QUEEN'S BENCH FOR SASKATCHEWAN

Citation: **2022 SKQB 13**

Date: **2022 01 12**
Docket: QBG 2030 of 2018
Judicial Centre: Saskatoon

BETWEEN:

HODA HOSSEINI

APPELLANT

\- and -

THE COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN

RESPONDENT

Counsel:

Crystal L. Norbeck and Andrea C. Johnson — for the appellant
Sean M. Sinclair — for the respondent

JUDGMENT — GERECKE J.
January 12, 2022

A. INTRODUCTION

[1] This is an appeal by Dr. Hoda Hosseini from a decision of the Discipline Committee [Discipline Committee] of the College of Dental Surgeons of Saskatchewan [College]. The appeal is brought under s. 38(1) of *The Dental Disciplines Act*, SS 1997, c D-4.1 [*Act*].

[2] Dr. Hosseini was charged with professional incompetence under s. 26 of the *Act* arising from her care and treatment of [redacted] [Patient]. The charges may be summarized briefly as follows:

a. Dr. Hosseini removed an existing dental implant in the #36 area and placed a second implant [Second Implant] in the same area. The Second Implant transected the inferior alveolar nerve canal [IA canal], resulting in nerve injury to the Patient. It was alleged that:

   i. The intrusion of the second implant into the IA canal was avoidable with proper planning; and

   ii. A competent specialist dentist would have recognized the intrusion when the second implant was placed, and the second implant should have been removed then;

And that thereby Dr. Hosseini displayed a lack of knowledge, skill or judgment and/or a disregard for the welfare of the Patient.

[3] The Discipline Committee found Dr. Hosseini to be incompetent in her care of the Patient, with respect to both allegations summarized above. That decision on substantive matters was rendered November 26, 2018 [DC Decision].

[4] The Discipline Committee then held two subsequent hearings. The first arose from complaints by Dr. Hosseini that the Discipline Committee had lost jurisdiction resulting from a reasonable apprehension of bias. The grounds for the bias argument were:

a. Bruce Gibson, a lawyer, served as Chair of the Discipline Committee and his charges for fees suggested an outsized role in decision-making and a lack of independence between the lawyer's legal advice and the task of adjudication; and

b. certain findings and questioning by the Discipline Committee which Dr. Hosseini alleged indicated that the Discipline Committee was not

impartial.

[5] The Discipline Committee denied the bias application in a decision dated April 25, 2019 [Bias Decision].

[6] The Discipline Committee then held a penalty hearing. In a decision dated May 2, 2019 [Penalty Decision], it ordered a formal reprimand, publication of the charges and penalties in a College newsletter, reimbursement of the Patient for $8,213, payment of the College's costs to the extent of $50,000, and that the College deliver a copy of the DC Decision and the Penalty Decision to the governing body of dentists for Manitoba, where Dr. Hosseini now practices.

[7] The grounds of appeal will for the most part be reproduced in full in the body of this decision. For the purpose of this introduction, those grounds may be distilled to the following matters:

a. Interpretation of s. 26 of the *Act*, and whether a single incident can amount to professional incompetence as described in s. 26;

b. Assessment by the Discipline Committee of the expert evidence heard by it;

c. The Discipline Committee's refusal to allow questions concerning s. 26 to be put to Dr. Wagner, the expert witness for the Professional Conduct Committee [PCC] that acted as prosecutor;

d. The Discipline Committee's rejection of evidence from Dr. Toporowski on the basis that she was not an impartial witness;

e. Whether the Chair, Bruce Gibson, was eligible to serve on the Discipline Committee;

f. Whether the role played by Bruce Gibson raised a reasonable apprehension of bias, given that he charged fees substantially higher than any other member of the Discipline Committee;

g. Whether the imposition of costs of $50,000 was excessive; and

h. Whether the Discipline Committee erred by treating certain discussions around costs as covered by "without prejudice" settlement privilege.

[8] For the reasons that follow, I conclude that Dr. Hosseini's appeal must be dismissed in its entirety.

B. BACKGROUND FACTS

[9] Dr. Hosseini is a periodontist, which is a type of specialist dentist. A periodontist's training pertains to the gums and soft tissue surrounding the teeth. Dr. Hosseini's practice includes dental surgery to place dental implants. From late 2012 to early 2016 she practiced in Saskatchewan and was a member of the College. From October 2012 to July 2015 she worked in the Cityview clinic in Regina [Cityview]. She now practices in Winnipeg.

[10] In July 2014 Dr. Hosseini placed a dental implant for the Patient [First Implant]. This was her initial treatment of

[11] The IA canal is located in the lower part of the mandibular bone. The IA canal, which is surrounded by bone, houses the trigeminal nerve. Dr. Hosseini and all of the expert witnesses agreed that when placing an implant, to avoid entering the IA canal, a minimum 2 mm buffer should always be maintained. It is important to ensure that an implant does not enter or transect the IA canal. Damage to the nerves contained in the IA canal may result in permanent loss of feeling in a patient's jaw and face.

[12] The First Implant was 10 mm in length. In placing the First Implant, Dr. Hosseini performed appropriate measurements to ensure that the 2 mm safety gap was maintained.

[13] In follow-up examinations, Dr. Hosseini determined that the First Implant had not appropriately incorporated with the surrounding bone, which meant that it might not be able to properly support a crown when placed. She informed the Patient that the First Implant would need to be replaced. The Patient, who lives a distance from Regina, preferred to minimize ███ attendances and opted for a replacement implant that would be inserted in the same space.

[14] On January 9, 2015, Dr. Hosseini replaced the First Implant with a 13 mm implant [Second Implant]. Although it was 13 mm in length, the Second Implant was designed to have a top polished portion of 1.5 mm that would not be screwed into the bone. As a result, 11.5 mm of the Second Implant was placed into the bone.

[15] During the January 9, 2015 procedure [Procedure], Dr. Hosseini noticed more bleeding than expected. She obtained two dimensional x-rays available at Cityview but the image was not clear. She then obtained two-dimensional panoramic x-rays [Panorex] from a clinic in the same building. From that she still could not determine whether the implant had entered the IA canal, or whether it was merely overlapping the IA canal in bone adjacent to the IA canal.

[16] Dr. Hosseini gave the patient two options – immediate removal of the Second Implant followed by a bone graft and then a further attempt to place an implant, or to wait and see, monitoring to determine whether the implant was merely overlapping to the side and not intruding in the IA canal. The Patient chose the latter option.

[17] Dr. Hosseini followed up numerous times with the Patient, including phoning ███ on the evening of January 9, 2015. The Patient reported numbness, though

reduction of it over time.

[18] It later became apparent that the Procedure had not been successful and that the Second Implant had entered the IA canal.

[19] An oral and maxillofacial radiologist completed a diagnostic imaging report in August 2017, concluding that approximately 3.7 mm of the Second Implant was located within the IA canal. Dr. Hosseini accepts that finding.

[20] Dr. Hosseini testified that in retrospect she believed that when she measured the available bone space she relied in part on her prior measurements taken when she placed the First Implant, and forgot to account for bone loss that occurred after the First Implant was placed.

[21] The Patient suffered permanent nerve damage. ███ testified that it feels like ███ lip is frozen all the time, the bottom gums are very sensitive, and salt makes it burn like it's on fire. The Patient filed a complaint with the College, leading to the charges being laid against Dr. Hosseini.

[22] In September 2017, the Patient saw Dr. Robert Wagner who, at that time, practiced in Regina. He later removed the Second Implant at the request of the Patient and ultimately became the PCC's expert witness.

C. DISCIPLINE COMMITTEE PROCEEDINGS

(a) Discipline Committee Hearing

[23] The Discipline Committee heard testimony from the Patient, Dr. Hosseini and three expert witnesses: Dr. Wagner, Dr. Elizabeth Toporowski, and Dr. Keyvan Abbaszadeh. Dr. Toporowski and Dr. Abbaszadeh were called as experts on behalf of Dr. Hosseini.

[24] The DC Decision thoroughly captures the sequence of events and the expert testimony, and no complaint is raised by the appellant in that respect. No objection was taken to the expertise of any of the three expert witnesses, and each was accepted as appropriately qualified.

[25] At the hearing, Dr. Hosseini acknowledged that she had made a mistake.

[26] Dr. Wagner testified that for implant procedures, there is a single standard of care, irrespective of the dentist's expertise. Non-specialist dentists, periodontists and oral surgeons each are subject to the same standard of care.

[27] Dr. Wagner testified that Dr. Hosseini made three errors that breached the standard of care, all of which were in connection with the Procedure:

a. She failed to perform a CBCT (cone beam 3D scan - a 3D x-ray) at the outset of the Procedure, which would have better shown the available bone.

b. She failed to accurately measure the bone present (which is possible to do if a 3D x-ray is not available) and used an implant that was too long.

c. It was a breach of the standard of care for Dr. Hosseini to not recognize that the Second Implant was placed into the nerve and to not remove it immediately. Appropriate postoperative radiographs combined with clinical findings could have indicated intrusion into the IA canal, and the Second Implant could have been removed or backed out to the appropriate level. Given how long the Second Implant remained in place, there is no opportunity for the Patient's condition to improve.

[28] When asked whether this was a small or trivial error, or a very serious error, Dr. Wagner opined that it was a very serious error and was avoidable. What was

shown on the Panorex imaging combined with increased bleeding should have been a flag if out of the ordinary from prior procedures with the Patient. Given that flag, Dr. Wagner testified that the Second Implant should have been removed immediately, and that it would not be appropriate to leave it in place to see how things developed. Nor was it appropriate to leave it to the Patient to decide.

[29] Dr. Wagner also testified that he was a practitioner in Regina in 2014 and that it was possible to get a "same day" emergency 3D x-ray, which would confirm whether the Second Implant was in the IA canal. There would be a greater chance of healing if an intruding implant were removed immediately.

[30] Dr. Toporowski stated that Dr. Hosseini carried out careful planning for the Procedure. Though she did not dispute that the Second Implant entered the IA canal by 3.7 mm, she still held the view that Dr. Hosseini correctly determined measurements indicating that adequate space was available for the selected implant. Dr. Toporowski did not carry out her own measurements; she concluded based on the clinical notes that Dr. Hosseini had measured correctly. The DC Decision found that Dr. Hosseini's clinical notes put into evidence did not record any specific measurements taken by her. Dr. Toporowski opined that Dr. Hosseini did not breach the standard of care by failing to recognize the intrusion of the Second Implant in the IA canal when it was placed. Dr. Toporowski stated that the use of 3D CBCT radiographs was not standard protocol for periodontists placing implants in Saskatchewan in 2014-2015.

[31] I will not delve deeper here into Dr. Toporowski's testimony as the Committee's treatment of it is among the grounds for appeal.

[32] Dr. Abbaszadeh characterized the poor outcome from the Procedure as a "one off-complication". He did not acknowledge that Dr. Hosseini had breached the standard of care. Rather, he concluded that regardless of the "surgical misadventure"

Dr. Hosseini's actions were consistent with that of a competent practitioner.

[33] On cross-examination, Dr. Abbaszadeh acknowledged that he was aware of very few instances where an implant entered a nerve canal, and that he had never seen it happen. He agreed that the standard is to maintain the 2 mm buffer. He testified that 3D imaging is not the standard and that it was not necessary for Dr. Hosseini to have done more planning than she did. The Patient asked to minimize the visits, so Dr. Abbaszadeh was unwilling to fault Dr. Hosseini for how she continued caring for the Patient following the Procedure.

[34] Dr. Abbaszadeh's testimony may fairly be characterized as equivocal. At times, he defended the steps taken by Dr. Hosseini and disagreed with Dr. Wagner's opinions. He did not accept Dr. Wagner's opinion that based on two-dimensional imaging it was immediately apparent that the Second Implant was placed into the IA canal. However, he agreed that it was apparent from the CBCT 3D imaging that was done later that the nerve was likely either partially or fully transected. He acknowledged that one could fault Dr. Hosseini for the implant fixture selection – his report stated that she should have chosen a shorter implant – along with not immediately addressing the suspect implant and not obtaining 3D imaging before the Procedure.

[35] Dr. Abbaszadeh testified that a prudent practitioner would treat every implant placement as a new one, such that measurements should be made each time. This would include taking into account bone loss.

(b) Discipline Committee Decision

[36] The Discipline Committee made the following findings of particular import:

a. Dr. Hosseini was candid in her testimony. At the hearing she readily acknowledged that in performing her calculations, she failed to account

for the crestal bone loss that occurred after placement of the First Implant. She took her measurements from the top of the crestal bone but missed that the bone at the top was no longer present. This was despite the fact that the very reason for placing the Second Implant was the loss of crestal bone following the First Implant.

b. The evidence clearly established the Second Implant's intrusion into the IA canal by more than 3.5 mm. Such an intrusion demonstrated a lack of knowledge and judgment in treatment planning and skill in implant placement. Dr. Abbaszadeh had testified that a prudent practitioner would measure the bone available, taking into account bone loss since the First Implant. That was not done by Dr. Hosseini, which she essentially admitted.

c. The failure to obtain CBCT imaging before placing the Second Implant did not breach the standard of care. However, the Discipline Committee accepted the evidence of Dr. Wagner that this was not a "narrow miss". The 13 mm implant chosen by Dr. Hosseini for the Procedure was too long, further demonstrating a lack of knowledge and judgment in her treatment planning. Correct measurement of the available bone and selection of the appropriate implant size is crucial. Intrusion into the IA canal is one of the most egregious errors a practitioner placing implants can make.

d. The Discipline Committee chose not to give any weight to the testimony of Dr. Toporowski concerning the planning, placement and decision on removal of the Second Implant. They found that she appeared to be advocating for Dr. Hosseini throughout her testimony. Because this represents a ground of appeal, I will address the Discipline Committee's

findings below in a separate section.

e. With respect to the failure to recognize the intrusion into the IA canal, Dr. Hosseini had noted increased bleeding following placement of the Second Implant. Dr. Hosseini sent the Patient for a panoramic x-ray to obtain a more accurate image of the implant placement. Although there could have been several reasons to explain the increased bleeding, the Discipline Committee found that Dr. Hosseini held concerns. When that imaging appeared distorted, Dr. Hosseini concluded that she was still in a safe zone concerning the nerve. The Discipline Committee found that Dr. Hosseini failed to exercise good judgment when she did not give adequate weight to the panoramic x-ray. Further, given her concerns about its quality, it would have been prudent to seek better confirmation of the Second Implant's location. The Committee stated: "Better respect of and correlation between radiographic images and clinical assessment at this stage was crucial. Identifying the intrusion into the alveolar canal and immediate removal of the second implant provided the best potential for healing and minimizing nerve damage".

f. Immediate removal of the Second Implant, where the placement had over-extended the safety zone, was the most prudent course of action. The ramifications of not following that course were serious. That lack of clinical judgment impeded the healing potential of the nerve and consequently created a higher chance of irreversible damage.

g. Leaving the decision on whether to remove the Second Implant to the Patient was an error: "Where there is increased bleeding and at least the potential of implant intrusion into the nerve canal, the decision on the need for a definitive diagnosis and the safest course of action is one for

the specialist."

h. A competent practitioner, when faced with distortion in the panoramic image, should have undertaken further testing, whether that be a second panoramic image or a CBCT, which Dr. Wagner testified was available in Regina on the same date.

i. Although the Discipline Committee had concerns with Dr. Hosseini's approach following placement of the Second Implant, it accepted that the Patient likely under-reported ██ symptoms. Once the decision was made to leave the Second Implant in place, Dr. Hosseini's follow-up with the Patient was appropriate.

[37] The Discipline Committee then laid out its conclusions on the allegations against Dr. Hosseini:

a. It did not find professional incompetence had been established demonstrating that Dr. Hosseini was unfit to continue in the practice of her profession or provide one or more services ordinarily provided as part of the practice of her profession.

b. Nonetheless, it held that professional incompetence had been established in relation to her treatment of the Patient. The PCC conceded that it was not arguing that she is an incompetent practitioner but rather that she acted incompetently in her care of the Patient.

c. Dr. Hosseini testified that she had upgraded her skills and training since the incident involving the Second Implant. She now performs a CBCT at the outset of planning an implant. The Discipline Committee concluded that she therefore had taken the necessary measures to avoid a recurrence

of the incident and the public's welfare is not at risk.

d. Based on the same evidence, the Discipline Committee found that Dr. Hosseini practiced her profession in a way that she was unable to give full force and effect to her training, experience and judgment as acquired during her education, contrary to s. 9.2(2)(x) of the Bylaws.

e. The intrusion of the Second Implant into the IA canal was avoidable with proper planning. Dr. Hosseini's failure to account for bone loss and choosing a 13 mm implant where there was insufficient space, displayed a lack of knowledge, skill or judgment and was professional incompetence within the meaning of the *Act* and contrary to s. 9.2(2)(x) of the Bylaws.

f. Dr. Hosseini's failure to undertake further exploration where increased bleeding was noted and the panoramic image showed at least a possibility of intrusion into the nerve canal displayed a lack of knowledge, skill or judgment and was professional incompetence within the meaning of the *Act* and contrary to s. 9.2(2)(x) of the Bylaws.

g. Failure to remove the Second Implant also displayed a lack of knowledge, skill or judgment and was professional incompetence within the meaning of the *Act* and contrary to s. 9.2(2)(x) of the Bylaws.

(c) Dr. Hosseini's Bias Application

[38] After the DC Decision was issued, on March 14, 2019, Dr. Hosseini initiated an application to the Discipline Committee claiming a reasonable apprehension of bias and unfairness to her. I will merely summarize the grounds, as I will discuss them below in greater detail. In brief, Dr. Hosseini alleged that the decision

appeared to have been made by a non-member of the profession (Bruce Gibson, the chair who also is a lawyer) who fulfilled conflicting roles of providing legal opinions to the Discipline Committee while also sitting as a decision-maker as a member of that same committee. That caused a lack of structural independence and deprived the Discipline Committee of the freedom to decide the case without improper external influence. The allegations stemmed from the costs incurred to have Bruce Gibson involved, which greatly exceeded the amounts billed by the dentist members of the Discipline Committee. Dr. Hosseini also alleged that the Discipline Committee's findings, questioning and limitations on questioning gave rise to a reasonable apprehension of bias and concerns that it was not impartial.

[39] The Discipline Committee determined that a reasonable apprehension of bias had not been established and dismissed the application.

(d) Penalty Hearing and Decision

[40] At the penalty hearing, the PCC argued that Dr. Hosseini's conduct represented a significant failure to adhere to her professional obligations. The penalties requested by it were identical to what the Discipline Committee ordered with a single exception: the PCC asked for costs to reimburse the College, including legal expenses, in the amount of $90,038.96, being 75% of the College's actual costs. The Discipline Committee instead ordered costs of $50,000.

[41] During the penalty phase Dr. Hosseini alleged that the PCC had acted in bad faith leading up to that hearing. She alleged that the PCC sought increased costs arising from her refusal to abandon her arguments concerning a fair hearing. She advised the Discipline Committee that there were exchanges of offers concerning costs. She argued that efforts to settle the penalty dispute prior to the sentencing hearing were not privileged and that such efforts should be considered when addressing penalty.

[42] In particular, Dr. Hosseini took issue with the PCC's position that she did not admit to a mistake in treating the Patient until her testimony before the Discipline Committee. In a letter to PCC counsel dated March 27, 2018, Dr. Hosseini's counsel acknowledged that "Placing the implant in the nerve canal was a mistake". In the same letter, Dr. Hosseini's counsel denied that Dr. Hosseini had been negligent, and asked for a mediated solution rather than have the discipline hearing proceed. That proposal was not accepted by the PCC. That letter, and various emails and correspondence exchanged between counsel concerning the negotiations over the quantum of costs, were marked for identification by the Discipline Committee. The Discipline Committee held that the PCC had not waived settlement privilege and determined the correspondence to be inadmissible.

[43] As noted above, the penalty imposed by the Discipline Committee comprised the following: a formal reprimand, publication of the charges and penalties in a College newsletter, reimbursement of the Patient for $8,213, payment of the College's costs to the extent of $50,000, and that the College deliver a copy of the DC Decision and the Penalty Decision to the governing body of dentists for Manitoba.

D. STANDARD OF REVIEW

(a) Introduction

[44] As I will discuss below, more than one standard of review applies to this appeal. Many of the grounds raised by Dr. Hosseini fall into the category of discretionary decisions. Courts have framed the applicable standard of review for such decisions in various ways. Below I attempt to provide a single formulation.

[45] To the extent that any pure questions of law arise, the standard of review will be correctness. As well, the correctness standard applies to questions of procedural fairness.

(b) What is the main standard of review to be applied?

[46] The leading authority in Saskatchewan on standard of review in statutory professional discipline appeals is *Strom v Saskatchewan Registered Nurses' Association*, 2020 SKCA 112, 453 DLR (4th) 472 [*Strom*]. *Strom* arose from charges against a registered nurse who had posted comments on social media about care her grandfather had received in the health care facility where he had died a month before the posts were made. Ms. Strom appealed her conviction to this Court. At the time *Strom* was argued to this Court, *Canada (Minister of Citizenship and Immigration) v Vavilov*, 2019 SCC 65, 441 DLR (4th) 1 [*Vavilov*], had not been decided. Indeed, it had not yet been decided when the appeal to Court of Appeal was initially argued in *Strom*.

[47] Before turning to *Strom*, it is appropriate to consider s. 26 of the *Act*, under which Dr. Hosseini was charged. Section 26 represents important context when considering the standard of review. It reads as follows:

> **Professional incompetence**
> **26** Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment, or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:
>
> (a) continue in the practice of that member's profession; or
>
> (b) provide one or more services ordinarily provided as a part of the practice of that member's profession;
>
> is professional incompetence within the meaning of this Act.

[48] Following is s. 27, which sets out what constitutes professional misconduct:

> **Professional misconduct**
> **27** Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:

> (a) it is harmful to the best interests of the public or the members of the association;
>
> (b) it tends to harm the standing of the member's profession;
>
> (c) it is a breach of this Act or the bylaws of that member's association; or
>
> (d) it is a failure to comply with an order of the professional conduct committee, discipline committee or council of that member's association.

[49] The broad formulations of professional incompetence and professional misconduct are not unique to the *Act*. At paragraphs 66 and 67 of *Strom*, Barrington Foote J.A. observed that similar formulations exist for agrologists, registered psychiatric nurses, and accountants. At the end of oral argument, I invited counsel to provide written submissions as to what similar legislative provisions exist for other professions and received back extensive lists from each party. Similar provisions exist in at least 15 pieces of Saskatchewan legislation concerning self-governing professions. Sections 26 and 27 therefore do not exist in isolation. They represent part of a broader framework that has been established by the Legislature. Below I will discuss whether that has any implications for the standard of review.

[50] Jurisprudence concerning standard of review has evolved with respect to professional discipline appeals. As noted in *Strom* at para 57, before *Vavilov* it was settled law that the standard of review on statutory appeals was the same as on judicial reviews. *Vavilov* held at para. 37 that "where the legislature has provided for an appeal from an administrative decision to a court, a court hearing such an appeal is to apply appellate standards of review to the decision".

[51] As noted in *Strom*, the appellate standards of review articulated in *Housen v Nikolaisen*, 2002 SCC 33 at para 37, [2002] 2 SCR 235, do not include reasonableness. Rather, Barrington-Foote J.A. described the standards of review as follows:

[59] … Alleged errors of law – including as to the scope of the decision-maker's authority – are reviewed on the correctness standard. Alleged errors of fact are reviewed on the palpable and overriding error standard. Absent an extricable question of law, the palpable and overriding standard also applies to alleged errors in the answer to a mixed question of fact and law.

[60] If an alleged error relates to a discretionary decision, the standard of review as it is generally expressed in Saskatchewan is that an appellate court will intervene only if the decision-maker erred in principle, misapprehended or failed to consider material evidence, failed to act judicially, or reached a decision so clearly wrong that it would result in an injustice: *Rimmer v Adshead*, 2002 SKCA 12 at para 58, [2002] 4 WWR 119 [*Rimmer*]; *Saskatchewan Crop Insurance Corporation v McVeigh*, 2018 SKCA 76 at para 26, 428 DLR (4th) 122 [*McVeigh*]; *Abrametz v Law Society of Saskatchewan*, 2020 SKCA 81 at para 74. Other courts have used different language to describe the standard relating to discretionary decisions. In *Penner v Niagara (Regional Police Services Board)*, 2013 SCC 19, [2013] 2 SCR 125 [*Penner*], for example, Cromwell and Karakatsanis JJ. said this:

> [27] A discretionary decision of a lower court will be reversible where that court misdirected itself or came to a decision that is so clearly wrong that it amounts to an injustice: *Elsom v. Elsom*, [1989] 1 S.C.R. 1367, at p. 1375. Reversing a lower court's discretionary decision is also appropriate where the lower court gives no or insufficient weight to relevant considerations: *Friends of the Oldman River Society v. Canada (Minister of Transport)*, [1992] 1 S.C.R. 3, at pp. 76–77.

[61] The *Penner* formulation of this standard has been adopted by courts of appeal in several provinces: see, for example, *1944949 Ontario Inc. (OMG ON THE PARK) v 2513000 Ontario Ltd.*, 2019 ONCA 628 at para 13; *Kish v Sobchak Estate*, 2016 BCCA 65 at para 34, 394 DLR (4th) 385; *Lamb v Canada (Attorney General)*, 2018 BCCA 266 at paras 46–47, [2018] 9 WWR 1; *Twinn v Twinn,* 2017 ABCA 419 at para 14. See also, to the same effect, *Canada (Attorney General) v Fontaine*, 2017 SCC 47 at para 31, [2017] 2 SCR 205.

[62] I read the test described in *Penner* as the same in substance as that described in *McVeigh*. *McVeigh* is helpful in explicitly making the point that a misapprehension of or failure to consider material evidence – which constitutes an error of law or principle – may justify appellate intervention. *Penner* is helpful in explicitly stating that a failure to give any or sufficient weight to a relevant consideration may also do so, although it must be kept in mind that the allocation of weight is, within the limits of the discretion granted, for the initial

> decision-maker. An appellate court is not entitled to substitute its own discretion for that of the trial court or chambers judge merely because it would have exercised the original discretion differently: *Friends of the Oldman River Society v Canada (Minister of Transport)*, [1992] 1 SCR 3 at 76–77.
>
> [Emphasis added]

[52] The analysis does not end there, however, as s. 26 and its many counterparts state that professional incompetence "is a question of fact, but …". That compels a court to consider whether and how the "question of fact" formulation impacts the standard of review. Barrington-Foote J.A. discussed this extensively in *Strom*. In the following passage, he reviewed the history behind the "question of fact" language used in ss. 26 and 27 of the *Act* and their counterpart provisions, and determined that the statement in section 26(1) that professional misconduct is a question of fact does not preclude review or conclusively settle what the standard of review will be:

> [66] … Does the statement in s. 26(1) that professional misconduct is a question of fact conclusively settle the standard of review question? The effect of using that phrase in s. 26(1) was not considered by the Chambers judge and has not otherwise been judicially considered. However, the use of this curious language to describe decisions as to professional misconduct is not unique to the *Act*. It appears to have first been used in Alberta in 1928: *An Act to amend The Medical Profession Act*, SA 1928, c 33, s 9. It no longer appears in this context in that province. In Saskatchewan, it appeared in s. 17 of *An Act respecting The Institute of Chartered Accountants of Saskatchewan*, SS 1934, c 41. See also, for example, s. 18 of the British Columbia *Legal Professions Act Amendment Act, 1948*, SBC 1948, c 36.
>
> [67] It presently appears in this context in many Saskatchewan professional regulatory statutes: see, for example, *The Agrologists Act, 1994*, SS 1994, c A-16.1, s 28; *The Registered Psychiatric Nurses Act*, SS 1993, c R-13.1, s 28; *The Accounting Profession Act*, SS 2014, c A-3.1, s 26. The standard of review has been considered in relation to some of these statutes. In *Davies v Council of The Institute of Chartered Accountants of Saskatchewan* (1985), 19 DLR (4th) 447 (CanLII) (Sask QB), the Institute argued that a provision that stated the issue of professional misconduct was "a question of fact for the sole and final determination of the council or the disciplinary committee" (*The Chartered Accountants Act*, RSS 1978, c C-7, s 8(2)) meant that it had an "unfettered right to determine the existence of

what unprofessional conduct amounts to" (at para 49). Justice MacLeod rejected that argument, commenting as follows:

> [50] … Taken at face value, the provision would defeat any appeal. This could not have been intended. Rather, I hold that s. 18(1) is a declaration of the responsibilities of the Institute or Discipline Committee, but it is not intended to frustrate the right of appeal.

…

[69] There are also several decisions touching this issue that were made after *Dunsmuir*, but prior to *Vavilov*, and thus at a time when it was settled law that the standard of review on statutory appeals was the same as that on judicial review: *Edmonton East* at paras 29–30. As such, the choice was between reasonableness and correctness. In each of those cases, the Court adopted the reasonableness standard. In *Cameron v The Saskatchewan Institute of Agrologists*, 2018 SKCA 91 [*Cameron*], for example, this Court applied a reasonableness standard to a finding that Mr. Cameron had been guilty of professional misconduct. The standard of review was not at issue, as the parties had agreed to that standard. However, the Court did refer to *Meier v Saskatchewan Institute of Agrologists*, 2014 SKQB 389 at para 27, [2015] 3 WWR 608 [*Meier*], where Layh J., having referred to the use of the phrase "question of fact" in the statute, commented that "[f]indings of fact are the purview of the discipline committee and command a high degree of deference when subjected to judicial review – thence the appropriateness of the 'reasonableness' standard". Justice Layh's reasoning on this point was not disturbed on appeal (*Meier v Saskatchewan Institute of Agrologists*, 2016 SKCA 116, 405 DLR (4th) 506).

[70] The reasonableness standard was also applied in *Sydiaha v Saskatchewan College of Psychologists,* 2014 SKQB 112 at paras 10–13, 443 Sask R 139, and *Pomarenski v Saskatchewan Veterinary Medical Association Professional Conduct Committee*, 2019 SKQB 264 at paras 11–13. In both cases, Currie J. referred to the use of the phrase "question of fact" in the statutes as one of several factors which supported that conclusion. He also referred to the fact that the regulators had been granted broad powers to decide whether a member was guilty of professional misconduct, that misconduct and incompetence are most familiar to those in the profession (the "expertise" factor which, post-*Vavilov*, is no longer relevant in determining the standard of review), and that these administrative bodies were interpreting their home statutes.

[71] Given that the appellate standard now applies, the bottom-line conclusion in these cases that the reasonableness standard applies is not authoritative. However, they are of interest in that <u>these courts did</u>

not treat the phrase "question of fact" as having conclusively determined the standard of review, although both *Meier* and *Cameron* suggest that language might leave the court with "little choice" but to select the deferential reasonableness standard. Rather, the courts also considered other factors which confirmed that the Legislature had granted broad authority to the professional regulators that made the decisions being appealed.

[72] In my view, that is the correct approach. Indeed, it is self-evident that the exercise undertaken by the Discipline Committee cannot be characterized as deciding a question of fact *simpliciter* for standard of review purposes. Issues will arise on an appeal of a finding of professional misconduct that are not questions of fact. That is so in this case, where Ms. Strom and the SRNA have raised questions as to the interpretation of s. 26(1) of the *Act*. Questions of statutory interpretation are questions of law. Indeed, the statutory framework is always in play, regardless of whether there is an extricable question of law. This fundamental "rule of law" principle, which is central to this case, was reiterated in *Vavilov*:

> [108] Because administrative decision makers receive their powers by statute, the governing statutory scheme is likely to be the most salient aspect of the legal context relevant to a particular decision. That administrative decision makers play a role, along with courts, in elaborating the precise content of the administrative schemes they administer should not be taken to mean that administrative decision makers are permitted to disregard or rewrite the law as enacted by Parliament and the provincial legislatures. Thus, for example, while an administrative body may have considerable discretion in making a particular decision, that decision must ultimately comply "with the rationale and purview of the statutory scheme under which it is adopted": *Catalyst*, at paras. 15 and 25-28; see also *Green*, at para. 44. As Rand J. noted in *Roncarelli v. Duplessis*, [1959] S.C.R. 121, at p. 140, "there is no such thing as absolute and untrammelled 'discretion'", and any exercise of discretion must accord with the purposes for which it was given: see also *Congrégation des témoins de Jéhovah de St-Jérôme-Lafontaine*, at para. 7; *Montréal (City) v. Montreal Port Authority*, 2010 SCC 14, [2010] 1 S.C.R. 427, at paras. 32-33; *Nor-Man Regional Health Authority*, at para. 6. Likewise, a decision must comport with any more specific constraints imposed by the governing legislative scheme, such as the statutory definitions, principles or formulas that prescribe the exercise of a discretion: see *Montréal (City)*, at paras. 33 and 40-41; *Canada (Attorney General) v. Almon Equipment Limited*, 2010 FCA 193, [2011] 4 F.C.R. 203, at paras. 38-40. The statutory scheme also informs the acceptable approaches to decision making: for example, where a decision maker is given wide

> discretion, it would be unreasonable for it to fetter that discretion: see *Delta Air Lines* [2018 SCC 2], at para. 18.
>
> [73] In the result, a discipline committee deciding whether a registered nurse is guilty of professional misconduct is not deciding a question of fact for standard of review purposes. It is either deciding a question of mixed fact and law or making a discretionary decision. As to which, there is no bright line which neatly divides these two categories. Both call for the decision-maker to find the facts and apply legal principles to those facts. …
>
> [Emphasis added]

[53] Next, Barrington-Foote J.A. found that the "question of fact" phrase was intended by the Legislature to limit appellate review. It represents a direction to courts to give a discipline committee broad discretion to determine what constitutes professional misconduct – or, in this case, professional incompetence:

> [76] Notwithstanding the absence of a bright line between questions of fact and law and discretionary decisions, there are considerations that bear on the proper characterization of the professional misconduct issues in this appeal. I would begin with the obvious; that is, that the *Act* explicitly states that professional misconduct is a question of fact. In my view, the Legislature's choice of that phrase was intended to limit appellate review. Put differently, it confirms that the Legislature intended the Discipline Committee to have broad discretion to determine what constitutes professional misconduct.
>
> [77] This conclusion accords with the language of s. 26(1), read in accordance with the modern principle of interpretation; that is, in its grammatical and ordinary sense and in light of the purpose of the Act and the intention of the Legislature: *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 SCR 27; *The Legislation Act*, SS 2019, c L-10.2, s 2-10. In broad terms, that purpose is to provide for an independent professional regulatory body to license and regulate registered nurses, with an overriding objective or primary purpose of safeguarding the public interest …
>
> …
>
> [81] Further, and in particular, interpreting the use of the phrase "question of fact" in s. 26(1) as having been intended to grant broad discretion to the Discipline Committee accords with the nature of the "facts" at issue when misconduct is alleged. Section 26(1) confirms that those facts include not only the particular conduct of the registered nurse – which includes but is not limited to the specific misconduct identified in s. 26(2) – but findings as to the impact of misconduct on

> the best interests of the public, nurses or the standing of the profession. These are inherently broad, policy-laden concepts. The notion of "palpable and overriding error" seems illsuited to the appellate review of questions of this kind, as compared to the more encompassing standard of review for discretionary decisions.
>
> ...
>
> [84] I also note that decisions by professional regulators as to whether there has been professional misconduct have often been explicitly described in the case law as discretionary decisions.
>
> ...
>
> [86] Taking all of these factors into account, I conclude that the decision as to whether Ms. Strom's conduct amounted to professional misconduct within the meaning of s. 26(1) was a discretionary decision. As such, the standard of review is that described in *Rimmer*, *McVeigh*, *Okanagan* and *Penner*. That standard accommodates the review of the errors that have been alleged by Ms. Strom and SUN.
>
> [Emphasis added]

[54] From the analysis in *Strom* (not all of which has been reproduced here), the following principles may be drawn:

a. Questions as to what is professional incompetence, to the extent that they involve purely statutory interpretation, are questions of law. While a tribunal may have considerable discretion, its decision must ultimately comply with the rationale and purview of the relevant statutory scheme. However, there are limited contexts in which pure questions of law will arise.

b. A discipline committee deciding whether a professional is guilty of professional incompetence is not deciding a question of fact, for the purpose of determining the standard of review. It is either deciding a question of mixed fact and law, or making a discretionary decision. In either case, the tribunal must find the facts and apply legal principles to those facts.

c. The statement that professional incompetence is a question of fact was intended by the Legislature to limit appellate review. It confirms that the Legislature intended that any discipline committee would have broad discretion to determine what constitutes professional incompetence.

d. The public interest and effective professional regulation are not separate. Although the primary purpose of legislation that regulates professions is protection of the public, the public interest is also served by having self-governing professions that function properly. See *Strom* at para 27. Because protection of the public and the standing of the profession may entail broad, policy-laden concepts, "palpable and overriding error" is not an appropriate standard of review.

[55] Therefore, for the most part it is appropriate to use the standard of review applicable to discretionary decisions. That standard has been expressed in multiple ways that I will explore below.

(c) What is the content of the standard of review applicable to discretionary decisions?

[56] As noted above, *Strom* directs that the primary standard of review to be applied in a statutory appeal of this nature is that applicable to discretionary decisions. However, Barrington-Foote J.A. did not set out a single formulation of that standard of review, instead referring to numerous decisions that contained at least slightly differing formulations. I will not attempt to provide an exhaustive review, but examples include the following:

a. In *Penner v Niagara (Regional Police Services Board)*, 2013 SCC 19,

[2013] 2 SCR 125, the standard of review was described as follows:

> [27] A discretionary decision of a lower court will be reversible where that court misdirected itself or came to a decision that is so clearly wrong that it amounts to an injustice. Reversing a lower court's discretionary decision is also appropriate where the lower court gives no or insufficient weight to relevant considerations ….

In *Strom*, Barrington-Foote J.A. praised that phrasing for explicitly stating that failure to give sufficient weight to a relevant consideration may be a reversible error, while cautioning that the allocation of weight belongs with the decision-maker of first instance.

b. In *Rimmer v Adshead*, 2002 SKCA 12, [2002] 4 WWR 119, the Court of Appeal framed the standard of review applicable to its review of discretionary decisions by Queen's Bench judges:

> [58] … the powers in issue are discretionary and therefore fall to be exercised as the judge vested with them thinks fit, having regard for such criteria as bear upon their proper exercise. The discretion is that of the judge of first instance, not ours. Hence, our function, at least at the outset, is one of review only: review to determine if, in light of such criteria, the judge abused his or her discretion. Did the judge err in principle, disregard a material matter of fact, or fail to act judicially? Only if some such failing is present are we free to override the decision of the judge and do as we think fit. Either that, or the result must be so plainly wrong as to amount to an injustice and invite intervention on that basis.

c. The Court of Appeal slightly reframed the standard of review in *Saskatchewan Crop Insurance Corporation v McVeigh*, 2018 SKCA 76, [2019] 1 WWR 290 [*McVeigh*]. In *Strom,* Barrington-Foote J.A. described this formulation as helpful in expressing that misapprehension of or failure to consider material evidence may justify appellate intervention. As Schwann J.A. stated in *McVeigh*:

> [27] … an appellate court should only interfere if a

> chambers judge erred in principle, misapprehended or overlooked material evidence, took irrelevant factors into consideration, failed to act judicially or reached a decision that was so clearly wrong that the decision will result in an injustice …

c. Finally, Barrington-Foote J.A. referenced *British Columbia (Minister of Forests) v Okanagan Indian Band*, 2003 SCC 71, [2003] 3 SCR 371, which stated:

> 43 As I observed in *R. v. Regan*, [2002] 1 S.C.R. 297, 2002 SCC 12, however, discretionary decisions are not completely insulated from review (para. 118). An appellate court may and should intervene where it finds that the trial judge has misdirected himself as to the applicable law or made a palpable error in his assessment of the facts. As this Court held in *Pelech v. Pelech*, [1987] 1 S.C.R. 801, at p. 814-5, the criteria for the exercise of a judicial discretion are legal criteria, and their definition as well as a failure to apply them or a misapplication of them raise questions of law which are subject to appellate review.

[57] In light of the guidance from *Strom* and the decisions discussed above, a discretionary decision of a tribunal will be reversible where it:

a. misdirected itself as to the applicable law;

b. made a palpable error in assessment of the facts;

c. misapprehended or overlooked material evidence;

d. gave no or insufficient weight to relevant considerations; or

e. failed to act "judicially" or came to a decision that is so clearly wrong that it amounts to an injustice.

[58] That is the standard of review that I will apply to discretionary decisions of the Discipline Committee.

(d) Does a separate standard of review apply to interpretation of s. 26 of the *Act*?

[59] One ground for appeal advanced by Dr. Hosseini has at least the potential to bring even further considerations to bear. That ground reads as follows:

> 3. THAT the appeal is taken upon the following grounds:
>
> a. That the Discipline Committee erred in law and deprived the Appellant of a fair hearing by incorrectly interpreting and applying *The Dental Disciplines Act* and bylaws of the College of Dental Surgeons of Saskatchewan and specifically misinterpreted and misapplied s. 26 of the *Act*:
>
> i) by concluding a single incident involving an ordinary error amounted to Professional Incompetence;
>
> …

[60] Dr. Hosseini says that s. 26 of the *Act* requires a finding of general incompetence for the Discipline Committee to have convicted. She argues that no conviction is possible under s. 26 for a single incident, and that she cannot be convicted for professional incompetence where she was not found to be generally incompetent. She argues that only if she had been charged under s. 27 (Professional Misconduct) would it have been possible to convict her for the errors she made concerning the Procedure.

[61] I raise that here because of the very similar definitions for professional incompetence and professional misconduct that appear in legislation for self-governing professions. As noted above, there are at least 15 such instances in Saskatchewan legislation. From a factual point of view, dentists, doctors, accountants, lawyers, agrologists, etc., are in the best position to determine what is incompetence or misconduct in their respective professions. Nonetheless, with the Legislature having used the same formulation concerning so many self-governing professions, is it desirable that we could end up with a patchwork of decisions saying that for one

profession a single act can amount to professional incompetence, but for others a single act would not suffice (that a general level of incompetence would be needed to be proven to convict)? If that is not desirable from a public policy perspective, is there a distinct standard of review that should be applied in determining whether a discipline committee interpreted its own legislation correctly? Should a discipline committee be expected to also consider the broader framework created by the Legislature generally for self-governing professions and, if so, what standard of review should be applied to that?

[62] At least a potential answer lies within *Vavilov* itself. It contemplated that a correctness standard may apply in certain situations. The majority stated as follows:

> [53] In our view, respect for the rule of law requires courts to apply the standard of correctness for certain types of legal questions: constitutional questions, general questions of law of central importance to the legal system as a whole and questions regarding the jurisdictional boundaries between two or more administrative bodies. The application of the correctness standard for such questions respects the unique role of the judiciary in interpreting the Constitution and ensures that courts are able to provide the last word on questions for which the rule of law requires consistency and for which a final and determinate answer is necessary: *Dunsmuir*, at para. 58.

[63] The concept of general questions of law of central importance to the legal system springs from prior Supreme Court jurisprudence, including *Dunsmuir v New Brunswick*, 2008 SCC 9, [2008] 1 SCR 190. In *Vavilov*, the majority said the following:

> [58] In *Dunsmuir*, a majority of the Court held that, in addition to constitutional questions, general questions of law which are "both of central importance to the legal system as a whole and outside the adjudicator's specialized area of expertise" will require the application of the correctness standard: para. 60, citing *Toronto (City) v. C.U.P.E., Local 79*, 2003 SCC 63, [2003] 3 S.C.R. 77, at para. 62, per LeBel J., concurring. We remain of the view that the rule of law requires courts to have the final word with regard to general questions of law that are "of central importance to the legal system as a whole". However, a return to first principles reveals that it is not necessary to evaluate the decision maker's specialized expertise in order to determine whether

the correctness standard must be applied in cases involving such questions. As indicated above (at para. 31) of the reasons, the consideration of expertise is folded into the new starting point adopted in these reasons, namely the presumption of reasonableness review.

[59] As the majority of the Court recognized in *Dunsmuir*, the key underlying rationale for this category of questions is the reality that certain general questions of law "require uniform and consistent answers" as a result of "their impact on the administration of justice as a whole": *Dunsmuir*, para. 60. In these cases, correctness review is necessary to resolve general questions of law that are of "fundamental importance and broad applicability", with significant legal consequences for the justice system as a whole or for other institutions of government: see *Toronto (City)*, at para. 70; *Alberta (Information and Privacy Commissioner) v. University of Calgary*, 2016 SCC 53, [2016] 2 S.C.R. 555, at para. 20; *Canadian National Railway* [2014 SCC 40], at para. 60; *Chagnon v. Syndicat de la fonction publique et parapublique du Québec*, 2018 SCC 39, [2018] 2 S.C.R. 687, at para. 17; *Saguenay* [2015 SCC 16], at para. 51; *Canada (Canadian Human Rights Commission) v. Canada (Attorney General)*, 2011 SCC 53, [2011] 3 S.C.R. 471 ("*Mowat*"), at para. 22; *Commission scolaire de Laval v. Syndicat de l'enseignement de la région de Laval*, 2016 SCC 8, [2016] 1 S.C.R. 29, at para. 38. For example, the question in *University of Calgary* [2016 SCC 53] could not be resolved by applying the reasonableness standard, because the decision would have had legal implications for a wide variety of other statutes and because the uniform protection of solicitor-client privilege — at issue in that case — is necessary for the proper functioning of the justice system: *University of Calgary*, at paras. 19-26. As this shows, the resolution of general questions of law "of central importance to the legal system as a whole" has implications beyond the decision at hand, hence the need for "uniform and consistent answers".

[60] This Court's jurisprudence continues to provide important guidance regarding what constitutes a general question of law of central importance to the legal system as a whole. For example, the following general questions of law have been held to be of central importance to the legal system as a whole: when an administrative proceeding will be barred by the doctrines of *res judicata* and abuse of process (*Toronto (City)*, at para. 15); the scope of the state's duty of religious neutrality (*Saguenay*, at para. 49); the appropriateness of limits on solicitor-client privilege (*University of Calgary*, at para. 20); and the scope of parliamentary privilege (*Chagnon*, at para. 17). We caution, however, that this jurisprudence must be read carefully, given that expertise is no longer a consideration in identifying such questions: see, e.g., *CHRC* [2018 SCC 31], at para. 43.

[61] We would stress that the mere fact that a dispute is "of wider public concern" is not sufficient for a question to fall into this category

> — nor is the fact that the question, when framed in a general or abstract sense, touches on an important issue: see, e.g., *Communications, Energy and Paperworkers Union of Canada, Local 30 v. Irving Pulp & Paper, Ltd.*, 2013 SCC 34, [2013] 2 S.C.R. 458, at para. 66; *McLean* [2013 SCC 67], at para. 28; *Barreau du Québec v. Quebec (Attorney General)*, 2017 SCC 56, [2017] 2 S.C.R. 488, at para. 18. The case law reveals many examples of questions this Court has concluded are *not* general questions of law of central importance to the legal system as a whole. These include whether a certain tribunal can grant a particular type of compensation (*Mowat*, at para. 25); when estoppel may be applied as an arbitral remedy (*Nor-Man Regional Health Authority Inc. v. Manitoba Association of Health Care Professionals*, 2011 SCC 59, [2011] 3 S.C.R. 616, at paras. 37-38); the interpretation of a statutory provision prescribing timelines for an investigation (*Alberta Teachers* [2011 SCC 61], at para. 32); the scope of a management rights clause in a collective agreement (*Irving Pulp & Paper*, at paras. 7, 15-16 and 66, per Rothstein and Moldaver JJ., dissenting but not on this point); whether a limitation period had been triggered under securities legislation (*McLean*, at paras. 28-31); whether a party to a confidential contract could bring a complaint under a particular regulatory regime (*Canadian National Railway*, at para. 60); and the scope of an exception allowing non-advocates to represent a minister in certain proceedings (*Barreau du Québec*, at paras. 17-18). As these comments and examples indicate, this does not mean that simply because expertise no longer plays a role in the selection of the standard of review, questions of central importance are now transformed into a broad catch-all category for correctness review.
>
> [62] In short, general questions of law of central importance to the legal system as a whole require a single determinate answer. In cases involving such questions, the rule of law requires courts to provide a greater degree of legal certainty than reasonableness review allows.
>
> [Emphasis added]

[64] At paras. 71 to 72, the *Vavilov* majority addressed a potential circumstance similar to the patchwork issue that I raise above. *Amici curiea* had argued that the Supreme Court should recognize an additional category of legal questions that would be reviewed on correctness, being legal questions where there is persistent discord or internal disagreement within an administrative body leading to legal incoherence. The concept was that the rule of law breaks down where legal inconsistency becomes the norm. The concern I raise is anticipatory. The *amici curiea*

were concerned about actual situations that could be identified. The majority were unwilling to have a correctness test apply even in those actual situations:

> [72] We are not persuaded that the Court should recognize a distinct correctness category for legal questions on which there is persistent discord within an administrative body. In *Domtar Inc. v. Quebec (Commission d'appel en matière de lésions professionnelles)*, [1993] 2 S.C.R. 756, this Court held that "a lack of unanimity [within a tribunal] is the price to pay for the decision-making freedom and independence given to the members of these tribunals": p. 800; see also *Ellis-Don Ltd. v. Ontario (Labour Relations Board)*, 2001 SCC 4, [2001] 1 S.C.R. 221, at para. 28. That said, we agree that the hypothetical scenario suggested by the *amici curiae* — in which the law's meaning depends on the identity of the individual decision maker, thereby leading to legal incoherence — is antithetical to the rule of law. In our view, however, the more robust form of reasonableness review set out below, which accounts for the value of consistency and the threat of arbitrariness, is capable, in tandem with internal administrative processes to promote consistency and with legislative oversight (see *Domtar*, at p. 801), of guarding against threats to the rule of law. Moreover, the precise point at which internal discord on a point of law would be so serious, persistent and unresolvable that the resulting situation would amount to "legal incoherence" and require a court to step in is not obvious. Given these practical difficulties, this Court's binding jurisprudence and the hypothetical nature of the problem, we decline to recognize such a category in this appeal.

[65] Having determined in *Vavilov* that significant variation between decisions was not an appropriate circumstance for the creation of a separate category where a correctness standard will apply, the Supreme Court would seem unlikely to approve the creation of a category to avoid a patchwork of decisions across discipline tribunals governing Saskatchewan's self-regulated professions. Moreover, there seems to be little basis to hold that the similar formulations in definitions of professional incompetence and professional misconduct would represent general questions of law of central importance to the legal system as a whole.

[66] In *Premier Horticulture Ltd. v United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union,*

Local 1-184, 2020 SKQB 77, Scherman J. held that a tribunal's treatment of settlement privilege would not fall in the category of general questions of law of central importance. Although the context was different, as it pertained to the applicability of statutory limitation periods, I am persuaded that the settlement privilege issue raised by Dr. Hosseini is no more of central importance to the legal system as a whole than was the issue before Justice Scherman, such that the correctness test should not be applied to that ground of appeal.

[67] Therefore, except as discussed next regarding issues of procedural fairness, I will use the standard applicable to discretionary decisions that I have outlined above.

(e) What is the standard of review for questions of procedural fairness and natural justice?

[68] The standard of review for such questions was not discussed in *Strom*, but was canvassed in *Abrametz v Law Society of Saskatchewan*, 2020 SKCA 81 [*Abrametz*]. *Abrametz* is under appeal to the Supreme Court. Pending determination of that appeal, it governs here. Barrington-Foote J.A. found that matters of procedural fairness, which include a reasonable apprehension of bias, result in loss of jurisdiction and this raises a question of law. See paras. 86 to 88 (the overall discussion from paras. 86 to 105 is also instructive).

[69] The applicable standard of review on such issues is correctness: *Abrametz* at paras 98 to 99. See also: *Saskatoon (City) v Amalgamated Transit Union, Local 615*, 2017 SKCA 96 at paras 24 to 32, [2018] 4 WWR 822, *Feng v Saskatchewan (Economy)*, 2020 SKCA 6 at para 43, 70 Admin LR (6th) 237 and *South East Cornerstone School Division No. 209 v Oberg*, 2021 SKCA 28 at para 33.

E. ANALYSIS

[70] I will deal with the grounds of appeal individually. Except where noted, the standard of review to be applied is that applicable to discretionary decisions.

Ground (a)(i) The Discipline Committee erred by concluding a single incident involving an ordinary error amounted to professional incompetence

(a) Standard of review

[71] I will apply the "discretionary decision" standard of review to this ground of appeal. The alternative would be correctness, on the basis that this ground could be viewed as raising a pure question of law. In my view, it does not raise a pure question of law.

[72] In *Strom*, Barrington-Foote J.A. analyzed a similar but not identical provision – s. 26(1) of *The Registered Nurses Act, 1988*, SS 1988-89, c R-12.2. His most germane comments may be summarized and paraphrased as follows:

a. At para. 76: *The Registered Nurses Act, 1988* states that professional misconduct is a question of fact. The Legislature used that phrase to limit appellate review. Put another way: "the Legislature intended the Discipline Committee to have broad discretion to determine what constitutes professional misconduct".

b. At paras. 77 to 80, Barrington-Foote J.A. discusses the overriding purpose of protection of the public interest as being the objective of such professional regulation. The grant of authority to discipline needs to be interpreted in that light. The Legislature must be seen as having given broad discretion to a discipline committee "to deal with the myriad circumstances in which the conduct of a registered nurse

could negatively impact the public interest …". (para. 80)

[73] Accordingly, the Discipline Committee, in interpreting s. 26 of the *Act*, was not undertaking an exercise of pure legal construction of a statute. Rather, it was exercising discretion as to what constitutes professional incompetence. The Legislature has shown its intention that discretion is to be accorded to the Discipline Committee, and the correctness test does not apply. The appropriate standard of review is the discretionary decision standard.

(b) Analysis

[74] It is common ground that Dr. Hosseini made an error. She makes several arguments as to why it was an error by the Discipline Committee to have found her guilty of professional incompetence. They are as follows. I will deal with each, though not in the same order as they appear below.

a. Unfitness is central to the definition of professional incompetence. To find a member guilty of a charge under s. 26, a discipline committee must either hold that the member is unfit to practice generally or unfit to provide one or more services ordinarily provided by her.

b. Section 26 set out an exhaustive list of the circumstances in which a member can be found professionally incompetent.

c. A finding of unfitness cannot be based on one simple mistake – a mistake or course of deficient conduct must amount to gross negligence.

d. The Discipline Committee found at paragraph 111 of the DC Decision that professional incompetence had not been established demonstrating that Dr. Hosseini was "unfit to continue in the practice

of her profession or provide one or more services ordinarily provided as part of the practice of her profession."

e. The Discipline Committee "put the cart before the horse" by looking to the sentencing powers, which included lesser penalties such as reprimands, to justify its decision to ignore the requirement of unfitness.

f. The Discipline Committee erred by finding that a contravention of the Bylaws amounts to professional incompetence.

[75] I find that the Discipline Committee did not commit an error in respect of this ground. I will elaborate below.

(i) Does s. 26 of the Act set out an exhaustive list of circumstances in which a member can be found professionally incompetent?

[76] In respect of this issue, the College and Dr. Hosseini hold diametrically different views on how to interpret s. 26. Again, s. 26 reads as follows:

> **Professional incompetence**
> **26** Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment, or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:
>
> (a) continue in the practice of that member's profession; or
>
> (b) provide one or more services ordinarily provided as a part of the practice of that member's profession;
>
> is professional incompetence within the meaning of this Act.

[77] Although the Discipline Committee convicted Dr. Hosseini of professional incompetence under s. 26, it did not find that she was so unfit as to be required to discontinue practice or the provision of any services. Paragraph 111 of the

DC Decision states:

> The Committee does not find professional incompetence has been established demonstrating Dr. H is unfit to continue in the practice of her profession or provide one or more services ordinarily provided as a part of the practice of her profession. …

[78] The essence of Dr. Hosseini's argument is that it is impossible to convict under s. 26 without finding that the member is unfit to practice generally or unfit to provide one or more services ordinarily provided by her, i.e., that s. 26 sets out an exclusive list of circumstances in which a member may be convicted of professional incompetence. She argues that unfitness is central to the legal definition of professional incompetence, and that the Discipline Committee was precluded from convicting her once it made that finding quoted above from paragraph 111.

[79] That argument was made to the Discipline Committee, which analyzed the point as follows:

> 74. … The Committee does not agree. <u>This logic ignores the role the Committee must perform in protecting the public by being able to review the specific conduct of dental practitioners licensed under the *Act*, where a member of the public has been harmed through specific steps taken during a procedure. Simply put, occasions will arise where a lack of knowledge, skill or judgment is demonstrated, and a procedure is performed in an incompetent manner. The Committee finds it is not limited to a finding of incompetence only where subsections (a) and (b) of section 26 are met; section 26 is a non-exhaustive definition</u> (*Sullivan on the Constructions of Statutes*) which allows the Committee to determine if specific conduct fits within a general category of professional incompetence. Nevertheless, it may still be demonstrated the particular practitioner has continued to practice and has performed similar procedures without incident. It may also be shown they have upgraded their skills and education. Consequently, they may have shown they are fit to practice and provide such services but can still be found to have acted in an incompetent manner.
>
> [Emphasis added]

[80] The College says the Legislature cannot have intended to hamstring the

Discipline Committee, thereby depriving the Patient of any professional complaint against Dr. Hosseini, simply because the Procedure constituted a single incident and not a pattern. Further, the College argues that it defies logic for the Discipline Committee to be precluded from sanctioning an incident of sufficiently poor judgment or performance until others are harmed so as to establish a pattern.

[81] Certain considerations bear on my evaluation of this issue. First, there is the standard of review, which requires me to pay substantial deference to a discretionary decision.

[82] Second, long before *Strom*, courts considered it necessary to interpret such provisions broadly and inclusively. In *Nanson v Saskatchewan College of Psychologists*, 2013 SKQB 191, 421 Sask R 58 [*Nanson*], Danyliuk J. stated the following in respect of s. 26 of *The Psychologists Act, 1997*, SS 1997, c P-36.01:

> [24] Professional regulators frequently have a wide or inclusive definition of prohibited conduct. This is to ensure that a regulator is not restricted from dealing with conduct that requires attention from the perspective of protection of the public.

[83] The argument that s. 26 creates an exhaustive list is largely answered in *Strom*, though there are some differences from the provision in issue there. At para. 99, Barrington Foote J.A. stated:

> [99] … [S]. 26(1) of the *Act* must be interpreted in accordance with the modern principle of statutory interpretation. With that in mind, I would first note that the ordinary and grammatical meaning of the provision, read in context and in light of the purpose of the *Act* as a whole, does not suggest the words after "question of fact" are intended to be an exclusive definition. Section 26(1) says first that professional misconduct is a question of fact and then says *and* conduct of the kind specified *is* professional misconduct. This language is inclusive, not exclusive. In effect, it deems conduct with the impacts listed in s. 26(1) to be professional misconduct. …
>
> [Emphasis added]

[84] Barrington-Foote J.A. also cited s. 2-10(2) of *The Legislation Act*, SS 2019, c L-10.2, which states:

> **2-10** …
>
> (2) Every Act and regulation is to be construed as being remedial and is to be given the fair, large and liberal interpretation that best ensures the attainment of its objects.

He observed that: "the inclusive interpretation is consistent with this principle, while the interpretation proposed by SUN is not. SUN's interpretation would unduly limit the ability of the Discipline Committee to fulfill its role." (para. 104).

[85] There are differences between s. 26 of the *Act* and the provisions in *The Registered Nurses Act, 1988* that were considered in *Strom*. Section 26(2) of *The Registered Nurses Act, 1988*, opens with "Without restricting the generality of subsection (1) …". Barrington-Foote J.A. relied on that phrase to interpret s. 26(1) of that *Act*, and in particular that the listed conduct in s. 26(1) is to be interpreted as inclusive rather than exclusive.

[86] Those differences create a sufficient distinction such that Barrington-Foote J.A.'s analysis is not binding on me. Nonetheless, I find it to be persuasive. *The Registered Nurses Act, 1988* contains substantially more detail on what constitutes professional misconduct than most of the corresponding self-governance legislation, and even there Barrington-Foote J.A. found the language to be inclusive rather than exclusive.

[87] The objects of the *Act* would be defeated by applying an exclusive interpretation to s. 26. Protection of the public interest, which is the paramount purpose of the *Act*, is not advanced by preventing a discipline committee from acting until it sees a pattern of conduct that warrants an order revoking the member's license or the curtailment of carrying out certain procedures.

[88] One factor considered by the Discipline Committee in its decision was that Dr. Hosseini had changed aspects of her practice, presumably as a result of the incident with the Patient. At paragraph 111, the DC Decision states:

> 111. ... where the radiograph and clinical assessment are different the Committee finds further exploration should be undertaken so that a more definitive assessment can be reached. Nevertheless, when asked what she would do now, if the radiograph and clinical assessment are different, she advised she would take a more cautious approach and request a CBCT. The Committee finds such a diagnostic test should be at the pre-planning or planning stage of implant placement, not post-operatively after the relatively irreversible step of having placed the implant has occurred. Nevertheless, in her testimony, upon further questioning from the Committee, she indicated prior to placing an implant on the mandible, she currently performs a CBCT at the outset of her planning so that implant placement is more precise. The Committee finds Dr. H was incompetent in her care of [redacted], however, she has recognized this grave error. Although the Committee still has some concerns, as referenced above, Dr. H has demonstrated she has taken the necessary measures to avoid such a "misadventure" in the future and the public's welfare is not at risk.
>
> [Emphasis added]

[89] That discussion, combined with Dr. Hosseini's argument that no conviction is possible under s. 26 absent a finding of general incompetence, leads to a problematic situation exemplified by the following hypothetical. A member who has been charged for incompetent conduct takes steps before the hearing to raise her level of competence. As a result, the member is clearly competent by the time the hearing occurs. Accordingly, it would no longer be appropriate to find that the member "is" unfit and/or to impose a sanction of revoking her license or restricting her practice. On Dr. Hosseini's theory of how s. 26 is to be interpreted, the member could thereby unilaterally nullify the prosecution and avoid any penalty at all. A practitioner could avoid jeopardy under s. 26 if they were to take sufficient steps to upgrade their competence in advance of their hearing.

[90] That would be an absurd result, which would compound the absurdity

noted by the Discipline Committee of a pattern of conduct needing to be established if Dr. Hosseini's interpretation were to prevail.

[91] The Discipline Committee's interpretation has the benefit of preserving flexibility. A member who has made a serious error may be prosecuted and convicted as may be appropriate to protect the public interest, while allowing the sanction to reflect the steps taken by the member to address the deficiencies that led to the error. It maintains the regulator's ability to govern its members while encouraging improvement on the part of the member in advance of a hearing. It also allows the regulator to act without having to establish an artificially high threshold of problematic conduct.

[92] Thus, not only is the Discipline Committee's interpretation of s. 26 consistent with *Strom*, it falls easily within the interpretive approach urged by Danyliuk J. in *Nanson*. Even on a correctness standard, I would uphold the Discipline Committee's approach. The discretionary standard requires considerable deference such that this is not a close call. No reviewable error exists in respect of this issue raised by Dr. Hosseini.

[93] Now I will turn to the remaining questions raised by this ground of appeal. I have somewhat modified the questions raised by Dr. Hosseini's arguments.

(ii) Is unfitness central to the definition of professional incompetence, such that to find a member guilty of a charge under s. 26 a discipline committee must either hold that the member is unfit to practice generally or unfit to provide one or more services ordinarily provided by her?

(iii) May a finding of unfitness be based on one mistake?

(iv) Must a discipline committee make a finding of unfitness before it can convict under s. 26?

(v) Must gross negligence be found in order to convict under s. 26?

[94] To questions (ii) and (v), the answer is "no". To questions (iii) and (iv), the answer is "yes". Many of the reasons for those answers appear in the preceding section. I will minimize my repetition of them here.

[95] These questions arise in part because of Dr. Hosseini's reliance on *Swart v College of Physicians and Surgeons of P.E.I.*, 2014 PECA 20, 361 Nfld & PEIR 5 [*Swart*], where the court stated:

> [104] It is not every failure of a physician that amounts to a finding of unfitness. Were it so, virtually every physician would, at some time or another over the course of his or her career, be found to be quite unfit as all human beings sooner or later make mistakes. The case law is consistent that mere negligence is not a sufficient basis for a finding of unfitness (***Huerto v. College of Physicians and Surgeons (Saskatchewan)***, 1999 CarswellSask 40 (SKQB), ***Huerto v. College of Physicians and Surgeons (Saskatchewan)***, 2004 CarswellSask 587 (SKQB), ***Re Adamo***, [2005] OCPSD 22 (Ontario College of Physicians and Surgeons Discipline Committee). There must be a failure amounting to gross negligence (***Complaints and Authorization Committee, College of Physicians and Surgeons of Newfoundland Re Carter, February 13, 2006***) or some quality of blatant disregard for the patient or the patient's well-being (***Reddoch v. Yukon Medical Council***, [2001] 161 BCAC 131).
>
> [105] Indeed the very definition of "*unfit member*" in the ***Medical Act*** makes it abundantly clear that the physician's transgression must be of such a nature and extent to make it desirable to either restrict or terminate the physician's ability to practise (***Act***, s.1(y)). Physicians are not held to a standard of perfection. In order to make a finding that a member is unfit to practise his or her profession, something beyond mere negligence or carelessness is necessary.
>
> [Underlining emphasis added]

[96] *Swart* has not been relied upon outside of Prince Edward Island for its substantive findings. Though *Swart* is a decision of the PEI Court of Appeal, that was the appeal of first instance. It was a statutory appeal, and the court stated that the reasonableness standard applied. The court found numerous procedural fairness errors that were significant in magnitude, so the discipline decision would have been quashed on those grounds alone.

[97] In my view, *Swart* does not assist Dr. Hosseini. I will explain.

[98] The appeal was brought from a decision by the Fitness to Practise Committee [PEI Committee] of the College of Physicians and Surgeons of Prince Edward Island. In addition to the numerous and serious procedural errors that it made, the PEI Committee found that Dr. Swart's "repeated errors in judgment amount to wanton and cavalier disregard" for his patient's health. The court found no evidence to support the various conclusions in that statement. The court summarized the circumstances as follows:

> [124] Dr. Swart discussed the options with the Patient prior to the surgery and provided her with literature on the surgery, the procedure and the possible complications. When she returned three hours post-operation, he did not send her away. He put her in the hospital and provided medications for her pain and nausea. She remained in hospital overnight. He did not discharge her without an examination. He directed his mind to the possibility of a bowel perforation. He concluded there were good bowel sounds and that no signs of a perforated bowel were present. He was in error and he ought to have done more but there is nothing malicious or disdainful in the doctor's actions.

[99] In the preceding paragraphs, the court determined that the PEI Committee's findings that Dr. Swart was guilty of repeated errors and that he was guilty of a "wanton and cavalier disregard" for the patient's health were entirely unsupported by the evidence. Rather, the court found that other than making a single error concerning "one patient only who was discharged from hospital when she ought not to have been", the evidence did not indicate that Dr. Swart fell below the standard of care in his treatment of the patient. See paras. 108 to 123. The single error was in not realizing that the patient did not show discomfort because the medications given to her could mask the symptoms that might alert him to the fact that her bowel had been perforated.

[100] Thus, *Swart* involved a single minor error amounting to mere negligence.

The court held that the hyperbolic language used by the PEI Committee was unwarranted and unsupported by the evidence. To the extent that Dr. Swart was negligent, it was only concerning the decision to discharge the patient without first obtaining additional imaging. He was not negligent in his conduct of the procedure itself.

[101] In my view, it was not necessary for the court in *Swart* to determine whether gross negligence need be established, or whether discipline could be imposed for a single act, having found that only a minor error had occurred.

[102] The disciplinary proceedings in *Swart* were conducted pursuant to the *Medical Act*, RSPEI 1988 c M-5. While its findings on procedural fairness and the evidence appear unassailable, I find the court's analysis of that legislation difficult to follow. For example, at paras. 97-98, the court appears primarily concerned about preventing confusion between the concepts of professional misconduct, incapacity and unfitness to practice (the last seeming to involve competence), but the focus then turns largely to incapacity and illness of the physician, which were irrelevant to those proceedings. In my view, a close reading of *Swart* makes it difficult to draw from it principles that would be relevant to Dr. Hosseini's appeal.

[103] When evaluating jurisprudence, particularly from other jurisdictions decided under different legislation, one must be cautious about taking broad statements and turning them into legal propositions. I can find no instance of a Canadian court applying the broad propositions that Dr. Hosseini attempts to rely on from *Swart*.

[104] *Swart* is also distinguishable on the evidence. Dr. Hosseini did not merely commit a single error amounting to mere negligence.

[105] Accordingly, I am not persuaded that I should follow *Swart* as Dr. Hosseini asks, and I decline to do so.

[106] *Swart* relied in part on *Huerto v College of Physicians and Surgeons of Saskatchewan* (1999), 178 Sask R 52 (QB) [*Huerto*], so it is appropriate that I review that decision as well. At para. 104, *Swart* cites *Huerto* for the proposition that "The case law is consistent that mere negligence is not a sufficient basis for a finding of unfitness". What G.A. Smith J. (as she then was) actually stated in *Huerto* was that a "finding of guilt on a charge of unbecoming, improper, unprofessional or discreditable conduct requires more than finding that a doctor has made an error of judgment, even one that was negligent": para. 90. Smith J. then quoted from *Saskatchewan College of Physicians and Surgeons v Camgoz* (1982), 20 Sask R 400 (QB) at 405 [*Camgoz*], as follows:

> 90 ...
>
> The principal ground of appeal advanced with respect to clause (a) of the charge is that the decision to conduct a vaginal or pelvic examination in this case does not amount to professional misconduct within the meaning of s. 43(m) of the Act. Having regard to the evidence of the medical witnesses, can it be said that the decision to conduct a pelvic or vaginal examination was within the range of possible courses of action that in the circumstances of this case reasonably competent and conscientious members of the medical profession might have chosen to take? We can only answer that question in the affirmative. Assuming, but without deciding, that the impugned decision to conduct a vaginal examination could form the basis of a charge under s. 43(m) of the Act and even if the decision so taken could be characterized as an error of judgment or a mistaken exercise thereof, it was not so blatant an error as to amount to professional misconduct. An exercise of judgment by a medical practitioner engaged in general practise even though it turns out to be mistaken (which we do not so find in this case) is not necessarily outside the range of possible courses of action that a reasonably competent general practitioner might choose to take.
>
> [Emphasis added]

[107] It is difficult to take from either *Huerto* or *Camgoz* any guidance as to what is required to convict of professional incompetence under the *Act*. Errors and negligence can fall within a continuum of severity.

[108] *Swart* also relied on *Reddoch v The Yukon Medical Council*, 2001 YKCA 13, 161 BCAC 131 [*Reddoch*], where the court stated as follows:

> [56] As the argument before us developed, the critical issue on this appeal became apparent. It is whether the words "unprofessional conduct" in this statute encompass the appellant's acts of omission which, on the findings of the Committee, can be summed up as a failure to exercise reasonable care and skill in the management of one patient whom neither he nor three other physicians believed to be gravely ill. In my opinion, the answer to that question is "no". The route which should have been gone down is not the route of s. 24 but the route of s. 22, an investigation into the standard of practice of the appellant.
>
> ...
>
> [58] It is open to the Legislature of the Yukon to define "unprofessional conduct" as including a single failure to exercise reasonable care and skill in the management of one patient. If it chooses to do so, it is not improbable that every physician in the Yukon will be guilty at some time or another of an offence. As I remarked in *de la Giroday v. Brough* (1997), 33 B.C.L.R. (3d) 171 at 175:
>
>> I doubt that there is a professional man or woman, no matter how generally competent and experienced, who has never had occasion to say to himself or herself, "How could I have been so blind?" Such might well have been the reflection of the defendant in *Lankenau v. Dutton*, [1999] 5 W.W.R. 71, 79 D.L.R. (4th) 705, 55 B.C.L.R. (2d) 218 (B.C.C.A.), who was, on the evidence, a most competent surgeon.
>
> [59] In coming to this conclusion, I am not in any way differing from the Inquiry Committee's conclusion as to what proper practice was in the circumstances or their conclusions as to what had in fact happened.
>
> [60] What I do say is that when the issue is one of a failure of reasonable care, the conduct of the physician in order to constitute "unprofessional conduct" must have about it some quality of blatancy - some cavalier disregard for the patient and the patient's well being.

[109] Section 24 of the Yukon *Medical Profession Act*, RSY 2002, c 149, which was interpreted by the court in *Reddoch*, dealt with "infamous or professional misconduct", such as having a mental ailment, emotional disturbance or addiction that

would cause a physician to be unfit. Section 22 related to adequacy of skill and knowledge. Dr. Reddoch had been convicted of "unprofessional conduct".

[110] Thus, the basis for overturning Dr. Reddoch's conviction was that his conduct did not fall within the concept of unprofessional conduct, which concept did not encompass competence. The remaining comments of the court in *Reddoch* were *obiter*.

[111] Though some of its observations were made in *obiter*, *Reddoch* makes a valid point that discipline committees and courts should be cautious about convicting for isolated and unfortunate errors that do not rise much beyond failure to meet the standard of care. With that, I do not quarrel. There is a continuum of quality of care that ranges from optimal care, through mere negligence, more severe negligence that falls short of gross negligence, gross negligence, and intention to harm or maliciousness.

[112] That leads to the question of "what severity of conduct can lead to a conviction of professional incompetence under the *Act*?". In my view, it is reasonable to say that a single act of mere negligence should not lead to a finding of professional incompetence. That does not equate to a finding that only gross negligence or more severe conduct could support a conviction. Barely failing to satisfy the standard of care is not the same as more severe negligence that still would fall short of gross negligence. For that proposition, I find support in *Harsch v Saskatchewan Government Insurance*, 2021 SKCA 159 [*Harsch*], in which the Court of Appeal reviewed the Supreme Court of Canada decision in *Finney v Barreau du Québec*, 2004 SCC 36, [2004] 2 SCR 17 [*Finney*]. *Harsch* involved a car accident, but its analysis dealt with the spectrum of culpable conduct. The Court of Appeal stated:

> [42] … While the Chambers judge observed that "[b]ad faith certainly includes malice or conduct intended to harm", she also recognized that, in some cases, "recklessness or serious carelessness" will suffice, and that "there are degrees of culpability with inadvertence at one end

> of the spectrum and gross negligence on the other", not all of which will be culpable (*Decision* at paras 11 and 13, citing *Finney*). This is, in my view, an accurate statement of the law.

[113] In *Finney*, the Supreme Court stated that "Gross or serious carelessness is incompatible with good faith." (para. 40) and that "The virtually complete absence of the diligence called for in the situation amounted to a fault consisting of gross carelessness and serious negligence." (para. 45)

[114] Though the contexts in *Harsch* and *Finney* were different, they shed light on the spectrum or continuum of culpability. Gross negligence appears to involve a "virtually complete absence of diligence". Further, a course of repeated merely negligent conduct could give rise to a finding that the conduct in aggregate constituted wilful and wanton misconduct: *Marchyshyn v Cole*, [1971] 1 WWR 730 (QL) (Sask CA) at paras 19-20.

[115] It is appropriate to now return to the four questions set out above, to which I will provide brief answers in light of the analysis in this and the preceding section:

> *(ii) Is unfitness central to the definition of professional incompetence, such that to find a member guilty of a charge under s. 26 a discipline committee must either hold that the member is unfit to practice generally or unfit to provide one or more services ordinarily provided by her?*

[116] The answer is no. A discipline committee is not bound to hold that the member is unfit to practice generally or unfit to provide one or more services ordinarily provided by her in order to convict under s. 26. That flows from my finding above that s. 26 does not set out an exhaustive list of circumstances in which a member can be found professionally incompetent.

> *(iii) May a finding of unfitness be based on one mistake?*

[117] The answer is yes, though it will depend on the severity of the mistake.

One minor error, though it may represent negligence that could support a civil claim, should not lead to a finding of unfitness. A more serious error, even if it falls short of gross negligence, could potentially lead to a finding of unfitness. That said, the "question of fact" formulation will always require a court sitting in appeal to accord considerable deference to the findings of a discipline committee.

(iv) Must a discipline committee make a finding of unfitness before it can convict under s. 26?

[118] If by "finding of unfitness", Dr. Hosseini means a finding that the member is unfit to practice generally or unfit to provide one or more services ordinarily provided by her, the answer is no. A discipline committee need not find that in order to convict under s. 26. A discipline committee need find only that the practitioner is guilty of professional incompetence, which may be satisfied by degrees of culpability not expressly enumerated by s. 26.

(v) Must gross negligence be found in order to convict under s. 26?

[119] The answer is no. Within the spectrum of culpability, it is possible to convict absent a finding of gross negligence.

[120] In light of those answers, I find that the Discipline Committee did not err in its interpretation of s. 26 of the *Act*.

(c) Conclusion on Ground (a)(i)

[121] Questions *(i)* through *(v)*, as I have reframed them to align with the form of arguments advanced by Dr. Hosseini, combine to address ground (a)(i) of Dr. Hosseini's notice of appeal. I find that the Discipline Committee did not commit a reversible error on that ground.

Ground (a)(ii) The Discipline Committee erred by concluding the purpose of the *Act* and s. 26 was to ensure this individual complainant would not be deprived of a remedy for this single incident.

[122] This ground stems from the following statement at paragraph 83 of the DC Decision:

> 83. … It cannot have been the legislature's intent to deny a member of the public a remedy because they have only been harmed through a single incident and not a pattern of conduct. It defies logic that this Committee could be precluded from determining a sanction for an act of professional incompetence until others are harmed and a pattern of poor professional knowledge, skill or judgment has been made out. This Committee must be able to review such conduct and, where necessary, make an appropriate order.
>
> [Emphasis added]

[123] Dr. Hosseini focused on the underlined portion of paragraph 83 and indeed reproduced only that passage in her written submissions. She argued that the passage suggests that the only venue through which an individual might receive a remedy is through the discipline process, which would be incorrect because: (a) it ignores the primary objectives of the professional regulatory system, being protection of the public and protection of confidence in the profession; and (b) it disregards that the Patient could have brought a civil claim for recovery.

[124] Dr. Hosseini submits that the Discipline Committee incorrectly presumed that a remedy could flow only through the discipline process.

[125] This ground is unfounded. The Discipline Committee was not making the point alleged by Dr. Hosseini. When one reviews the remainder of paragraph 83 reproduced above, along with the preceding paragraphs, it is clear that the Discipline Committee was in no way suggesting that its role was to provide the only possible remedy available to the Patient. Rather, paragraph 83 represents a continuation of the

point being discussed by the Discipline Committee as to whether a single incident could support charges under s. 26 of the *Act*.

[126] Nothing in the DC Decision, the Bias Decision nor the Penalty Decision suggests that the Discipline Committee's principal or even secondary objective was to give the Patient a remedy. The reference to denial of a remedy to a member of the public to which Dr. Hosseini points may not have been as articulate as ideal, but the surrounding context makes the Discipline Committee's point clear – that if a sufficiently serious issue should come to its attention arising from a single incident of patient care, it should not have to wait until the conduct is repeated such that a pattern has formed.

[127] Thus, the argument is nothing more than a straw man. No reversible error was made by the Discipline Committee in this respect.

Ground (a)(iii) The Discipline Committee erred by concluding the failure by the appellant to identify the misplacement of the implant from the available two-dimensional imaging constituted professional incompetence when the evidence disclosed none of the other two periodontists, two general dentists nor the oral surgeon who dealt with this complainant identified the misplacement from the two-dimensional imaging.

[128] The ground is framed in a manner that suggests the answer – if so many other dentists and specialists did not realize that the Second Implant intruded in the IA canal, how could Dr. Hosseini be expected to have known?

[129] The ground is founded on a misapprehension of the evidence and of what the Discipline Committee actually decided.

[130] Dr. Hosseini argues that Dr. Wagner stated that she erred in failing to immediately identify the Second Implant as being in the IA canal. That is not an

accurate reflection of Dr. Wagner's testimony or what the Discipline Committee found.

[131] The two dimensional x-rays showed that the Second Implant overlapped with the IA canal, at least from the angle(s) from which the x-rays were taken. That does not necessarily equate to the Second Implant intruding into the IA canal. The IA canal was contained within bone that Dr. Hosseini drilled into. To paraphrase Dr. Wagner's testimony, if the jaw bone were wide enough, it was at least possible that where a 2D x-ray showed the Second Implant overlapping with the IA canal, the Second Implant was beside the IA canal without intruding into it.

[132] Dr. Wagner testified that if the Patient "had a really wide jaw, and ██ had a really long implant, and you knew where the nerve was, then you could easily explain, no problem." However, he also testified that the Patient did not have a really wide jaw.

[133] Dr. Wagner testified that <u>the combination</u> of increased bleeding and what was shown on the Panorex (a panoramic two dimensional image that is found on page 61 of Exhibit J-1 and also the last page of Exhibit P-7) would flag him to immediately remove the Second Implant. He further testified that a 3D x-ray would have shown ("It would be fairly accurate") whether the Second Implant was in the IA canal, and that it was possible then to obtain a same-day 3D x-ray in Regina.

[134] What the Discipline Committee actually decided on this point was as follows:

> 114. … <u>Dr. H's failure to undertake further exploration to determine whether there had been implant intrusion into the nerve canal</u>, where increased bleeding was noted and the panoramic image, at the very least, showed a possibility of intrusion into the nerve canal displayed a lack of knowledge, skill or judgment and is professional incompetence within the meaning *The Dental Disciplines Act* and contrary to 9.2(2)(x) of the *Bylaws*. The Committee finds a competent specialist dentist would have recognized the intrusion when ██████'s implant was replaced, and failure to remove the implant also displayed a lack of knowledge, skill or judgment and is professional incompetence

> within the meaning of *The Dental Disciplines Act* and contrary to 9.2(2)(x) of the *Bylaws*.
>
> [Emphasis added]

[135] Perhaps this ground is aimed at the second part of paragraph 114 that begins with "the Committee finds …" but the second part is predicated on the finding made in the first part, which is that the combination of increased bleeding with what was shown by the two-dimensional images should have led a competent practitioner to obtain better imaging, which Dr. Hosseini did not do.

[136] The Discipline Committee did not hold that Dr. Hosseini's failure to identify the misplacement of the Second Implant from the available two-dimensional imaging constituted professional incompetence. It did not make the error, nor the finding, that Dr. Hosseini says it made.

[137] Accordingly, the appeal on Ground (a)(iii) is dismissed.

Ground (b) The Discipline Committee erred in law and deprived the appellant of a fair hearing in finding the appellant guilty of professional incompetence upon evidence which could not reasonably sustain that finding.

[138] This ground is closely related to Grounds (a)(i) and (iii) and was not argued as a separate ground. It is answered by my analysis in respect of Grounds (a)(i) and (iii). On the standard of review applicable to discretionary decisions, the Discipline Committee did not commit the error alleged and the appeal on this ground is dismissed.

Ground (c) The Discipline Committee erred in law and deprived the appellant of a fair hearing by misunderstanding the evidentiary purpose of opinion evidence and misinterpreting, improperly assessing and misapplying the opinion evidence received from Dr. Toporowski, Dr. Abbaszadeh and Dr. Wagner.

Ground (d) The Discipline Committee erred in law and deprived the appellant of a fair hearing in limiting cross-examination of Dr. Wagner. Further, the Discipline Committee erred in law and deprived the appellant of a fair hearing in applying its ruling on the objection to the cross-examination of Dr. Wagner to the admissibility and/or assessment of the opinion evidence of Dr. Abbaszadeh and Dr. Toporowski without further objection being made to the admissibility of that evidence and without providing the appellant with an opportunity to provide argument on this issue.

[139] Dr. Hosseini blended her arguments on Grounds (c) and (d) in her written and oral submissions, so I will deal with them together. The arguments in support of these grounds amounted to the following:

a. The fact that expert evidence was allowed by the Discipline Committee means that it can be presumed that opinion evidence was necessary and relevant, notwithstanding the specialized knowledge held by three of the Discipline Committee members.

b. To be necessary, Dr. Wagner's evidence must have pertained to standard of care, breach of the standard of care and how far Dr. Hosseini was from meeting the standard of care.

c. Dr. Wagner's evidence was merely that Dr. Hosseini breached the standard of care, and thus cannot support a finding of professional incompetence under s. 26.

d. The Discipline Committee erroneously restricted cross-examination of Dr. Wagner on the basis that the "ultimate issue" rule applied. The "ultimate issue" rule is no longer good law, except that opinion evidence on domestic law remains inadmissible.

e. Paragraph 38 of the DC Decision states that while expert reports were filed by consent, the Discipline Committee "has accorded no weight to any conclusions or comments" from the experts in their reports on the specific question of incompetence. Dr. Hosseini says that is an error of law and a misapplication and misunderstanding of the evidence such that the conclusion of professional incompetence was an error.

f. The Discipline Committee failed to analyze the evidence of Dr. Abbaszadeh and provide a reasonable explanation as to why it disagreed with or would disregard his opinion.

[140] Those arguments raise four questions, all of which must be viewed through the lens of the standard of review for discretionary decisions. For certain of the questions, that means that even if I would have done something differently from what the Discipline Committee did, that does not necessarily result in a finding of reversible error. The exception is where procedural fairness is in issue, in which case the standard of review is correctness.

a. *Did the Discipline Committee have expert evidence before it on which it could find that Dr. Hosseini committed an error serious enough on which it could base a finding of professional incompetence? Was there evidence of errors by her that went beyond a modest breach of the standard of care that should not attract professional discipline?*

b. *Did the Discipline Committee err in restricting cross-examination of Dr. Wagner?*

c. *Did the Discipline Committee err in stating that it would place no weight on the expert evidence on the specific question of incompetence?*

d. *Did the Discipline Committee fail to analyze the evidence of Dr. Abbaszadeh and provide a reasonable explanation as to why it disagreed with or would disregard his opinion?*

[141] With respect to how the Court should evaluate the Discipline Committee's treatment of expert evidence, the College relies on *Frondall v Frondall*, 2020 SKCA 135. There, Schwann J.A. stated:

> [52] … As this Court noted in *Clemens v McGruther*, 2019 SKCA 46 at para 34 [*Clemens*], the privileged position of the trier of fact and the deferential standard of review do not leave much room for appellate intervention on the broad question of weight. Simply put, "It is not the function of an appellate court to reconsider the expert evidence and come to a different conclusion" (*Clemens* at para 34): also see *Kolibab v Tenneco Canada Inc.*, [2000] 1 WWR 590 (Sask CA).
>
> [53] The trial judge provided cogent reasons in each instance as to why he preferred Mr. Thomson's opinion and rejected Mr. Weber's – or, conversely, accepted Mr. Weber's opinion but rejected Mr. Thomson's. Given the deferential standard of review, I see no overarching error in how the trial judge dealt with the issue of weight. The real question raised by Mr. Frondall's appeal is whether the evidence could not reasonably justify the conclusions reached by the trial judge: see *Joseph Brant Memorial Hospital v Koziol*, [1978] 1 SCR 491 at 504.

[142] Although Schwann J.A. applied the palpable and overriding error standard of review, her comments remain apt, and I adopt them. Now I will deal with the four questions set out above.

a. *Did the Discipline Committee have expert evidence before it on which it could find that Dr. Hosseini committed an error serious enough on which it could base a finding of professional incompetence? Was there evidence of errors by her that went beyond a modest breach of the standard of care that should not attract professional discipline?*

[143] The College argues that Dr. Wagner testified as to the seriousness of the breach by Dr. Hosseini (page references are to the hearing transcript from October 3, 2018):

a. Page 90 – The placement of the implant was not a narrow miss.

b. Page 99 – It was a breach of the standard of care to use a 13 mm implant given the amount of bone in which it was placed.

c. Page 102 – As opposed to a small or trivial error, it was "a very serious error".

d. Page 103 – The degree to which this implant went into the canal makes this different than an average case.

e. Pages 108-109 – It was inappropriate to leave the implant in and see how things developed. "I think when it's that far past the canal or into the canal, that's not really an option. It's not an opinion at that point. It's anatomical."

f. Page 108 – Given the bleeding observed by Dr. Hosseini. and what was shown on the Panorex, the implant should have been removed immediately.

g. Page 109 – It was not appropriate to leave it to the patient to decide whether to leave in the implant if there might be a transection of the canal because the patient is not the expert.

[144] On page 116-117 of the transcript for October 3, 2018, Dr. Wagner was asked by PCC counsel whether this was a minor or substantial miss *vis-à-vis* the standard of care. Dr. Wagner responded:

> **A** You know, it's just -- just really, in anatomy, I don't know if there is a -- I didn't know there -- within the standard of care or outside of it, I didn't know there was a range, and I think that in this particular case the implant was just too long for the bone that was receiving it when you include the final structure that you're coming near to.

[145] The Discipline Committee restricted Dr. Hosseini's counsel from asking questions concerning s. 26 of the *Act*, based on the "ultimate issue" concept. That is the next question I will address and is somewhat of a complicating factor. However, this

particular issue was argued by Dr. Hosseini as a distinct issue, so I will address it as such. In my opinion, there was ample evidence before the Discipline Committee that Dr. Hosseini committed a very serious error, one that went well beyond a minor breach of the standard of care.

[146] Accordingly, I find that the Discipline Committee did not commit an error on this question.

b. Did the Discipline Committee err in restricting cross-examination of Dr. Wagner?

[147] The question concerning restriction of cross-examination has been appropriately framed by Dr. Hosseini as a procedural fairness issue. The standard of review is correctness.

[148] In cross-examination of Dr. Wagner, Dr. Hosseini's counsel, Scott Hopley, began to ask Dr. Wagner about s. 26. Before even hearing the question, PCC counsel objected on the basis that Dr. Wagner should not be asked to opine on legal matters concerning s. 26, as opposed to the areas in which he had been qualified to give expert evidence. Mr. Hopley wanted to ask whether Dr. Wagner had given thought to the question of professional incompetence. The exchange is located at pages 126-135 of the October 3, 2018 transcript.

[149] The Discipline Committee upheld the objection on the basis that on the question of professional incompetence itself, that would be for it to decide. It discussed its reasoning both during the hearing and in the DC Decision, where the issue was addressed at paragraph 38. The Discipline Committee denied Mr. Hopley the ability to ask about professional incompetence under s. 26, but I do not view it as having prevented any other questions from being asked.

[150] The Discipline Committee permitted Mr. Hopley the opportunity to ask

questions concerning the standard of care, which he did. Mr. Hopley also was permitted to ask about factors that form part of s. 26, i.e., whether Dr. Wagner had turned his mind to whether Dr. Hosseini had a lack of knowledge, whether she had a lack of skill and whether she generally had a lack of judgment. No further objections to Mr. Hopley's questions were raised. He did not attempt to ask about the severity of Dr. Hosseini's breach of the standard of care.

[151] As an aside, Mr. Hopley was permitted to ask Dr. Abbaszadeh about his views of Dr. Hosseini's competence. There was a brief interjection by the PCC but my view is that Mr. Hopley was not restricted in his examination of Dr. Abbaszadeh

[152] The College points to s. 33(4) of the *Act*, which states that a discipline committee may accept any evidence it considers appropriate and is not bound by rules of law concerning evidence. Neither party directed my attention to s. 33(7), which provides that at a hearing there is to be a full right to "examine, cross-examine and re-examine all witnesses". That provision is clearly relevant.

[153] Provisions similar to ss. 33(4) and (7) were considered by the Court of Appeal in *Council of the Saskatchewan Veterinary Medical Association v Murray*, 2011 SKCA 1, [2011] 2 WWR 503 [*Murray*] and *Sautner v Saskatchewan Teachers' Federation*, 2017 SKCA 65 [*Sautner*]. In *Murray*, the issue was that the tribunal received into evidence a videotaped statement from a person who failed to comply with a subpoena and did not attend the hearing. Thus, it was a situation of no cross-examination being permitted. Lane J.A. analyzed s. 33(7) as follows:

> [28] The right to cross-examination, as provided by s. 22(7), cannot be absolute because any such reading of the provision would, in at least some cases, wholly frustrate the disciplinary regime set out in the *Act*. For example, there will be situations where a witness's evidence is available and necessary but the witness cannot be located, or has died, or is incapacitated, or refuses to attend or refuses to testify. ...

Lane J.A. found that he could not conclude that the tribunal would have made the same

decisions without the witness's evidence, such that the right of cross-examination had been breached and it was appropriate that the matter be remitted to be reheard by a differently constituted panel.

[154] *Sautner* was concerned with the inability to cross-examine the source of hearsay evidence. Herauf J.A. considered *Murray* but held as follows:

> 29 While s. 28(2) of the *Act* [1995, SS 1995, c E-0.2] grants the Committee considerable discretion to accept any evidence it considers appropriate, including hearsay evidence, without being bound by the rules of evidence, this discretionary power is limited by the inclusion of s. 28(4). Section 28(4) states that at a hearing, the parties have full right to cross-examine all witnesses. This Court has explained that the discretion to admit hearsay evidence pursuant to a provision such as s. 28(2) of the *Act* must be interpreted alongside the statutory right to cross-examine under provisions like s. 28(4) (see *Council of the Saskatchewan Veterinary Medical Association v Murray*, 2011 SKCA 1, 329 DLR (4th) 501 [*Murray*]).
>
> [30] There is a simple answer to this ground of appeal. First, the Committee opted to deal with this matter by stating it was not using or relying on this evidence in its report. The Committee explained how the evidence of Ms. Godlien's statements related to the second charge, which it found was not proved and, therefore, this evidence was irrelevant to its analysis and ultimate finding of guilt on count one.
>
> [31] Second, the Committee stated it was attributing no weight to this evidence, whether hearsay or not, in coming to its decision on the ultimate issue. By assigning no weight to this evidence, the Committee effectively cured any failure to consider the necessity of admitting the hearsay evidence because that evidence played no role in its decision-making.

[155] The final sentence of paragraph 38 of the DC Decision states:

> 38. … Although expert opinion reports were filed by consent (Exs. P5, D4 and D8), based upon the ruling by the Committee on the ultimate question of professional incompetence, the Committee has accorded no weight to any conclusions or comments provided by the experts in their reports on the specific question of incompetence.
>
> [Emphasis added]

[156] Other than asking about s. 26 in and of itself, Mr. Hopley does not appear

to me to have actually been restricted in his cross-examination. He was permitted to ask Dr. Wagner about anything other than whether Dr. Hosseini was professionally incompetent overall.

[157] As to how courts now deal with expressions of opinions on the ultimate issue, Danyliuk J. summarized the current state of the law in *1348623 Alberta Ltd. v Choubal*, 2016 SKQB 129, 66 RPR (5th) 232 [*Choubal*], as follows:

> [56] First, some of the nine questions posed to Dr. Figley are questions that are not properly within the realm of an expert opinion. For example, Question 7 asked Dr. Figley to state whether there were any misrepresentations in the listing agreement. That is not calling for a scientific opinion; it calls for a determination of law and in fact calls for the expression of an opinion on the ultimate issue the court must decide. While at law there is no longer a general and absolute prohibition against commentary on the ultimate issue (this concern has been folded into the standard analysis set out in *R v Mohan*, 1994 CanLII 80 (SCC), [1994] 2 SCR 9), there remains a concern that the closer an expert's evidence gets to giving an opinion on the ultimate issue, the more rigorous is the application of the criteria of reliability and necessity prior to the admission of the opinion. Here, Dr. Figley's opinion on such points is not required by the court; it is not necessary. The issue of whether misrepresentations were made is not an area for this expert. It is a determination of fact and law. Simply put, this is not an area with which the court needs expert assistance. See *Saskatchewan (Seizure of Criminal Property Act, 2009, Director) v Kotyk*, 2013 SKCA 140, 427 Sask R 193. Also see Sidney N. Lederman, Alan W. Bryant & Michelle K. Fuerst, *The Law of Evidence in Canada*, 4th ed (Markham, Ont: LexisNexis, 2014) at §12.152 and §12.153.
>
> [Emphasis added]

[158] Dr. Hosseini's contention that the ultimate issue rule is "dead" overstates the change that has occurred with respect to the appropriate legal approach. A finder of fact is entitled to restrict the evidence it receives on the ultimate issue, and to determine what weight to accord to the evidence it does receive. Similar to what Danyliuk J. held in *Choubal*, the Discipline Committee determined that it was responsible to determine the ultimate issue of whether Dr. Hosseini's conduct constituted professional incompetence. Other than that narrow point, the Discipline Committee did not restrict

cross-examination.

[159] I find no error arising from the Discipline Committee having upheld the objection during Dr. Wagner's cross-examination. Beyond that objection, there was no restriction of cross-examination.

c. Did the Discipline Committee err in stating that it would place no weight on the expert evidence on the specific question of incompetence?

[160] This is not a question of procedural fairness. Rather, it goes to whether the Discipline Committee failed to give sufficient weight to relevant evidence. The standard of review is that for discretionary decisions.

[161] I will paraphrase Dr. Hosseini's written submissions on this point. She asserts that the Discipline Committee erred in applying the ultimate issue rule and giving no weight to the evidence from the three expert witnesses as to the significance or extent of a breach of the standard of care, to the extent that factual considerations need to be considered in determining whether incidents factually support gross negligence or the incompetence necessary to arrive at a finding of professional incompetence.

[162] In my view, the Discipline Committee did not err as alleged.

[163] As Danyliuk J. explained in *Choubal*, while the absolute prohibition against expert evidence concerning the ultimate issue no longer exists, as the evidence gets closer to the ultimate issue, it is appropriate for the fact-finder to be more rigorous in establishing the necessity and reliability of the evidence. Danyliuk J. found in *Choubal* that he did not need expert evidence on the ultimate issue. Nor would the Discipline Committee need expert evidence on how to interpret s. 26 of the *Act*.

[164] Though Dr. Hosseini paints the Discipline Committee's comments in paragraph 38 of the DC Decision with a broad brush, their comments were actually quite precise: "the Committee has accorded no weight to any conclusions or comments provided by the experts in their reports <u>on the specific question of incompetence</u>" [emphasis added].

[165] There remain two complaints from Dr. Hosseini about the treatment of her expert witnesses that I will address below, but on this point she does not point to a single piece of evidence that she says was inappropriately disregarded or accorded no weight.

[166] In the paragraphs leading up to and following paragraph 38, the Discipline Committee reviewed the expert evidence in considerable detail. It discussed where the experts agreed and disagreed with one another. It discussed the significance and severity of Dr. Hosseini's errors and the evidence dealing with that. In my view, the Discipline Committee reviewed and weighed the expert evidence in an appropriate manner. In any event it would not be an error for the Discipline Committee to reserve to itself the responsibility for determining what constitutes professional incompetence.

[167] Finally, as the discretionary decision standard of review applies, deference is owed to the Discipline Committee. It did not commit the alleged error.

d. Did Discipline Committee fail to analyze the evidence of Dr. Abbaszadeh and provide a reasonable explanation as to why it disagreed with or would disregard his opinion?

[168] The simple answer to this question is "no".

[169] The Discipline Committee analyzed Dr. Abbaszadeh's evidence in detail. It weighed Dr. Abbaszadeh's evidence against that of Dr. Wagner. While some of Dr. Abbaszadeh's evidence was exculpatory, particularly where he characterized

Dr. Hosseini's now admitted error as an "unfortunate mathematical misadventure", some of it was not. He opined, as noted in the DC Decision at paragraph 93, that a prudent practitioner would measure the amount of bone available for the implant, taking into account the bone loss between removal of the First Implant and placement of the Second implant, and that a new measurement should be made every time. Dr. Hosseini failed to do exactly what Dr. Abbaszadeh said must be done. The Discipline Committee did not reject Dr. Abbaszadeh's evidence outright. Instead, it sifted carefully through what it heard from Dr. Abbaszadeh and Dr. Wagner. Paragraphs 96-98 of the DC Decision, which deal with issues central to the matter, are good examples.

[170] I find no error in the Discipline Committee's evaluation of Dr. Abbaszadeh's evidence. The Discipline Committee was not required at each stage to expressly explain why it preferred Dr. Wagner's evidence over that of Dr. Abbaszadeh. Further, it would be improper for this Court, on the applicable standard of review, to dig deep into the weighing of evidence. The reasons provided by the Discipline Committee were more than sufficient to explain why it decided as it did.

[171] As Dr. Toporowski is the subject of a separate ground of appeal, I will address the Discipline Committee's treatment of her evidence in my discussion of that ground.

Conclusion on Grounds (c) and (d)

[172] As noted, I find no error in the reasoning of the Discipline Committee in respect of these grounds.

[173] With respect to the reference in the latter part of Ground (d) that Dr. Hosseini was not allowed to make argument on how the Discipline Committee handled the evidence of Dr. Abbaszadeh and Dr. Toporowski, that was not pursued in her written or oral submissions and I will not address it other than to say that I do not

view it as having merit.

Ground (e) The Discipline Committee erred in law by making an arbitrary and unreasonable credibility finding in respect of Dr. Toporowski. The Discipline Committee's finding that Dr. Toporowski's evidence lacked veracity resulted from a fundamental misunderstanding of and analysis of expert evidence which deprived the appellant of a fair hearing and created the basis for a reasonable apprehension of bias.

[174] The Discipline Committee stated the following at paragraph 99 of the DC Decision:

> 99. The Committee has determined not to give any weight to the testimony of Dr. T concerning the planning placement and decision on removal related to the second implant, based upon our concerns outlined above in paragraphs 40, 44, 45 and 91. Throughout her testimony, the panel found Dr. T appeared to be advocating for Dr. H. Even when faced with the established fact that the inferior alveolar canal had been penetrated by 3.7 mm, she refused to acknowledge the same. …

[175] Dr. Hosseini treated this as a bias issue in her Amended Notice of Appeal, but it was not pursued in argument as being a procedural fairness issue. I find that it is not, such that the discretionary decision standard of review applies. It was for the Discipline Committee to evaluate the credibility of the witnesses, and it did so thoughtfully.

[176] Dr. Hosseini argues that the Discipline Committee was first required to complete a *White Burgess* analysis of independence, which refers to *White Burgess Langille Inman v Abbott and Haliburton Co.*, 2015 SCC 23, [2015] 2 SCR 182 [*White Burgess*]. Dr. Hosseini misapprehends the stage at which *White Burgess* comes into play. As Danyliuk J. explains in *Canadian Broadcasting Corporation v Fertuck*, 2021 SKQB 218 at para 44, *White Burgess* was concerned solely with the gatekeeper role concerning expert witnesses – admissibility – and not at all about the weight to be given to an expert's opinion.

[177] It might be argued that Dr. Toporowski should not have been qualified as an expert witness pursuant to the *White Burgess* test, but she was qualified. That left the Discipline Committee to evaluate her evidence and whether she lived up to the obligation to serve as an impartial expert whose role was to assist the Discipline Committee in reaching a decision. After hearing her evidence, they concluded that she did not. They heard her evidence; I can only read the transcript and their evaluation of her testimony. However, Dr. Toporowski was unable or unwilling to accept that Dr. Hosseini had erred when Dr. Hosseini herself acknowledged the error. Dr. Toporowski persisted in her view that the nerve canal had not been penetrated when the other experts and Dr. Hosseini agreed that it had. In that light, it was entirely fair for the Discipline Committee to question her overall credibility. Her pre-existing close professional relationship with Dr. Hosseini and the fact that Dr. Hosseini herself asked Dr. Toporowski to testify would reasonably have aided the Discipline Committee to find that Dr. Toporowski was acting as an advocate rather than an impartial expert.

[178] I find no error in the Discipline Committee's decision to place no weight on Dr. Toporowski's evidence.

Grounds (f)(i) and (ii)

[179] I will not reproduce these grounds in full. One involves an eleven-line compound sentence, and neither is clear as to what actual errors are alleged. Below I will summarize the real issues pursued by Dr. Hosseini.

[180] These grounds raise issues of procedural fairness. Accordingly, the standard of review is correctness.

[181] After all the witnesses had testified, and the Discipline Committee had prepared and issued its decision, Dr. Hosseini then for the first time raised issues of apprehension of bias. The main hearing was held October 3-5, 2018. The DC Decision

was rendered on November 26, 2018. On March 14, 2019, for the first time, Dr. Hosseini applied for a determination of whether the Discipline Committee had lost jurisdiction based on a reasonable apprehension of bias. That application was heard by the Discipline Committee on March 28, 2019. That resulted in a separate decision rendered by the Discipline Committee on April 25, 2019 (Bias Decision), from which some of the details below are derived. Dr. Hosseini alleged the apprehension of bias arose from three main factors.

a. Dr. Hosseini alleged that the DC Decision appeared to have been made by Bruce Gibson, a lawyer who served as chair of the Discipline Committee, who was alleged to have filled conflicting roles of giving legal advice to, and sitting as a decision-maker on, the Discipline Committee.

b. The decision-making structure created the appearance that the Discipline Committee was predisposed to determine the matter in a particular way. The presence of the person giving legal advice on the Discipline Committee caused a lack of structural independence and deprived the Discipline Committee of the freedom to decide the case "without improper external influence."

c. The questions asked by the Discipline Committee and rulings made by it created a perception that it was not impartial.

[182] The first ground further morphed during this appeal into a question of whether Mr. Gibson was even eligible to serve as a member of the Discipline Committee.

[183] The second and third grounds spring from the fact that, leading up to the penalty phase, the details on costs sought by the PCC were disclosed to Dr. Hosseini.

Dr. Hosseini learned that the vast majority of costs sought arose from professional fees charged by Bruce Gibson. She says that Mr. Gibson's fees were 35 times those charged by the dentist members of the Committee. Whether those fees were reasonable would be a separate question. For these purposes, Dr. Hosseini has apparently equated the disproportionate fees with disproportionate influence. She further suggests that the amount of fees charged by Mr. Gibson suggest that he had a financial incentive to find her guilty. Dr. Hosseini argued before me that Mr. Gibson "has a substantial [pecuniary] interest in reappointment".

> *(i) Was Bruce Gibson, the Discipline Committee chair, eligible to be part of the Discipline Committee?*
>
> *(ii) Did Bruce Gibson's participation raise a reasonable apprehension of bias because his professional fees were dramatically higher than those of the other Discipline Committee members?*
>
> *(iii) Was a reasonable perception of bias created by the questioning, rulings and determinations made by the Discipline Committee?*

[184] I will deal with the three questions in turn.

> *(i) Was Bruce Gibson, the Discipline Committee chair, eligible to be part of the Discipline Committee?*

[185] Bruce Gibson is a lawyer. He served as the chair of the Discipline Committee hearing panel. At the outset of the hearing, no objection was taken to the composition of the Discipline Committee, including with respect to Mr. Gibson's role as chair.

[186] It verges on abuse of process to have raised this issue for the very first time after the main hearing had been held and the decision had been rendered. In oral argument, Dr. Hosseini said that the question was not top of mind until she saw the fees

that Bruce Gibson charged.

[187] Section 32 of the *Act* governs the composition of a Discipline Committee. The *Act* governs discipline for multiple types of professionals, so the references in s. 32 to an "association" and a "council" refer to the dental surgeons' association and its governing council. It requires that:

a. An association shall establish a discipline committee appointed by at least three persons appointed by its council: s. 32(1).

b. A majority of discipline committee members are to be practicing members (of the association in question): s. 32(2). By reference to the College's bylaws, that means practicing dental professionals who are in good standing.

c. One discipline committee member is to be a councillor appointed pursuant to section 9(1) of the *Act*: s. 32(3).

d. PCC members are not eligible to be discipline committee members: s. 32(4). In other words, there cannot be an overlap between the prosecution and the committee conducting the hearing.

[188] Section 9(1) of the *Act* authorizes the Lieutenant Governor in Council to appoint three persons as councillors for each association. At least one such councillor [Councillor] must form part of each discipline committee pursuant to s. 32(3).

[189] In this case, the Discipline Committee had five members. Three were practicing dental professionals in good standing (the three with Dr. in their name), Nancy Croll (a Councillor) and Bruce Gibson.

[190] Dr. Hosseini now argues that all members of a discipline committee must

be either (a) practicing dental professionals in good standing, or (b) Councillors, and that no other persons may be appointed to a discipline committee. She says the process of appointing public Councillors would be unnecessary if an association could then appoint additional members of the public to a discipline committee. She says such an approach would render s. 9 devoid of meaning.

[191] That argument is unsupported by the *Act*. Section 32 says nothing of the sort. There is a minimum of three, but only a minimum is set. A committee may be larger. A majority of committee members must be practicing members of the relevant association. A committee must include at least one Councillor. Section 13(1) authorizes a council (such as the College) to establish any committee provided for by its bylaws or that it considers necessary.

[192] In oral submissions, Dr. Hosseini advanced the argument that to allow for additional persons (beyond practicing dentists and Councillors) to be appointed would take away from the privilege of the appointment or membership. The idea of self-regulation is members judging members. Over time, the legislation has approved the appointment of members of the public for the purpose of keeping professional associations accountable to the public. That may be an accurate historical background (though I have not attempted to examine that history), but it does not speak to the actual provisions of the *Act* nor how they should be interpreted.

[193] If the Legislature had wished to require that every discipline committee was required to be comprised solely of practicing dental professionals in good standing, or s. 9(1) Councillors, it could easily have done so, but it did not. The Legislature could have prohibited lawyers from committee participation but did not. Dr. Hosseini is attempting to read in a requirement that does not exist and should not be read in.

[194] As the College argued, because of the need to properly conduct hearings,

resolve legal issues, and compose decisions, other professional regulatory bodies have often included lawyers as full members on their discipline committees.

[195] The argument that including another member of the public who is not a Councillor renders s. 9(1) devoid of meaning is grounded in nothing. Section 9(1) was satisfied by the inclusion of a Councillor.

[196] Dr. Hosseini cited no authority other than some jurisprudence speaking broadly to peer review by practicing members of one's own profession being a large part of effective self-governance, which is addressed in s. 32 by requiring that a majority of discipline committee members always be practicing dental professionals in good standing.

[197] The appeal on this question has no merit.

> *(ii) Did Bruce Gibson's participation raise a reasonable apprehension of bias because his professional fees were dramatically higher than those of the other Discipline Committee members?*

[198] The bylaws permit the chair to appoint an advisor to a panel. Dr. Hosseini argues that by virtue of the quantum of the fees he charged, Bruce Gibson was clearly appointed to act in his capacity as a lawyer rather than a layperson panel member.

[199] Dr. Hosseini says this argument was raised late because she assumed that Mr. Gibson was on the Discipline Committee as a Councillor and only realized he was not when she saw the professional fees he charged.

[200] No evidence of actual bias was brought to my attention. Dr. Hosseini mostly danced around saying it directly, referring to the absence of "structural protections" concerning the independence of the lawyer chair and the remaining Discipline Committee members. She says that Mr. Gibson did not have the security of

tenure enjoyed by other Discipline Committee members and is "acutely aware of the availability of others who could replace him in his position if the College is not satisfied with the outcome of the decision rendered by a panel of which he is the chair."

[201] In other words, Dr. Hosseini's argument is that Mr. Gibson did what he was put there to do by the College, i.e., to convict her, and that he would know that if he failed to ensure that result the College would not appoint him to future discipline committees and he would lose future fees.

[202] It is well-established that challenges concerning the composition of a tribunal, including with respect to structural independence and impartiality, must be raised at the outset. As one example, I refer to *Zündel v Canada (Human Rights Commission)*, [1999] 3 FC 58, [1999] FCJ 392 [*Zündel*]. In *Zündel*, faced with a similar argument, the court (citing *2433-6877 Québec Inc. c Québec (Régie des alcools, des courses et des jeux)*, [1997] JQ No 2039 (QL) (Que Sup Ct) held that:

> [18] … the law is well settled that arguments challenging the structural independence and impartiality of a tribunal must be raised at first instance and not doing so waived the option to so challenge the tribunal …

[203] At the beginning of the hearing Dr. Hosseini was asked whether she objected to the composition of the Discipline Committee. She did not. She raised this challenge only after the hearing had concluded and the DC Decision was rendered. Accordingly, I find that the challenge was raised by Dr. Hosseini too late and that the appeal grounds concerning it must be dismissed.

[204] In the event that I am wrong about that, I will analyze the substance of the complaint.

[205] Dr. Hosseini noted the development of a practice of appointing lawyers to such committees to avoid results seen in cases such *Wolfrom v Assn. of Professional*

Engineers and Geoscientists of the Province of Manitoba, 2001 MBCA 152, [2002] 2 WWR 616, and *Venczel v Ontario Assn. of Architects* (1989), 74 OR (2d) 755 (H Ct J). In those cases, discipline committees had engaged legal counsel who went beyond the roles of advisors and played active roles in the hearings and committee deliberations.

[206] Here, Dr. Hosseini finds fault with the appointment of a lawyer to be a member of the panel, arguing that his role impaired the independence of the Discipline Committee. She refers to *Canadian Pacific Ltd. v Matsqui Indian Band*, [1995] 1 SCR 3 [*Matsqui*], which held that a reasonable apprehension of bias can arise where:

> 98 ...
>
> (1) There is a complete absence of financial security for members of the tribunals;
>
> (2) Security of tenure is either completely absent (in the case of Siska), or ambiguous and therefore inadequate (in the case of Matsqui);
>
> (3) The tribunals, whose members are appointed by the Band Chiefs and Councils, are being asked to adjudicate a dispute pitting the interests of the bands against outside interests (i.e., those of the respondents). Effectively, the tribunal members must determine the interests of the very people, the bands, to whom they owe their appointments.

[207] In the next paragraph, the Supreme Court cautioned that it was the <u>combination</u> of those three factors that led to the conclusion that the appeal tribunals lacked sufficient independence. A single factor would not necessarily lead to that same conclusion.

[208] One must also not confuse the independence required of judges and those applicable to administrative tribunals. They are not the same. See, for example, of *Saskatchewan Federation of Labour v Government of Saskatchewan*, 2013 SKCA 61 at para 51, [2013] 9 WWR 515 [*SFL*].

[209] At para. 50 of *SFL*, the Court of Appeal stated that no greater degree of

independence is required of a particular tribunal than that required by its enabling statute. Accordingly, if the enabling statute permits the appointment of Mr. Gibson, which I have found that it did, the Court should not casually interfere in a case of pure speculation.

[210] No case similar to the present situation was cited to me. The decision I located that aligns most closely with this situation is *Katz v Vancouver Stock Exchange* (1995), 82 BCAC 16 [*Katz*], appeal dismissed by SCC (1996), [1996] 3 SCR 405. The context was the appointment of hearing panels as part of the regulation of securities traders by the stock exchange, which is one akin to the present case. The appellant complained only of the lack of institutional independence (lack of tenure and financial security) of the panel chair, who was a lawyer.

[211] With respect to security of tenure, there was evidence before the court in *Katz* concerning that which does not exist here. In brief, panel chairs were selected on a rotational basis subject to availability, and there had been little change in the group of lawyers from which the chair was selected in several years. Thus, *Katz* can be distinguished on that basis.

[212] More important is the court's discussion in *Katz* concerning security of remuneration. At para. 35 the court stated:

> 35 As to security of remuneration, the evidence is clear that the lawyer members submit their fee for services based on time spent and hourly rates, and these fee accounts are paid as rendered. It is true that the lawyer members do not have a written contract with the Exchange and there is nothing in the bylaws of the Exchange that would guarantee their security of remuneration. Their right to be paid their proper accounts for services rendered, however, must be presumed as a matter of law. There is no doubt about the purpose for which they are retained, or the specific services which they render.
>
> [Emphasis added]

[213] The financial security discussion in *Katz* would translate into the

following question in the present case: would Mr. Gibson have been paid irrespective of whether he was part of a Discipline Committee that convicted Dr. Hosseini? There is no suggestion that his payment depended on whether she was convicted.

[214] The financial security factor does not mean financial security for life or a specified duration. It means that the tribunal member's compensation is not subject to arbitrary interference by the appointing party. No evidence of that exists here. Mr. Gibson billed a substantial amount of fees and there is no suggestion that he went unpaid or was at any risk of being unpaid if the Discipline Committee did not convict. Indeed, in other cases, the lack of remuneration has led to arguments that tribunal members might lack independence. See *McOuat v Law Society of B.C.*, 2001 BCCA 104, [2001] 3 WWR 435. At some point, tribunals need to be able to operate free of arguments founded on pure speculation.

[215] Although evidence was not called here concerning the appointment of Mr. Gibson as it was concerning the lawyer chair in *Katz*, there is no suggestion that Mr. Gibson did not have security of tenure that would get him through the process of hearing the charges against Dr. Hosseini.

[216] The third factor in *Matsqui* was also addressed in *Katz*. At para. 30, the court in *Katz* expressly distinguished the case before it from *Matsqui*. The tribunal established by the stock exchange was not adjudicating a dispute against outside interests:

> 30 The facts in the present case are significantly different than those in ***Matsqui***. Here we have a self-regulating industry and a tribunal set up to protect the interests of the integrity of the industry itself as well as the investing public. That is a goal that must be viewed as common to every person engaged in the industry who comes under the jurisdiction of the Vancouver Stock Exchange.

[217] Finally, I have not encountered a single decision in which a reasonable apprehension of bias was found to exist because a tribunal member who was paid an

hourly rate charged considerably more than other members of that tribunal. There is no precedent for that assertion and I am unpersuaded by it.

[218] In my view, none of the three factors in *Matsqui* have been established to exist here. Two clearly do not exist. The one concerning security of tenure might exist, but was not established on evidence. I need not decide who would bear that onus as I would not find a reasonable apprehension of bias solely on that factor. The challenge was also raised late, after the witnesses had testified and the Discipline Committee had rendered the DC Decision.

[219] Finally, my review of the transcript discloses nothing to suggest that Mr. Gibson had disproportionate or outsized influence on the Discipline Committee's decision-making process. Though real bias need not be established, I see nothing to suggest even an appearance of bias.

[220] I find that the appeal on this question is without merit.

(iii) Was a reasonable perception of bias created by the questioning, rulings and determinations made by the Discipline Committee?

[221] I was directed to nothing that suggested to me that the Discipline Committee was anything but impartial. Nor in my review of the record did I encounter anything to suggest a lack of impartiality. I consider its questions to have been entirely fair and appropriate. I have examined its rulings and determinations in this decision and find no issue either.

[222] The appeal on this question is without merit.

Conclusion on Grounds (f)(i) and (ii)

[223] The appeal on Grounds (f)(i) and (ii) is unfounded.

Ground (g)(i) The Discipline Committee erred in law by imposing an order of costs in the amount of $50,000 which amount was excessive in the circumstances.

[224] The standard of review applicable to discretionary decisions will apply to this and the remaining ground.

[225] Section 34(2) of the *Act* gave the Discipline Committee broad discretion as to making an order in respect of costs of the investigation and hearing. The Discipline Committee held a penalty hearing in which Dr. Hosseini was given the opportunity to make submissions. The College asked for about $90,000, being about 75% of the costs it incurred, which included legal fees. In the Sentencing Decision rendered on May 2, 2019 (Sentencing Decision), the Discipline Committee ordered that Dr. Hosseini pay costs of $50,000, less than 50% of the College's costs.

[226] On the quantum of costs, Dr. Hosseini's written submissions stated that her only complaint on this specific ground was whether Dr. Wagner or other expert witnesses were needed. Had no impartial experts been called, I have little doubt that Dr. Hosseini would challenge that the Discipline Committee relied too much on its own expertise. Dr. Hosseini could have saved time and expense by not calling Dr. Toporowski, which was a questionable choice from the start. I find no issue with Dr. Wagner having been called to provide expert evidence.

[227] In oral argument, despite her written argument stating that the foregoing was the only issue concerning this ground, Dr. Hosseini focused on the costs being inappropriately high, which she said dovetails with the panel's composition. I have already disposed of her arguments concerning Mr. Gibson's role.

[228] The Sentencing Decision deals well and thoroughly with the submissions it received concerning costs, applicable case law, and comparables.

[229] I find no basis to interfere with the Sentencing Decision on this ground. Accordingly, this ground of appeal is unfounded.

Ground (g)(i) The Discipline Committee erred in law in excluding evidence of bad faith negotiation on the part of the Professional Conduct Committee with respect to costs and therefore failing to take that conduct into consideration on the question of costs.

[230] Emails were exchanged between the parties concerning possible resolution(s). They are set out in the record at tab 3.2.10. They were without prejudice negotiations. In the Penalty Decision the Discipline Committee stated:

> 46. In *Tucker-Lester, supra* [2012 SKQB 443] the court found a party is entitled to waive some types of privilege including solicitor-client and litigation privilege. However, settlement privilege is jointly held and cannot be waived by one party. In reviewing the correspondence found at D-10 and D-11 for identification, we have determined at no time was settlement privilege waived or intended to be waived by the PCC. Initially, there was discussion of a mediated resolution. None was reached. There was subsequent correspondence concerning moving forward with a joint costs agreement to place before the DC at the Sentencing Hearing but no such agreement was ever reached. Such dialogue is privileged. The offer discussed in the correspondence found in D-10 never came to fruition as there was no agreement. The PCC wanted to save the legal expense that it would incur preparing for and arguing the bias application and appeal, but Dr. H wanted the same argued. This panel sees the overall benefit in counsel engaging in open and frank discussions to try to reach a compromised position that can be jointly brought forward to the panel before a substantive hearing or at the time of sentencing. We find such discussions remain confidential until both parties agree to bring the same forward at the time of sentencing.

[231] I agree with the Discipline Committee's reasoning and find no basis to disturb its findings on the point. This ground of appeal is without merit.

CONCLUSION

[232] Dr. Hosseini's appeals on all grounds are dismissed.

[233] The College asks for costs in the amount of $2,000. In light of the many grounds of appeal and Dr. Hosseini's lack of success on any of them, I find its request for costs to be entirely reasonable. The College shall have costs to be fixed at $2,000.

J.

D.G. GERECKE