice 3.0 – "Provision of Information" and College Code of Ethics Article A5 – "Informed Choice and Consent of Treatment." In failing to clearly outline the nature of the treatment in advance, failing to explain that the treatment could involve the unclasping of the Complainant's bra and the lowering of her clothes to the level of her hips, and in failing to obtain the complainant's consent to those things, Dr. Sharp failed to manage the appropriate boundaries within his doctor-patient relationship with the Complainant. Furthermore, he did not meet the appropriate Standard of Practice or comply with the Code by obtaining informed consent.

In relation to the second allegation, the Hearing Tribunal reviewed the facts and Dr. Sharp's formal Admission that he had failed in his professional duty to protect Patient C from harm. The Hearing Tribunal did not have much information about the impact on the Complainant but accepted that by agreement it was proven that Dr. Sharp's conduct had caused the Complainant distress and that the impact was longstanding. The Hearing Tribunal accepted that in this respect there was damage to the Complainant and the alleged conduct was unprofessional whether viewed as a breach of College Code of Ethics Principle 2 or more generally as conduct which harmed the integrity of the Profession.

Finally, the Hearing Tribunal was satisfied that the facts established through the Agreed Statement of Facts with respect to the third allegation demonstrated a breach of Standard of Practice 1.2 – "Professional Communication" in that Dr. Sharp failed to interact with the Complainant in a manner that was professional in content and presentation. The Hearing Tribunal was satisfied that the conduct rose to the level of unprofessional conduct.

In sum, the Hearing Tribunal found that the conduct in relation to all three allegations is factually proven, and clearly constitutes "unprofessional conduct" in the circumstances.

8. Joint Submission Regarding Penalty

The Complaints Director and Dr. Sharp made a Joint Submission Regarding Penalty (Exhibit 4) in relation to four components of a proposed penalty but were unable to agree on a fifth component.

The parties jointly proposed that the Hearing Tribunal impose orders requiring:

1. Payment of the costs of the investigation and the hearing reduced by the sum of $5,000.
2. Payment of a fine of $1,000 with respect to each of the three allegations.
3. Within six (6) months of the date of the Hearing Tribunal's written decision, Dr. Sharp:
   (a) to provide a written reflection paper satisfactory to a Complaints Director acting reasonably regarding Dr. Sharp's insights into his actions;
   (b) if requested by Patient C, to provide a letter of apology in a form acceptable to the Complaints Director acting reasonably.
4. Publication by the College of the Hearing Tribunal's written decision, with Dr. Sharp's name, pursuant to College Bylaw 8.1.

The Joint Submission Regarding Penalty also indicated that:

> Both parties agree that there should be a further penalty order requiring Dr. Sharp to successfully complete an appropriate ethics course within six (6) months of the date of the Hearing Tribunal's written decision, however, the parties will make separate submissions to the Hearing Tribunal in that regard…

With respect to those elements of the penalty that were proposed jointly, Mr. Maxston submitted that the law was clear that the appropriate sanction was ultimately within the discretion of the Hearing Tribunal. Mr. Maxston also submitted that the law was equally clear that in circumstances in which parties made a joint submission as to penalty that a Hearing Tribunal should give great deference to the negotiated settlement. He argued that the Parties have a reasonable expectation that a Hearing Tribunal will accept joint submissions as to penalty and that there is an important public interest component in this approach because it facilitates resolution and avoids lengthy and costly proceedings. He referred to a series of cases that have established a general rule that a Hearing Tribunal should not interfere with a joint submission on sanction unless it is in the public interest to do so because the proposed penalty is clearly inappropriate and so far outside of what the Hearing Tribunal could consider acceptable that it is required to intervene. Ms. Carter agreed with Mr. Maxston's submission on the applicable law.

In the Joint Submission Regarding Penalty, the parties set out a number of factors relevant to assessing penalty, including the fact that Dr. Sharp's conduct fell below the required ethical standards, and that Dr. Sharp had admitted his conduct and demonstrated acceptance of responsibility for his actions.

9. Additional Evidence on Penalty

Each of the parties then addressed the one aspect of penalty upon which they had been unable to agree, being an appropriate ethics course to be completed by Dr. Sharp. In this respect the Hearing Tribunal heard oral evidence from two witnesses: the Registrar of the College of Chiropractors of Alberta, Dr. Todd Halowski, called by Mr. Maxston, and Dr. Sharp testifying on his own behalf.

Dr. Halowski

Dr. Halowski testified as to changes to the HPA in April of 2019 relating to sexual misconduct and sexual assault and which provided specific guidance and requirements to regulated health professionals. In conjunction with those changes a new educational course was developed by a group of Health Regulatory Colleges. That course included direction in establishing and maintaining professional boundaries with patients and was made available to all Alberta Health Care Providers in late 2019 or early 2020. This course was mandated for chiropractors and was taken and passed by Dr. Sharp on May 20, 2020, February 14, 2021 and October 25. A New Trauma Informed Care course (the "NTIC") was then introduced that was more specific to Chiropractic Practitioners. The NTIC became mandatory in 2022 and introduced more information around establishing and maintaining patient boundaries.

Dr. Halowski confirmed that Dr. Sharp had completed the more general course in 2020 and 2021 but expressed concern that the events in this case had occurred around six (6) weeks after Dr. Sharp had completed the course for the second time in February of 2021. Dr. Halowski suggested that this fact indicated that the teachings from the course had not become part of Dr. Sharp's regular practice.

Dr. Halowski acknowledged that Dr. Sharp had taken and passed the new course on August 24, 2022 and again just prior to the Hearing on November 20, 2022. He testified that while the new course was more thorough than the older course and discussed patient boundaries in more detail, this course was intended as education for all members of the CCOA, not as remediation for members who had demonstrated issues with the subject matter.

Dr. Halowski was asked to review and comment on Exhibit 6, a letter from Dr. Sharp's counsel outlining the steps that Dr. Sharp had taken to educate himself and change his practice since this complaint. Dr. Halowski acknowledged those efforts, but again emphasized the difference between education and remediation.

Dr. Halowski provided evidence about an ethics course known as PROBE and advised that this was a course that the College considered appropriate in discipline cases. He testified it was used by the CCOA and by almost all other regulators of health professionals in Alberta and others across the country including other provincial regulators of chiropractors. In his view the PROBE course was designed to fulfill credentialing requirements for remedial purposes. It provides case studies and time for participants to practice ethical decision-making including decisions relating

to informed consent and patient boundaries. He advised that it was a 25-hour course delivered on-line at a cost of about $2,200.

Dr. Halowski was asked to juxtapose the PROBE course with the NTIC. He explained that the NTIC was competence based and provided information to members. In contrast, the PROBE course focused on the development of the skills and judgment to assist in applying that knowledge in a practice context. He suggested there was a significant difference between a short course followed by an online assessment to ensure that material had been read and a customized and facilitated learning experience over a much longer period.

Dr. Halowski was of the view that a member who had experienced issues in terms of informed consent and patient boundaries would benefit from additional time spent building the skills, attitude and judgment around these issues and this would also benefit the member's practice and his patients and future patients.

Mr. Maxston asked Dr. Halowski about the steps that Dr. Sharp had already taken as set out in the letter from his counsel marked as Exhibit 6. Dr. Halowski expressed concern that the approach still seemed to be somewhat passive. For example, the sign placed at the head of the knee chest table did not adequately reflect the fact that informed consent requires communication and conversation with the patient not simply the provision of information. He also expressed concerns about whether informed consent was being adequately documented.

Dr. Halowski was cross-examined by Ms. Carter. He was unable to comment on how many members of the College had actually taken the PROBE course. He also readily conceded that aside from Exhibit 6 he had no knowledge of the steps Dr. Sharp had taken to change his practice in light of the complaint at issue in this proceeding and that he did not know what Dr. Sharp discussed with his patients in obtaining their informed consent.

Dr. Halowski was asked to assume that in addition to the sign shown in Exhibit 6, that once it was determined that a patient might benefit from treatment on the knee chest table, Dr. Sharp or a staff member would review the information on the sign and then Dr. Sharp would discuss what the treatment involved and that it might or would require exposure of the unencumbered back of the patient and therefore the unclasping of a bra or the lowering of garments or both. Dr. Halowski was also asked to assume that all of this would occur before the patient was asked to take his or her position on the knee chest table and before treatment was commenced and that only if the patient gave express consent to the manner of treatment and the potential disrobing and was given the option of unclasping their own bra and lowering their own garments, would treatment proceed. Dr. Halowski was asked whether based on these assumptions whether he would have some comfort that Dr. Sharp had taken adequate steps to address the matters relating to this proceeding. Dr. Halowski indicated that all these steps were appropriate and provided some comfort but noted the assumptions did not include documenting the consent. Ms. Carter advised that this was the second part of the question, and that Dr. Halowski should also assume that Dr. Sharp would then note the informed consent on the patient record. Dr. Hawloski confirmed that this would also be appropriate.

Dr. Halowski was also questioned about an email that had been sent to a particular demographic of members of the College on July 13, 2021 including Dr. Sharp (part of Exhibit 6). That email alerted the recipients that they were in a risk zone based on demographic factors that contributed to the likelihood of a complaint made against them related to professional misconduct (sexual abuse or misconduct). The purpose of the email was to make the recipients aware of the risks that that they could proactively mitigate them. It suggested various actions, all of which Dr. Sharp had taken. It did not recommend the PROBE Course. Counsel also noted that unfortunately this had been sent out only after the events leading to this complaint.

Dr. Halowski confirmed that when he testified that Dr. Sharp may not have adequately learned from the training because the complaint arose shortly after that training, he did not know what Dr. Sharp might have learned as a result of taking the NTIC. Dr. Halowski also acknowledged that there had been no further complaints about Dr. Sharp since this one.

In relation to the PROBE course, Dr. Halowski conceded that of the seven items listed as the types of infractions or violations addressed by PROBE, only two related to boundary violations and informed consent and that both of these issues are addressed in the NTIC course. Dr. Halowski also acknowledged that he had not taken the PROBE course and only had the information about PROBE that formed part of Exhibit 6. On re-direct he pointed out that the course material suggests that it is a personalized program that addresses a participant's particular misstep and allow them to probe into that misstep and recommit to professional ideals and so is appropriate in terms of remediation.

The Hearing Tribunal asked Dr. Halowski whether he was aware of any other available courses to address remediation in relation to the matters at issue in the Hearing and Dr. Halowski was not, but it was not clear whether he had actively tried to find any. No other course option appears to have been discussed between the parties, and none was put forward to the Hearing Tribunal.

Dr. Halowski also acknowledged on cross-examination that if PROBE was required, that in addition to the cost of the course, Dr. Sharp would miss work and that this would impact his staff and his patients. When asked whether given all of these considerations Dr. Halowski would still recommend the PROBE course, he advised that he would.

Dr. Sharp

Dr. Sharp testified that aside from the complaint that was the subject of these proceedings, he had not been the subject of any other complaint of this kind, despite having practiced as a chiropractor for 33 years.

Dr. Sharp advised that in addition to the original course relating to trauma informed care, he had taken the NTIC twice and passed it twice. He advised that the NTIC was 'meatier' than the original course and said he took the course a second time before the hearing in order to ensure he had not missed anything and to confirm that his understanding remained current and complete.

Dr. Sharp testified that the CCOA mandated courses, particularly the NTIC had helped him have a better understanding of his patient interactions and how he handles himself in a clinical setting. He testified that he understood the importance of a dialogue with the patient in relation to informed consent and the professionalism required in that interaction as well as the need for appropriate note keeping.

Dr. Sharp was asked to take the Hearing Tribunal through the step-by-step process that was now followed in his office when it was determined that a female patient might benefit from a treatment on the knee chest table. He explained about the signs that were posted and that these provided a bridge to a discussion with a patient about the nature of the treatment and the potential that a patient's bra might need to be unclasped or garments moved away from the area of treatment. He indicated that he would ask the patient what they thought about that and whether they were okay with that occurring. He advised that he would ensure that he had express consent from the patient before the patient was positioned on the knee chest table. He said that once the patient had taken position on the knee chest table Dr. Sharp would obtain consent again to the treatment before commencing it. He advised that this has been the practice since he became aware of the concerns that had been raised by the Complainant.

Dr. Sharp indicated that the original course which addressed issues relating to sexual abuse and sexual misconduct was quite general in terms of explaining the changes to the legislation and providing scenarios relating to a wide variety of health care providers. The NTIC had content that was more specific to chiropractors, reviewed appropriate Professional Standards and Guidelines and also outlined 9 or 10 ethics situations or case studies to illustrate the issues. He considered the NTIC to be much different than the original course that he had taken and passed prior to this complaint.

Dr. Sharp also testified that prior to receiving the July 13, 2021 email from the College, he was not aware that he fell into a risk zone in terms of demographics and was unaware of the study referenced in the email. He said that since then he had gained a far better understanding of the importance of informed consent and the awareness of the need to assume that patients had experienced trauma and to approach them with that understanding from the outset.

Dr. Sharp was also asked about the PROBE course. He testified that he had looked into it and tried to obtain more information. He thought that there might be an overlap between PROBE and the NTIC. He expressed concern that PROBE was only available online during business hours and said that he had staff to pay and patients to see and had his own expense and time limitations. Dr. Sharp advised that he had changed his practice as a result of the courses he had taken and felt that he had a better grasp on patient boundaries, informed consent and record keeping. He has taken steps to address this in terms of his own conduct and the conduct of his staff. He confirmed that he now makes notes of the informed consent that he obtains.

Dr. Sharp testified that he had not had a female patient refuse treatment on the knee chest table since he changed his practice, but that he has had discussions with patients about trauma they

have experienced and that he has talked their concerns through with them and provided other treatment options. He said that all his patients have felt comfortable proceeding with treatment on the knee chest table after his discussions with them.

Dr. Sharp also testified about a letter of apology that he had written to the Complainant shortly after becoming aware of her complaint. He was asked to read part of the letter into the record and was clearly distraught while he was reading it and at other points in his testimony. Dr. Sharp advised the Hearing Tribunal that he had sent the letter to the College in the hope that it would be forwarded to the Complainant but had learned at the hearing that it had not been sent.

On questioning by Mr. Maxston, Dr. Sharp acknowledged that hiring a locum for his practice was an option to cover time required by the PROBE course, however he said that he had not hired a locum for 15 years because of issues that had arisen the last time he had hired one. He conceded that there were other occasions when he was required to close his practice or take time off work for things mandated by the College.

Dr. Sharp also readily conceded that patient boundary and informed consent offences of any kind were serious in nature. He acknowledged that the requirement for informed consent was a long-standing requirement and that educating and informing patients about treatment was also an obligation that had existed throughout his practice.

10. Decision on Penalty

The Hearing Tribunal agrees with the Joint Submission Regarding Penalty and finds that the orders jointly proposed by the parties are appropriate in this case, having regard to the conduct identified in the Notice of Hearing.

The Hearing Tribunal makes the following orders pursuant to section 82 of the HPA:

1. Dr. Sharp will pay the costs of investigation and hearing reduced by $5,000, in equal monthly instalments over a 24 month period, without interest, commencing on the 15th day of the month immediately following the date of the written decision of the Hearing Tribunal.

   Provided, however, that if Dr. Sharp defaults with respect to a time payment, the entire balance of the unpaid costs shall become immediately payable and the College shall, without the necessity of any further steps, automatically cancel Dr. Sharp's practice permit until the entire balance of the costs are paid in full.

2. Dr. Sharp will pay a fine of $1,000 for each finding of unprofessional conduct (for a total of $3,000 in fines) within thirty (30) days of the date the Hearing Tribunal’s written decision is provided however, that if Dr. Sharp defaults with respect to this payment the entire fine shall become immediately payable and the College shall, without the necessity

of any further steps, automatically cancel Dr. Sharp's practice permit until the entire fine is paid in full.

3. Within six (6) months of the date of the Hearing Tribunal's written decision, Dr. Sharp:

   (a) will provide a written reflection paper satisfactory to a Complaints Director acting reasonably regarding Dr. Sharp's insights into his actions; and

   (b) if requested by Patient C, will provide a letter of apology in a form acceptable to the Complaints Director acting reasonably.

4. The College shall publish the Hearing Tribunal's written decision, with Dr. Sharp's name, pursuant to College Bylaw 8.1.

In making the above orders, the Hearing Tribunal considered the evidence, and the submissions presented by the parties. While the Hearing Tribunal is not bound to accept a Joint Submission, considerable deference should be afforded, and the Hearing Tribunal should only deviate from a Joint Submission if it would bring the administration of justice into disrepute. The Hearing Tribunal determined that the orders jointly proposed were sufficient to achieve the goal of public protection, and to deter other members of the profession from engaging in similar conduct in the future.

The Hearing Tribunal then considered the submissions with respect to the PROBE Course and the factors relevant to penalty as set out in the Joint Submission Regarding Penalty including:

1. The nature and gravity of the proven allegations;

2. The age and experience of the member;

3. The previous character of the member and in particular the presence or absence of any prior complaints or findings of unprofessional conduct;

4. The number of times the unprofessional conduct was proven to have occurred;

5. The role of the member in acknowledging what had occurred;

6. Whether the member had already suffered serious financial or other penalties as a result of the allegations having be made;

7. The impact of the incident on the complainant;

8. The presence or absence of any mitigating circumstances;

9. The need to promote specific and general deterrence and, thereby, to protect the public and ensure safe and proper practice;

10. The need to maintain the public's confidence in the integrity of the profession; and

11. The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct.

The Hearing Tribunal was not in a position to review similar cases as to penalty because counsel could not identify any cases sufficiently similar to this one.

The Hearing Tribunal understands and accepts that allegations in relation to patient boundaries and informed consent are serious. The Hearing Tribunal also accepts that the events that occurred caused distress to the Complainant and had lasting implications. These factors and the fact that the conduct breached the Colleges Standards of Practice and Code of Ethics call for a significant penalty in this case.

On the other hand, the Hearing Tribunal notes that the events involve a single attendance by the Complainant and was the first complaint of this nature against Dr. Sharp over his 33-year practice. The Hearing Tribunal accepts that Dr. Sharp acknowledged that his conduct was unprofessional and agreed to proceed by way of joint submissions except for the requirement to attend the PROBE course. The Hearing Tribunal agrees with counsel's submission that these actions demonstrate Dr. Sharp's acceptance of responsibility for his actions. All of these matters weigh in favour of a reduced penalty.

The Hearing Tribunal was provided with an estimate of the Investigation and hearing costs that are to be paid by Dr. Sharp as a result of the jointly proposed order as to costs. The Hearing Tribunal viewed the costs, even with the reduction by $5,000 as having a significant financial impact on Dr. Sharp.

The final factors considered by the Hearing Tribunal were specific and general deterrence and the need to maintain the public's confidence in the integrity of the profession. The Hearing Tribunal understands and accepts that Dr. Sharp has made changes to his practice in relation to treatment on the knee chest table and that he has twice taken and passed the NTIC, being the mandatory course required by the College which addresses patient boundaries and informed consent. The Hearing Tribunal also accepts Dr. Sharp's evidence that he has a much better grasp on these issues than he had before the events that led to this hearing and acknowledges the efforts that he has made in this regard.

However, as noted by Mr. Maxston on behalf of the Complaints Director and acknowledged by Dr. Sharp, obtaining informed consent is not a new requirement as a result of the 2019 amendments to the HPA. In terms of the NTIC course, the Hearing Tribunal accepts the evidence

of Dr. Halowski that the NTIC is geared more towards education than to the remediation of demonstrated errors in judgment regarding patient boundaries and informed consent. The Hearing Tribunal agrees that there is a distinction between being provided with information and having the opportunity to learn about and discuss the application of that information in a clinical setting. The Hearing Tribunal was not satisfied based on the evidence before it that Dr. Sharp's successful completion of the NTIC course mandated for all members of the College was sufficient to ensure that Dr. Sharp appreciated the basis for the errors in judgment that led to this hearing or that he is fully equipped to address other potential patient boundary issues that could arise in his practice.

The Hearing Tribunal considers Dr. Sharp's completion of the PROBE course as an important component of maintaining public confidence in the integrity of the profession and a valuable tool for Dr. Sharp's benefit and for the benefit and safety of his current and future patients over the balance of his practice. The Hearing Tribunal understands that the PROBE course entails additional expense to Dr. Sharp in terms of its cost and the impact on his practice, but taking all relevant factors into consideration, the Hearing Tribunal does not consider the requirement to complete the PROBE course to be prohibitive or unduly severe.

Accordingly, in addition to the four orders specified above the Hearing Tribunal makes the following order pursuant to section 82 of the HPA:

5. Dr. Sharp shall successfully complete the PROBE course within six (6) months of the date of the Hearing Tribunal's written decision, or such further time period as agreed to by the Complaints Director, acting reasonably.

DATED THIS 8th DAY OF DECEMBER IN THE CITY OF EDMONTON, ALBERTA.

COLLEGE OF CHIROPRACTORS OF ALBERTA

Shelly Flint
Chair, Hearing Tribunal
CCOA

cc. Hearing Tribunal members