IN THE MATTER OF ***The Medical Profession Act, 1981*** and Dr. Mehdi Horri, Medical Practitioner

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN

-and-

DR. MEHDI HORRI

Decision of the Hearing Committee
Brian Scherman K.C.
Dr. Rupesh Chawla
Maya Scott

June 10, 2025

Counsel:

For the College of Physicians and Surgeons:
Evan Thompson and Luke Brisebois
For Dr. Horri:
David Thera and Kelsey O'Brien

Introduction

1. Following patient complaints, Council of the College of Physicians and Surgeons Saskatchewan (Council/CPSS) appointed a Preliminary Investigation Committee (PIC) consisting of Drs. Ann Doig and Angela McDougall to investigate the complaints. Following the PIC investigation and report Council laid 14 charges particularized in the Amended Notice of Hearing attached to this Decision as Schedule A and directed that these charges be heard by the Hearing Committee (the "Committee"). Subsequently Charge 7 was withdrawn. During the hearing counsel for the College of Physicians and Surgeons of Saskatchewan (the "College") advised they were not seeking a conviction on Charge 4.

2. The charges heard and decided by the Hearing Committee can be summarized as follows:
    a. One charge of failing to maintain the standard of practice of the profession arising from a surgical procedure on Patient 1 conducted by Dr. Horri in his clinic on October 4, 2022 - Charge 1;
    b. Eleven charges of unbecoming, improper, unprofessional or discreditable conduct relating to:
        i. The aforesaid surgery on Patient 1- Charge 2;
        ii. Failing to obtain an informed consent in relation to that surgery – Charge 3
        iii. Failing to have a chaperone present during procedures or encounters with Patients 1 and 2 [Charges 5 and 8] and with female patients generally throughout the years 2018 to 2023 [Charge 14], contrary to an undertaking he had given to the College in 2018 to have a chaperone present during all procedures or encounters involving female patients;
        iv. Altering medical records with relation to Patients' 1, 2 and 3 after becoming aware of CPSS investigations relating to those patients – Charges 6, 9, and 11;
        v. Inappropriately touching and/or commenting on female Patient 3's genitals during an examination – Charge 10;
        vi. Harassing or encouraging a potential witness in the College's investigation into his conduct to provide false information – Charge 12; and

vii. Failing to maintain appropriate medical records regarding Patients 1, 2 and 3 – Charge 13.

Applicable Legislation and Bylaws

3. The College specifically relies upon:
   a. Sections 46(o) and (p) of The Medical Profession Act, 1981(the "Act") and
   b. CPSS Bylaws
      i. 7.2 adopting the Code of Conduct with specific reference to section 7.2(l);
      ii. 8.1 (a) and (b), (vi), (ix), (xxii); and
      iii. 23.1.

These sections and bylaws are reproduced in part below as they existed in July through December of 2022, which is the relevant time period for the allegations contained in the various charges, with the exception of Charge 14.

The Act

46. Without restricting the generality of "unbecoming, improper, unprofessional or discreditable conduct", a person whose name is entered on a register is guilty of unbecoming, improper, unprofessional or discreditable conduct, if he or she:

...

(o) does or fails to do any act or thing where the discipline hearing committee considers that action or failure to be unbecoming, improper, unprofessional or discreditable;

(p) does or fails to do any act or thing where the council has, by bylaw, defined that act or failure to be unbecoming, improper, unprofessional or discreditable.

Bylaws

7.2 Code of Conduct

The CPSS expects that physicians will:

(l) Not harass, intimidate or threaten a person with whom the physician is connected in their practice of medicine.

8.1 Bylaws Defining Unbecoming, Improper, Unprofessional or Discreditable Conduct

(a) In this section:

(i) "standard of practice of the profession" means the usually and generally accepted standards of practice expected in the branches of medicine in which the physician is practicing.

…

(b) The following acts or failures are defined to be unbecoming, improper, unprofessional or discreditable conduct for the purpose of Section 46(p) of the Act. The enumeration of this conduct does not limit the ability of Discipline Hearing Committees to determine that conduct of a physician is unbecoming,

improper, unprofessional or discreditable pursuant to Section 46(o):

. . .

(vi) Falsifying a record in respect of the examination or treatment of a patient.

(ix) Failing to maintain the standard of practice of the profession.

. . .

Bylaw 8.1 was amended subsequent to the subject charges being laid to provide that *A physician does not fail to maintain the standard of the profession if there exists a responsible and competent body of professional opinion that supports the physician's conduct or judgment.*

23.1 Medical Records

(a) All members of the College of Physicians and Surgeons of Saskatchewan shall keep, as a minimum requirement, the following records in connection with their practice:

i) In respect of each patient a legibly written or typewritten record setting out the name, address, birthdate and Provincial Health Care Number of the patient;

(ii) In respect of each patient contact, a legibly written or typewritten record setting out:

1. the date that the member sees the patient;
2. a record of the assessment of the patient which includes the history obtained, particulars of the physical examination, the investigations ordered and where possible, the diagnosis; and
3. a record of the disposition of the patient including the treatment provided or prescriptions written by the member, professional advice given and particulars of any referral that may have been made. Prescribing information should include the name of medication, strength, dosage and any other directions for use.

(b). The patient record should include every report received respecting a patient from another member or other health professional.

(c) The records are to be in the English language and kept in a systematic manner.

(d) The records must be completed in a timely manner.

(e) The records may be made and maintained in an electronic computer system providing:

(i) the system provides a visual display of the recorded information;

(ii) the system provides a means of access to the record of each patient by the patient's name and if the person has a Provincial Health Care Number, by the health number;

(iii) the system is capable of printing the record information promptly;

(iv) the system is capable of visually displaying the recorded information for each patient in chronological order;

(v) the system maintains an audit trail that:

1. records the date and time of each entry of information for each patient;
2. indicates any changes in the recorded information;
3. preserves the original content of the recorded information when changed or updated; and
4. is capable of being printed separately from the recorded information of each patient;
5. the system includes a password or otherwise provides reasonable protection against unauthorized access, and
6. the system backs up files and allows the recovery of backed up files or otherwise provides reasonable protection against loss of, damage to and inaccessibility of information.

. . .

Applicable Legal Principles

4. The College and Dr. Horri appropriately agree that:
    a. The College bears the burden of proof in disciplinary matters. This includes factual allegations relevant to the charges and what the relevant standards of the profession are.
    b. The standard of proof is proof on the balance of probabilities regarding which burden the Supreme Court of Canada said in *FH v McDougall* 2008 SCC 53 at paragraph 46:

> Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. But again, there is no objective standard to measure sufficiency. In serious cases, like the present, judges may be faced with evidence of events that are alleged to have occurred many years before, where there is little other evidence than that of the plaintiff and defendant. As difficult as the task may be, the judge must make a decision. If a responsible judge finds for the plaintiff, it must be accepted that the evidence was sufficiently clear, convincing and cogent to that judge that the plaintiff satisfied the balance of probabilities test. (emphasis added)

    c. The Committee's factual findings must be based on the evidence received and not on personal experience, knowledge or opinion.
    d. Committee members may use specialized knowledge or expertise in assessing the evidence; but not to enhance the evidence.
    e. The standard of practice of the profession must be proven through experts qualified to give such evidence.
    f. What is unprofessional conduct is to be determined by the standards of the medical profession.

> See; *Green v The College of Physicians and Surgeons Saskatchewan* 1986 CanLII 3238 (Sask C.A.) paras 13, 21and 10-12; *Ali v. The College of Physicians and Surgeons Saskatchewan* 2013 SKQB 38 at para. 32; *Huerto v The College of Physicians and Surgeons Saskatchewan* (1994) 124 Sask. R. 3 (C.A.) 3 at para 20 and 1999 CanLII 12552 (SKKB)at para 86.

5. The assessment of witness credibility and reliability is central to the fact-finding process. Without the relevant facts being found we cannot proceed to the next step of determining whether the charges have been proven. The Committee has made its assessments of the

credibility and reliability of the various witnesses with full regard to those factors and submissions made by Counsel in both their written and oral submissions. Where specific credibility or reliability discussion is necessary or appropriate, we do so in our analysis of the proof of the various charges.

Agreed Facts

6. An Agreed Statement of Facts between CPSS and Dr. Horri was filed as Exhibit C1 on the Hearing, which agreed facts are background facts to this decision.

Have the Charges been proven?

Charge 1 Unprofessional conduct by performing a surgical procedure on Patient 1 that did not maintain the standard of practice of the profession

7. The College specified the particulars of the conduct alleged to be "unbecoming, improper, unprofessional or discreditable conduct" (for the balance of the decision we shorthand this phrase and concept by using the phrase "conduct unbecoming") being that he:

   "performed a surgical procedure in regard to [Patient #1] without adequate prior investigation and/or without obtaining an opinion from a surgeon and/or thereby did not maintain the standard of practice of the profession".

8. As the Charge is particularized, the failure to maintain the standard of practice of the profession is based on the specific allegation of having performed a surgical procedure without adequate prior investigation and/or obtaining an opinion from a surgeon. This is a standalone and particularized charge that is to be decided without reference to the allegations particularized in Charges 2 and 3. Thus, in deciding Charge 1 we do not consider whether Dr. Horri applied sufficient clinical knowledge, surgical skills or had an informed consent. Those allegations will be assessed separately.

9. For Charge 1 to be proven we need clear, convincing and cogent evidence of experts as to:

i. whether Dr. Horri's prior investigation was inadequate and/or what additional investigations were called for, by the standards of the profession, before the surgical procedure conducted should be performed; and

ii. did the standards of the profession require obtaining an opinion from a surgeon before he performed the procedure.

10. The evidence of Patient 1, [redacted] and Dr. Horri regarding the investigation by Dr. Horri can be summarized as follows:

Patient 1 testified that:

a. On August 2, 2022, she attended at Dr. Horri's office for a PAP smear test. She testified that she had a lump in the area of her left armpit that was bothering her. She knew it had to be addressed at some point and said she had put it off as long as she should and so raised it with Dr. Horri.

b. She informed Dr. Horri that some years previous she had a growth in her right armpit, removed by a surgeon in a hospital, which was found to be excess breast tissue. She thought her left side growth was the same.

c. Dr. Horri looked at the right-side scar and examined her left-side lump. She said he spent a long time, examining the lump with his hand, moving it around and asked if it was painful. She said he felt it was probably a swollen lymph node, he could do it in his office and she took from their conversation that he was talking about draining a lymph node.

d. Dr. Horri made it sound like the best option for her was to do it in his office and, she then said "Sounds Good. Let's do it." This we understand to be what she said to Dr. Horri at the time. He told her that, if she wanted to proceed, she should book an appointment at his Thursday lumps and bumps clinic.

e. While they discussed her history of removal of the right-side lump there was no discussion about obtaining that prior record. She also said there was no discussion of getting an ultrasound. In response to a specific question about whether there was anything about the risks and benefits being provided "in writing", her answer was no and that she did not provide a written consent.

f. She could not remember during her evidence in chief whether she booked a lumps and bumps clinic appointment that day or phoned it in subsequently. Exhibits on the hearing and her testimony on cross examination make it clear she subsequently made the booking for the lumps and bumps clinic by phone.

Dr. Horri testified that:

g. He had no present recollection of the August 2, 2022, examination of the lump nor of the October 4, 2022, surgical procedure. For the purposes of his testimony, he relied on his medical records, what his standard practice is and paraclinical information. On examination he found there to be a non-tender mobile round lesion and based on his standard practice he would have discussed with Patient 1 the possibilities of it being a lipoma, a cyst or a lymph node and that there is often no need to do anything with such a lump. If she wanted it removed, he would have given her the option of excision in his office or referral to a general surgeon for removal on the basis that this was his standard practice. He said the gold standard to identify precisely what such a lump is, is to remove it and send it for pathology. He said there was no need for other investigations and he would not have suggested doing a lymph node drainage because that is not something he has ever done.

[redacted] testified that:

h. She was present at the August 2, 2022, PAP smear procedure and during the examination and discussion of the lump on Patient 1's left side. After the PAP procedure there was a discussion about Patient 1's left "axilla" and that she had a "lipoma" there. They discussed a treatment plan which included a discussion about doing it in the office under local anaesthetic or for a referral to a general surgeon to remove it under a general anaesthetic.

i. When ask by College Counsel to describe the conversation in general words without medical terms she said, referring to what Patient 1 was stating: "I have a lump, I want it gone. How can we remove it".

j. When asked why she used the word "lipoma", Ms. [redacted] said it was because she previously had a lipoma in her right armpit removed in hospital under a general and

thus had a conversation with Patient 1 telling her that she viewed such a removal as an uncomfortable experience and suggested to Patient 1 that she consider having it done in the hospital under a general anaesthetic.

The evidence of the experts

Dr. Strydom

11. Dr. Eben Strydom, called by the College and Dr. Brian Geller, called by the Defence, prepared written reports based upon assumptions they were provided. Counsel for the College and Dr. Horri agreed that both of these physicians had the qualifications to provide opinion evidence as to the standards of practice of the family physician profession. Their written reports of opinions are found at Tabs 19 and 20 of Exhibit C1. Counsel for both the College and Dr. Horri agreed these written reports were to be treated as part of their hearing opinion evidence; along with their in-person testimony at the hearing.

12. Dr. Strydom stated his evidence that Dr. Horri failed to meet the standard of practice of the profession in that he should not have performed the surgery without additional prior investigation consisting of obtaining the medical records of the prior right-side excision, a related family history, an ultrasound imaging and a surgeon's opinion. He was of the opinion that:

    a. Knowledge of Patient 1's history of a right-side lump, that on pathological examination was determined to be accessory mammary tissue, should have led to accessory mammary tissue as the likely diagnosis, as opposed to lipoma or lymph node.
    b. An ultrasound should have been obtained to inform future care as it can well differentiate cysts, accessory mammary tissue or lymph nodes with almost a hundred percent accuracy and their relationship to underlying structures and vascularity.
    c. The axilla is anatomically a very complex area with dense neurovascular and lymphatic structures such that an adequate prior investigation should typically include obtaining an opinion from a surgeon.

d. Removal of the axilla area lump or lesion in an in-office invasive procedure as described in the Statement of Assumptions does not meet the standard of practice of a family physician.

13. Dr. Strydom did not provide a definitive opinion that an opinion of a surgeon must be sought, but stated that in the vast majority of cases it would be appropriate for a family physician to obtain an opinion from a surgeon. He was of the opinion that given the risks associated with axilla surgery such surgery should occur in a hospital where supports beyond those available in a clinical office procedure room would be available. He stated he personally would not do axilla surgery outside of a hospital setting.

14. We are not satisfied that the evidence of Patient 1 on these and other aspects of her evidence is reliable for the following reasons:
    a. Her own evidence is that Dr. Horri conducted a lengthy examination of the lump during which he told her:
        i. he did not think it was breast tissue and was probably a swollen lymph node [time register 51.48];
        ii. at time register 52.49 he could fix it in his office, she didn't need to go the hospital, she didn't need to go through what she went through before and he made it sound like that was the best option for her; and
        iii. at time register 53.35 she agreed to that saying "that sounds really great. Sounds good. Let's do that."
    b. At no time when discussing that August 2, 2022, examination did she expressly state Dr. Horri was speaking of draining a lymph node; albeit during cross examination, while saying she could not state his exact words, she said that what she 'took' from that conversation was that he was going to drain a lymph node [time register 27.52].
    c. During cross examination, when put to her that Dr. Horri told her at the August meeting he could refer her to surgeon to have it removed under a general anaesthetic she responded [at time register 30.19] she "didn't feel like he offered that". At 31.56 she acknowledged she could not deny that she was told this was an option, but said that is not what she remembers.

d. On cross examination she agreed [32.09 to 32.27] that she made the choice to have what she though was something being drained at his office but knew she had options.
e. She did not remember the chaperone telling her that the chaperone had a lump removed under general anaesthetic and she should think about that, but at 33.12 stated "she spoke a lot during so I don't remember everything she said".
f. During her evidence in chief, she could not remember whether she booked the October 4, 2022, procedure on August 2, 2022, while in the office or later by telephone. During cross examination she acknowledged she would have booked it later by telephone.
g. The Ex. C1 Tab 19 record of the booking shows the appointment booking to be for "LT ARMPIT LYMPH NODE DRAINAGE/REMOVAL". Although disputed by Patient 1, we conclude she was the likely source of the information. Common sense leads to the conclusion that this information would probably have come from Patient 1 since the person receiving the call to book an appointment would likely have no other way of knowing why the patient was seeking a lumps and bumps clinic appointment.

15. Dr. Horri's evidence is that his standard practice in such cases would be:
    a. After examination to provide his differential diagnosis, which he said would have been a lipoma, a cyst or a lymph node, he advises such patients that there is often no need to do anything.
    b. If the patient wanted the lump or lesion removed, he would have given the option of excision in his office or referral to a general surgeon for removal.
    c. The gold standard to identify precisely what a lump or lesion is, is to remove it and send it for pathology. He said there was no need for other investigations and he would not have suggested doing a lymph node drainage because that is not something he has ever done.

16. The College's position is that Dr. Horri failed to meet the standard of practice of the profession by reason that he performed the surgery without adequate investigation and/or without obtaining an opinion from a surgeon. On these alleged particulars of Charge 1, relying on the evidence of Dr Strydom, the College took the position that:

a. an adequate investigation included obtaining a relevant family history, obtaining the medical records respecting the prior right side lump removal, and investigating the subject lump by ultrasound for the information this would provide before making the decision to proceed; and
b. given the risks of surgery in the axilla area an opinion of a surgeon should have been sought.

17. Dr Strydom's opinion was based on the Statement of Assumptions he was provided. These assumptions included, inter alia:
    i. Dr Horri told Patient 1 that she had a swollen lymph node that was filled with liquid and that it would be a simple and easy procedure to drain it in his office; and
    ii. Patient 1 told Dr. Horri she was there to get a lymph node drained and that Dr. Horri did not explain what the procedure would entail.

18. We find that the assumptions outlined in the Assumption of Circumstances forming part of Ex D-2 for ID and by Dr. Geller at page 2 of his written report to be proven facts, with the exception of the statement that "Consent was documented".

19. We conclude it is more likely that the August 2, 2022, examination proceeded consistent with what Dr. Horri stated to be his standard practice than Patient 1's recollections, sense or feelings as to what transpired.

20. It is significant that Patient 1 did not book a procedure on August 2, 2022. This fact is consistent with taking time to think about what she was going to do; having been given the options of doing nothing, or having the procedure in the office or by a surgeon under a general.

21. The evidence of the witness [redacted] is significant in this and other respects. She testified that after the PAP procedure, for which she was present:

a. there was a discussion between the patient and Dr. Horri about Patient 1's left "axilla" and that she had a "lipoma" there;
b. There was discussion of a treatment plan which included a discussion about doing it in the office under local anaesthetic or for a referral to a general surgeon to remove it under a general; and
c. [redacted] herself had a discussion with Patient 1 suggesting she consider having the procedure done in the hospital under general anaesthetic given her own experience with the removal of a lipoma from her armpit.

22. Ms. [redacted], following a full-time course at Sask Polytechnical, had 20 years experience as a nurse's aide in various health care facilities including St Joseph's Hospital in Estevan. It is logical that Ms. [redacted], who was only an occasional chaperone in Dr. Horri's clinic and having herself had a lipoma removed under a general anaesthetic, would have been focused on the discussions surrounding the Patient 1's lump in her axilla and any treatment plan being discussed since she herself had undergone a hospital excision of her lipoma. Further, given her view that surgery under a general anaesthetic was the way to go, it is an understandable human reaction for her to share her views in such circumstances.

23. We are satisfied that Ms. [redacted]'s evidence is credible and reliable. The evidence of Ms. [redacted] referenced above was presented by her when called by the College as its witness. Given our conclusion that the evidence of Ms. [redacted] is credible and reliable contributes to our view that the evidence of Patient 1 is unreliable. As noted above at paragraph 15 Patient 1's evidence was, in various respects, lacking precision using descriptors like she "felt" or "thought".

24. Although in closing submissions Counsel for the College suggested Ms. [redacted] may, in respect to aspects of her evidence, have had a reason to be partial to Dr. Horri in light of a past personal relationship, we find no basis to conclude that Ms. [redacted]'s evidence is not both credible and reliable. The evidence she gave included evidence of a text message exchange between her and Dr. Horri (Ex. C1 Tab 24) that the College relies upon for Count 12. Ms. [redacted] voluntarily provided this evidence to the PIC after being interviewed by the PIC and, at this Committee's hearing, gave evidence to prove the fact of this text exchange; which

evidence is potentially negative for Dr. Horri. We are unable to conclude that Ms. [redacted] presented as a witness partial to Dr. Horri in her testimony and find her evidence to be both credible and reliable.

25. If, as Patient 1 testified she told Dr. Horri on October 4, 2022, that she was there to have a lymph node drained, it makes no sense he would none the less have proceeded to excise the "lump". That would not merely be a failure to obtain informed consent, but an assault. Dr. Horri testified it was not his practice to drain lymph nodes. The pathological report of the specimen described it as "mature adipose and fibrous tissue consistent with lipoma". This result supports that Dr. Horri's assessment and treatment of the lump was of it being something to be excised as opposed to being a lymph node that could appropriately be dealt with by aspiration or drainage.

26. As of June 23, 2023, Bylaw 8.1(a)(i) which defined "standard of practice of the profession" was amended by adding to the prior text the following:

> *A physician does not fail to maintain the standard of practice of the profession if there exists a responsible and competent body of professional opinion that supports the physicians conduct or judgement*

27. We are of the opinion that this amendment had the effect of making express what was implicit in the prior definition that 'standard of practice of the profession' means the "usually and generally accepted" standards of practice. The words "a responsible and competent body of professional opinion" can reasonably be interpreted as equivalent to "usually and generally accepted standards of practice" and we so interpreted the definition as it existed at the time Charge 1 was laid.

28. In *Huerto v College of Physicians and Surgeons* 2004 SKQB 360 Justice Smith quoted with approval the following from the Hearing Committee's decision in that case:

> . . . a physician with a high level of skill may conscientiously make a clinical choice which has a negative effect, and most such "mere errors of judgment" do not constitute a departure from the standards of the profession. They are simply an inevitable component of human judgment, no matter how informed and careful….
> A physician may also, of course, commit errors of a careless nature

> which do represent a lapse in compliance with the professional standard expected of a reasonable physician, and these may be characterized as "negligent." As with most errors of judgment, most conduct described as negligent does not raise questions of the suitability of the physician as a member of the profession or invoke the disciplinary authority of the College of Physicians and Surgeons.

29. If an error of judgment does not constitute a departure from the standard of practice of the profession, it must surely follow that actions in respect of which there exists a responsible and competent body of professional opinion that supports the physician's conduct or judgement does not constitute a departure from the standards of the profession.

30. Given the evidence of Dr. Geller, we conclude that there does exist within the profession a responsible and competent body of professional opinion supporting Dr. Horri's action of conducting the surgery in question in his clinic without prior investigation beyond the examination he conducted and/or without obtaining the opinion of a surgeon.

31. We find that the opinions expressed by Dr. Geller at pages 2 and 3 of his report establish there is a responsible and competent body of professional opinion supporting Dr. Horri's actions in conducting the surgery in question as and when he performed it. In this respect we have specific reference to the final two paragraphs on page 2 of his report and the reasons he therein advances for his opinion. We find such reasons to be appropriate considerations.

32. During his oral evidence Dr Geller expressly stated that not all surgery in the armpit area should be treated as having the axilla surgery risks that concerned Dr. Strydom. On cross examination he stated, inter alia, the following:

> Speaker 3 (01:06:24):
> So I just want to make sure that we're clarifying our terms a little bit. So in general, the armpit is referred to as the axilla, but if you're talking about surgery, generally when we talk about surgery in the axilla, we're talking about deeper surgeries that go extend down closer to the brachial plexus or some of the major arteries. And so that would be an axillary surgery. I would not classify the removal of a subcutaneous lesion from the axilla or armpit as axillary surgery

33. It is significant to note that during his oral evidence Dr. Strydom made statements to the effect that:

    i. If a patient can provide information on the pathology of a prior extraction he may accept it; but if he was not satisfied with what the patient can provide then he would follow up on prior records;
    ii. The standard of practice for a differential diagnosis depends on what the patient wants and what he the physician thinks should be done;
    iii. While the comfort level of physicians differ, from his personal perspective he would have done more to investigate what the lesion on the axilla was; and
    iv. With regard to the procedure on Patient 1, he did not think the standard of practice of the profession was adhered to because of the location and the fact that the lack of support would make it challenging.

In respect of point iv above it needs to be noted that the College at conclusion of the evidence advised that they were not relying on the particular stated in Charge 2 of having performed the surgical procedure in an office unsuited for the procedure.

34. It was evident to the Committee that Dr Strydom has a demanding personal standard regarding when, where and in what circumstances he would conduct other than the most routine excision. His personal practice was to book his "lumps and bumps" surgical procedures into the hospital's emergency room which would have facilities and support personnel beyond those available in a physician's procedure room. Further he had demanding personal standards with respect to any surgical procedure in the axilla.

35. These statements are in no way to be taken as a criticism of Dr. Strydom, his personal standards and his view of what are the appropriate standards of practice. However, we find more compelling the opinion of Dr. Geller that it was within the standards of the profession for Dr. Horri to conduct the surgery in question in his clinical procedure room and to do so without additional investigations, an ultrasound or obtaining an opinion from a surgeon.

Conclusion on Charge 1

36. The burden on the College to prove on the balance of probabilities that Dr. Horri failed to maintain the standard of practice of the profession includes satisfying us that there is not within the profession a responsible and competent body of professional opinion that supports the physician's conduct or judgement. There may be more than one prevailing view within the profession as to how to deal with the situation that Dr. Horri was dealing with. Even if the evidence was that the majority view within the profession was Dr. Strydom's view; that would not condemn a differing responsible and competent body of professional opinion to the status of failing to maintain the standards of the profession. Accepting the opinion evidence of Dr. Geller and based upon our analysis of the evidence of Patient 1, Ms. [redacted] and Dr. Horri, we conclude that the College has failed to prove Charge 1 on the balance of probabilities

Charge 2 Failing to maintain the standard of practice of the profession by performing a surgery in an unsuited office setting and/or by not applying sufficient clinical knowledge or skill

37. This charge of unprofessional conduct is based on the particular allegation that Dr. Horri did not apply sufficient clinical knowledge or surgical skills for the procedure performed. It is to be noted that the Charge relates to a failure during the procedure; not matters arising prior to or after the procedure. As noted, the College has advised they do not rely on the particular alleged that he performed the surgical procedure in an office setting unsuited for the procedure and that they are not seeking a conviction on Charge 4.

38. The College, having taken the position that they are not relying on the allegation of Dr. Horri having performed the surgery in an office setting unsuited for the procedure, the remaining evidence with respect to the allegation of failing to apply sufficient clinical knowledge or surgical skills largely related to two matters namely:

    i. The use of two parallel incisions to remove the lesion or lipoma as opposed to a more common single C shaped incision; and

ii. Whether the subsequent bleeding and hematoma the patient endured was the consequence of failure on the part of Dr. Horri to effect adequate hemostasis.

39. Dr Strydom's report provided his opinion with respect to this charge at pages 7 and 8 of Ex C1 Tab 19 under the number 7. There he stated the initial assessment was inadequate by reason of failing to incorporate the known history of mammary tissue in the right axilla. Charge 2 does not allege this as a failing. What remains of Charge 2 after the College advising it does not rely on the allegation of the office setting was unsuited to the procedure are the above noted particulars relating to the performance of the procedure. Thus, the above noted opinion of Dr. Strydom is not of assistance in deciding Charge 2.

40. Dr Strydom then goes on to express the opinion that

a. Attempting to remove the lesion in his office procedure room demonstrated an under appreciation of the risks involved for the patient and difficulties for the surgeon should complications arise based on a "neurovascular mind field when dissecting the axilla"; and

b. The use of two incisions was unusual and the excessive bleeding was indicative of injury to one or more blood vessels which were not ligated or controlled resulting in postoperative bleeding and hematoma formation.

41. He opined that Dr. Horri did not apply sufficient clinical knowledge or surgical skills for the procedure performed because he regards the axilla as a neurovascular minefield and thus a procedure room as not an appropriate facility to do the surgery. In his evidence, he acknowledged he did not know what the procedure room looked like, the lighting and whether cauterization equipment was available. Nor was there evidence of what was done or not done in respect of the bleeding issues during the surgery.

42. The opinion of Dr Geller previously discussed was to the effect that:

i. such surgeries by family physicians in their procedure rooms is within the standard of practice of the profession;

ii. Lesion dissections from armpits are often superficial and are not appropriately described as axilla surgery;
iii. Bleeding is a common risk of any surgery and even if steps are taken to achieve hemostasis, subsequent bleeding and hematomas can result.

43. Given Dr Strydom did not know any details of Dr. Horri's procedure room facilities, what bleeding issues were encountered or what was done or not done in respect of hemostasis it is our conclusion that his view that any surgery in the axilla is a minefield is overly general. There is no evidence that the surgery in question penetrated into the deeper vascular and other structure of the axilla. We find his stated opinions that two incisions were "unusual" without more and his unsupported conclusion that one or more blood vessels were not ligated or controlled are opinions that do not carry sufficient weight to discharge the burden of proof of the charge.

Conclusion on Charge 2

44. The Committee concludes that Charge 2 has not been proven by the College on the balance of probabilities requirement.

Charge 3 - Failing to obtain an informed Consent for the surgical procedure on Patient 1

45. In Defense Counsel's Brief of Law for the Committee they submitted the following as the law regarding informed consent:

> 28. Charge 3 alleges that Dr. Horri failed to obtain informed consent for the procedure performed on Patient 1. Generally, informed consent requires a physician to inform a patient of any unusual or special risks before proceeding with a medical treatment.[31] Doctors do not, however, have a duty to disclose every conceivable risk that may occur during a medical procedure. An objective approach must be taken when deciding whether a risk is material and ought to be disclosed; the central question becomes whether a reasonable person in the patient's position would want to know of the risk.[32] As a general rule, a doctor must answer any specific questions posed by the patient.[33] Because the specific requirements for informed consent will vary depending on the treatment or procedure at issue, among other factors, expert evidence is particularly helpful when assessing consent issues as possible unprofessional conduct.
>
> 29. Importantly, consent to treatment may be express or implied. The Canadian Medical Protective Association's "Consent – A Guide for Canadian Physicians" is accepted by the College as an authoritative statement of the requirements for consent in its Informed Consent Guideline (September 2011). It states as follows regarding implied consent:
>
> Much of a physician's work is done on the basis of **consent which**

> **is implied either by the words or the behaviour of the patient or by the circumstances under which treatment is given. For example, it is common for a patient to arrange an appointment with a physician, to keep the appointment,** to volunteer a history, to answer questions relating to the history and **to submit without objection to physical examination. In these circumstances consent for the examination is clearly implied.** To avoid misunderstanding, however, it may be prudent to state to the patient an intention to examine the breasts, genitals or rectum. The foregoing notwithstanding, in many situations the extent to which consent was implied may later become a matter of disagreement. Physicians should be reasonably confident the actions of the patient imply permission for the examinations, investigations and treatments proposed. When there is doubt, it is preferable the consent be expressed, either orally or in writing.[34]

30. Implied consent was further explained in *Allan v New Mount Sinai Hospital*:

> …**An actual, subjective consent, however, is not always necessary if the doctor reasonably believes that the patient has consented.** Thus, if a patient holds up an arm for a vaccination, and the doctor does one, reasonably believing that the patient is consenting to it, the patient cannot complain afterwards that there was no consent: *O'Brien v. Cunard SS. Co* (1891), 28 N.E. 266. Silence by a patient, however, is not necessarily a consent. Whether a doctor can reasonably infer that a consent was given by a patient, or whether he cannot infer such consent, and must respect the wishes of the patient, as foolish as they may be, always depends on the circumstances. [35]

31. Consent may be implied from the words or conduct of a patient.[36] In assessing implied consent, the question is whether a reasonable person in the physician's position would have thought that the patient consented to the treatment.[37]

[29] *Visconti v College of Physicians and Surgeons of Alberta*, 2010 ABCA 250 (CanLII) at para 15 [*Visconti*].
[30] *Ibid* at para 12 citing *Re Golomb and College of Physicians and Surgeons of Ontario*, 1976 CanLII 752 (ONSC);
Bryan Salte, *The Law of Professional Regulation*, 2nd ed (Toronto: Lexis Nexis, 2023) at page 155.
[31] *Reibl v Hughes*, 1980 CanLII 23 (SCC), [1980] 2 SCR 880; *Gerelus v Lim et al*., 2008 MBCA 89 (CanLII), at
para 29 [*Gerelus 2008*].
[32] *Gerelus 2008, ibid* at para 33, citing *Ciarlariello v Schacter*, 1993 CanLII 138 (SCC), [1993] 2 SCR 119.
[33] *Gerelus et al v Lim et al*, 2006 MBQB 194 (CanLII) at para 123 [*Gerelus 2006*].11
[34] Page 4, emphasis added.
[35] *Allan v New Mount Sinai Hospital* (1980), 1981 CanLII 1694 (ON SC), 109 DLR (3d) 634, 28 OR (2d) 356 (Ont
HC), at para 28. Appeal allowed on a different point in (1981), 1981 CanLII 3002 (ON CA), 125 DLR (3d) 276 (Ont
CA).
[36] *Kemp v Vancouver Coastal Authority Ltd.,* 2017 BCCA 229 (CanLII) at para 105.
[37] *Glaholt v Ross*, 2011 BCSC 1133 (CanLII)) at para 188, [2011] BCJ No 1593 (BC SC.

46. Council for the College did not take issue with this overall statement of the law and the relevant considerations. We view the foregoing as a fair summary statement of applicable law and the legal principles we are to apply.

47. The subject charge of failing to obtain an informed consent has two distinct aspects. The first being whether the patient was sufficiently informed of the risks and the benefits of the proposed procedure(s) and the second being whether there was in fact a consent given. The first aspect largely involves what was discussed on August 2, 2022. The second involves what transpired on October 4, 2022, and whether an express or implied consent existed in respect of the specific procedure that occurred that date. For the reasons the follow we are of the opinion that the operating issue here is whether a consent was provided on October 4, 2022.

48. The opinion evidence relating to consent is quite limited. At Topics or Questions 10 and 11 of his Opinion letter or Report, Dr. Strydom provides an opinion respecting information he views should be provided by a physician to a patient in order to provide an informed consent respecting the removal of a 2x2 lump from the left axilla. He does not however express an opinion on whether or not Dr. Horri failed to meet the standards of practice in the profession. That is appropriate because an opinion on whether there was an informed consent can only be made with all the facts surrounding the consent issue being stated and an opinion given based on those assumed facts. The only factual circumstances respecting consent in the Statement of Assumptions he was given is at his point 19 of his report to the effect that Dr. Horri did not have the patient sign a consent form. For his part Dr. Geller expressed no opinion on the topic of consent.

49. Regarding the information provided aspect, Patient 1 was asked at time register 55.23 and responded as follows:

> Did Dr. Horri say anything to you at that time about any risks associated with cutting into the axilla, that part of body in particular? No.
> Was there any information that was provided to you in writing? No.
> Like about the procedure or risks, benefits, that sort of options, that sort of thing?
> No, nothing like that.

50. Weighing against this evidence is the evidence of Ms. [redacted] that after the PAP procedure there was a discussion about Patient 1's left "axilla", that she had a "lipoma" there and they discussed a treatment plan which included a discussion about doing it in the office under local anaesthetic or for a referral to a general surgeon to remove it under a general anaesthetic.

When asked to describe the conversation in general words without medical terms, she said referring to what Patient 1 was stating: "I have a lump, I want it gone. How can we remove it".

51. In cross examination, while stating she had no recollection of her physician discussing the risks of her 2008 right axilla surgery, Patient 1 acknowledged she would have been aware of the risks associated with the surgery including bleeding and infections. That being so, it is logical to conclude she would, in August of 2022, have similarly been aware of such risks being associated with armpit surgery. However, her evidence was she understood Dr. Horri's view at the time to be that what she had was a swollen lymph node that could be drained.

52. On the benefits side, Dr. Horri's evidence was that his standard practice was he would have discussed with her the possibilities of it being a lipoma, a cyst, or a lymph node and that there is often no need to do anything. Given that Patient 1 was, by reason of her prior axilla surgery, aware of the risks associated with axilla surgery any discussion with Dr. Horri may have been brief, thereby explaining her lack of memory of such discussion.

53. We are left in a situation where given the conflicting evidence as to what was discussed on August 2, 2022, we are unable to conclude that it has been proven that there was a failure to on Dr. Horri's part to fulfill the information aspect regarding the potential nature of the lump then examined and the potential procedures discussed. That said, we also find no decision was made by Patient 1 on August 2, 2022, and thus no consent was given that date. The EMR records for August 2, 2022, do not note a consent then given and we are of the opinion the decision on Charge 3 necessarily turns on whether a consent was given on October 4, 2022, to the specific procedure that occurred that day.

54. The evidence is clear no written consent was given. Nor does it support a finding that a verbal consent was provided on October 4, 2022. As stated in the Informed Consent Guidelines quoted at paragraph 28 of Defence Counsel's Brief, consent can be implied either by the words or behaviour of the patient or by the circumstances under which treatment is given. As stated in the decision quoted at paragraph 30 of that Brief: "An actual subjective consent,

however, is not always necessary if the doctor reasonably believes that a patient has consented."

55. The relevant evidence is quite limited. The only reference to consent in the entire evidence of Patient 1 was the following at time register 55.44:

> Q. Did he provide you with a written consent form or written consent to sign
> A. No

56. The evidence of Dr. Horri was also limited, referencing asking Patient 1 on October 4, 2022, what she was there for and stating she lifted her arm in response. Dr. Horri's only express evidence on the topic of consent is found at time record 1.28.21, in cross-examination, where it had been put to him that on October 4, 2022, he didn't go back and look to the record prior to starting the procedure, to which he agreed. He then stated as follows:

> I didn't see any need to. You will have the same discussion that we had on the day that I talked about the procedure and consent on the day of to make sure that they know what we are doing and make sure that they are still agreeable to proceed.

There clearly was no consent given on August 2, 2022, since at that point Patient 1 was told if she wished to proceed she was to make a lumps and bumps clinic appointment, which she did not do that date.

57. There was no EMR record of nor express testimony of Dr. Horri regarding what was done on October 4, 2022, "to make sure that they know what we are doing and make sure that they are still agreeable to proceed". What we find is that "on the day of" the procedure he proceeded on the basis that given their discussions of August 2, 2022, the fact that Patient 1 had booked a lumps and bumps appointment and her lifting her arm in response to his question regarding what she was there for he assumed she was consenting to a surgical process of extraction of a lesion or lump in her armpit.

58. We find that an implied consent to the surgical procedure that occurred on October 4, 2022, cannot be properly inferred for the following reasons:

a. In the opinions of both Drs. Strydom and Geller the standard of practice for an informed consent would not be met if the patient did not understand what the proposed procedure was and what it entailed.
b. The EMR's of August 2 and October 4, 2022, do not document a verbal consent having been given to any specific procedure.
c. The initial discussion regarding the lump on August 2, 2022, was 3-5 minutes long and occurred 2 months before the procedure was completed. The evidence makes it clear that no consent was given that day. Patient 1 left apparently having been told that if she wished to proceed with aspiration of a swollen lymph mode or removal of a lump, she was to book a lumps and bumps clinic appointment.
d. Based on the evidence as a whole, we conclude Patient 1 attended on October 4, 2022, not understanding what specific procedure was going to occur. Was it a drainage or was it an excision? The clinic's record relating to her appointment booking indicates discussion of the alternatives of drainage or removal.
e. Little to no conversation occurred between Dr. Horri and Patient 1 prior to the procedure commencing on October 4, 2022. The evidence is simply that she motioned to her armpit when asked what she was there for and Dr. Horri said there would be some freezing. There was no evidence that Dr. Horri told the patient the freezing was a prequel to a surgical removal of the lump. It could well have been understood by the patient as a prequel to an aspiration.
f. There is no record in the EMR of a verbal response was to the question "what are we doing today" nor testimony from Dr. Horri of any response. This is understandable because he testified he had no memory and was relying on his clinical notes for his evidence.

59. In *Skeels (Estate of) v Iwashkiw*, 2006 ABQB 335 the court said, inter alia:

> [112] The lack of charting does not necessarily mean that procedures were not conducted, nor is the mere lack of charting *prima facie* evidence of negligence in the treatment. However, the lack of charting makes it more difficult for a court to determine matters of credibility where individuals who are trained to chart, did not do so. This failing, despite the opportunity to do so, makes it harder for a court to accept that the correct steps were followed and appropriate procedures were done as it would have been logical for them to be recorded had they been done:[citations omitted]

60. This logic is applicable here. Dr. Horri's testimony was clearly to the effect that he had no independent memory of what transpired on October 4, 2022. His EMR's do no assist any suggestion that a verbal consent to the surgical procedure that occurred. Dr. Horri's defence to the charge can only be based on the proposition that it was reasonable in the circumstances to infer a consent.

61. Consent is fundamental to physician/patient interactions. While consents can be inferred in appropriate circumstances as stated in *Allan v New Mount Sinai Hospital*, an actual and subjective consent on the part of a patient is not always necessary if the doctor reasonably believes that the patient has consented. In this case there is no basis in the evidence to conclude that Patient 1 gave an actual subjective consent to the surgical extraction. You cannot consent if you don't know what is proposed to occur. Based on her evidence she was expecting was a drainage of the lump. Thus, we are unable to find on the evidence an actual subjective consent to the surgical extraction that occurred. Further and importantly, based upon all of the evidence we are unable to find that Dr. Horri had a basis to reasonably believe that Patient 1 was consenting to a surgical removal of the lump on October 4, 2022.

62. Given how fundamental the requirement of patient consent is to a physician's permission to interact, it logically follows that the more serious or intrusive the physician to patient contact is, the more demanding should be the assessment of where and why consent may be inferred. Thus, for a routine physical contact to conduct a non-intrusive examination, an implied consent may quite easily be inferred. As the proposed contact moves up the spectrum to contact with sensitive areas or sexual organs, penetration of bodily orifices, the taking of samples, injections and ultimately to surgical interventions the criteria to satisfy a reasonable inference of consent increases significantly. Indeed, it would be an unusual situation where consent to a surgical procedure can properly be inferred

63. Can it be considered reasonable for Dr. Horri to have concluded that Patient 1 was consenting to a surgical extract of the lump or lipoma on October 4, 2022 when:
    a. It was clear that no consent was given on August 2, 2022;

b. On October 4, 2022, Dr. Horri did not reference the EMR to refresh his memory either regarding prior discussions with the patient or the potential procedures to be done.
c. Based on his own evidence we find he would have had very limited recollection of their discussions on August 2 or October 4, 2022.
d. On October 4, 2022, he asked the patient why she was there and her response was to raise her arm and indicate her armpit.
e. From this he apparently concluded she was consenting to an extraction of a swollen lymph node or lump.

64. It is our finding that in all of the circumstances it was incumbent on Dr. Horri on October 4, 2022, to make the necessary inquiries to ensure the patient **then** understood the nature of the procedure he was proposing to undertake and to determine clearly that she consented to that procedure. In this instance, simply asking the patient what she was there for and treating her raised arm as an answer and consent is not reasonable.

Conclusion on Charge 3

65. We conclude that as charged Dr. Horri failed to maintain the standard of practice of the profession by failing to obtain an informed consent from Patient 1 in respect of the surgical intervention that he proceeded with on October 4, 2022.

Charges 5, 8 and 14 - breaches of undertaking to have chaperone present

66. On June 18, 2018, Dr Horri gave a written undertaking to the College that stated, inter alia, "I will not have any in-person professional encounter with female patients in my office practice, except in the presence of a female chaperone." He testified this undertaking arose in circumstances where in 2015 the College of Physicians and Surgeons of Ontario started investigating a relationship he had with a former patient and revoked his licence to practice, following which the Saskatchewan College revoked his licence on a reciprocal basis. The Ontario revocation was subsequently overturned by the Ontario courts, but in the interim Dr.

Horri provided the undertaking to the Saskatchewan College to obtain restoration of his Saskatchewan licence and it has remained in place.

67. The evidence is clear that no chaperone was present during the October 4, 2022, surgical procedure on Patient 1 – Charge 5. Dr. Horri admits no chaperone was present.

68. Regarding Charge 2, Patient 2 testified that on November 21, 2022, she was seen by Dr. Horri for an ear wax issue and on November 28, 2022, for a physical examination and that no chaperone was present on either occasion.

69. Dr. Horri agreed his undertaking required him to have a chaperone present for every interaction with a female patient. He explained his failure to comply during the procedure of October 4, 2022, on Patient 1 saying Ms. [redacted] had been in the room initially, but because he was focused on the procedure he did not note that she had left. Dr. Horri did not contest that a chaperone was not present during the November 21, 2022, attendance on Patient 2 for an ear wax issue. His position was that he saw her in respect of an ear wax in an office with the door open because she was claustrophobic and thus did not see himself as in breach of the undertaking.

70. He testified that one [redacted] was present as a chaperone on November 28, 2022, for the physical exam of Patient 2. The College's position is that the Committee should draw an adverse inference from Dr. Horri's failure to call [redacted] as a defence witness to rebut the evidence of Patient 2 that no chaperone was present.

71. With regard to Charge 14 and the allegation therein that between 2018 and 2023 inclusive Dr. Horri had encounters with female patients generally without a chaperone present in breach of his undertaking, the College says the evidence proves this to be so. Dr. Horri acknowledged that on January 3, 2023 he swore an affidavit, that was submitted to the College on his behalf, [Ex. C1, Tab 25 for ID] in which he at stated at paragraphs 16 and 17 that his diligence in complying with the undertaking had slipped overtime and that there had been some occasions where he had a meeting with a female patient in the clinic, giving

examples such as on a prescription renewal visit. This affidavit was sworn after the events which are the subject of Charges 5 and 8. He there stated that a chaperone was present in the room during the November 28, 2022, Patient 2 physical examination. He did not name that chaperone in the affidavit.

72. The College relies on the evidence of Ms. [redacted] that the practice she was aware of was that Dr. Horri would only call for a chaperone for female patients where he was going to be hands on or sensitive examination appointments stating, inter alia:

> Speaker 5 (00:13:22):
> For hands-on female exams?
>
> What I knew initially I didn't understand when I was first brought on that you were required to be there for every female exam. I thought it was simply because for hands on exams, like a pelvic or a breast exam or anytime you would place hands on the female body, I didn't understand that that was the case. It was never explained to me or told to me that he needed a chaperone for every single female. I thought it was just for hands-on exams.

73. During cross examination Dr. Horri gave the following testimony:

> Speaker 3 (00:54:58):
> I'm going to suggest to you, Dr. Horri, that the practice in your clinic in 2022 was instead that you would tell the staff when a chaperone would be required?
> Speaker 5 (00:55:08):
> Well, I would ask them to come and help me.
> Speaker 3 (00:55:11):
> Okay, so that's how they would know that a chaperone is required? Yes.
> Speaker 5 (00:55:14):
> And
> Speaker 3 (00:55:14):
> That would be for sensitive examinations,
> Speaker 5 (00:55:19):
> Any? Yes.
> Speaker 3 (00:55:20):
> Okay. So that would be PAP exams, pelvic exams, rectal exams, I don't know the full categories, but sensitive examinations. You did have a chaperone present, correct?
> Speaker 5 (00:55:31):
> Yes.

74. The evidence of the clinic employee [redacted] was to the same effect. She testified she served as a chaperone when called to do so by Dr Horri, when a woman undressed or he would touch them stating at (00:09:36):

> Those are every time we are called, we are as a chaperone. If he does pap endometrial biopsy, IOD insertion or IOD removal. What else? Pessary change, pessary removal, pessary.

75. [redacted], a full time employee of the clinic, said she was not aware of Ms. [redacted] chaperoning at the clinic. Ms. [redacted] testified she knew the name but was not aware of her chaperoning at the clinic.

76. Dr. Horri acknowledged he knew the College was going to be disputing his position that Ms. [redacted] chaperoned Patient 2 and yet did not call Ms. [redacted] as a witness. He acknowledged that she was his housekeeper, that at times he would communicate with her by text message, that he would have payment records for payments to her for any work at the clinic and yet he gave no evidence whatsoever to explain reasons why he could not or did not call her as a witness on this issue in dispute or lead evidence to establish her presence in the office as a chaperone on the day in question.

77. We find that an adverse inference may and should be drawn with respect to the credibility of Dr. Horri's testimony that [redacted] was a chaperone at the November 28, 2022, physical examination of Patient 2.

78. We find that while subject to an undertaking to the College he would not have any in-person professional encounter with female patients in his office practice, except in the presence of a female chaperone, Dr. Horri did in fact have professional encounters with female patients in his office practice without the presence of a female chaperone. These encounters included:
    a. the October 4, 2022, surgical procedure on Patient 1;
    b. the November 21 and 28, 2022, encounters with Patient 2; and
    c. some such encounters with an unknown number of and unidentified female patients at some points after giving the undertaking up to and including 2023.

Conclusion on Charges 5, 8 and 14

79. We find that Dr. Horri's failure to honour his undertaking given to the College is, under s. 46(o) of the Act, unbecoming, improper, unprofessional or discreditable conduct and thus we find Charges 5, 8 and 14 proven.

80. While we find these Charges to have been proven it is not our responsibility to assess the seriousness or gravity of these offences. We have noted that while no chaperones were present during the October 4, November 21 and November 28, 2022, encounters with Patients 1 and 2. There was no evidence presented that Dr. Horri acted improperly during those encounters; other than the breach of his undertakings and thus the unbecoming conduct alleged in the charges respecting Patients 1 and 2. The same applies to our finding that there were some such encounters with an unknown number and unidentified female patients at some points after giving the undertaking up to and including 2023.

81. We note that we have received no evidence regarding the College's original reasons for obtaining the undertaking and/or whether those reasons continued to be of concern to the College in 2022.

Charge 6, 9, 11 - altering records after becoming aware of College investigations

82. Charges 6, 9, and 11 allege that Dr. Horri altered medical records after becoming aware of College investigations into Dr. Horri's conduct with Patients 1, 2, and 3. Dr. Horri acknowledged in his evidence that he made changes to the patient records after becoming aware of the College investigations, and the question with respect to these charges is whether such conduct is "unbecoming, improper, unprofessional or discreditable" under subsections 46(o) or (p) of the Act or Bylaw 8.1(b)(vi).

83. As stated below at paragraph 102 under the discussion of Charge 13, Dr. Doig's evidence establishes how and when the EMRs for Patients 1, 2, and 3 were changed by Dr. Horri. Many of these changes were not corrections or minor updates and included substantive alterations or additions to the EMR, which alterations or additions were made in some instances months after the patient interaction. Dr. Horri described his alterations to the EMR as his "completing" an incomplete record and the completion had to be done because the College wanted to see it. He explained that he did not note the alterations in the EMR because there is a digital record of every time you touch the EMR system.

84. Dr. Horri gave evidence that he understood a physician should be careful about changing the EMR after a patient complaint is received. He also gave evidence that he did not take steps to ensure the College was aware of the alterations, relying on the fact that the College could look at the audit trail to determine when the EMR had been touched. The EMRs for Patients 1, 2, and 3 showed the changes made by Dr. Horri to the EMR were not apparent on the face of the altered EMR, and Dr. Doig gave evidence that additional steps had to be taken to access the necessary logs and/or audit trail to determine when and how changes were made to the EMR.

85. Dr. Horri stated that he relied on his standard practise, recollection at the time, paraclinical information, and possibly the information in the patient complaints to fill in the details when he changed the EMRs. The accuracy and reliability of Dr. Horri's memory of these interactions with Patients 1, 2, and 3 is questionable given his busy medical practice and the passage of time from the patient interactions to the date the EMRs were changed. Moreover, the timing of the alterations to the EMRs and the failure to alert the College in its investigations of such alterations raises concerns about the true purpose underlying the alterations, and whether that purpose was to provide the College with a narrative favourable to Dr. Horri rather than to complete the medical record to assist with patient medical care.

86. Section 46(o) of the Act states that "unbecoming, improper, unprofessional or discreditable conduct" includes the physician doing any act or thing which the discipline committee considers to be such. The Committee is of the opinion that altering an EMR after becoming aware of a misconduct investigation, without any clear notation to show when and why such an alteration was made, is conduct unbecoming and unprofessional.

Conclusions on Charges 6, 9 and 11

87. Physicians are in a position of significant trust and authority and it is expected that a physician facing a conduct investigation will be cooperative, honest, and forthcoming with the professional regulatory body. Dr. Horri's failure to be forthcoming and transparent with the College about the alterations to the EMR was misleading and could have easily undermined the College's investigation had it not made further inquiries into the audit trail. As a result, we are satisfied that charges 6, 9, and 11 are proven.

Charge 10 – inappropriate touch/comments regarding Patient 3

88. On July 14, 2022, Patient 3 attended at Dr. Horri's office for a PAP test and also related to concerns that she may have been infected by her then partner with a sexually transmitted infection. Dr. Horri attended to these issues in his usual manner – and other than as regards the alleged inappropriate touching or comments there was no evidence of impropriety or failure to maintain the standard of practice of the profession. A regular chaperone was present throughout.

89. Patient 3 testified as follows:

> Speaker 1 (06:55):
> And was that in fact what happened on this occasion? Yeah. What if anything happened of note? I guess just after the pap exam,
> Speaker 4 (07:05):
> After that when the speculum was removed and before I was told I could get up and everything, that's when he grabbed my labia and kind of wiggled it and asked if I had ever considered having the excess removed.
> Speaker 1 (07:25):
> When this happens, when he says this to you, were you still in the same position as you've been in for the PAP exam itself?
> Speaker 4 (07:30):
> Yes. Yes. Still lying down with my feet in the holsters knee fence
> Speaker 1 (07:37):
> Immediately prior to you described it because did you say grabbing, was that
> Speaker 4 (07:42):
> Word? Yeah, like pinching between the finger
> Speaker 1 (07:45):
> Immediately before that happened. Had he been in contact with that part of your body just before that? Immediately before
> Speaker 4 (07:56):
> It is on route to put the speculum.
> Speaker 1 (07:59):
> Sorry, maybe I'm doing a bad job of one. I'm trying to wonder about, was this the continuation of the touching that had already started or was this something
> Speaker 4 (08:06):
> Separate?
> Speaker 1 (08:07):
> Okay. Yes, as much as you can, are you able to, you described that the touching as he was shaking. I don't believe that's what she said.
> Speaker 4 (08:25):
> Wiggling.
> Speaker 1 (08:25):
> Wiggling. Sorry.

Speaker 2 (08:26):
Wiggling. Thank

90. In respect of her reaction at the time and subsequent actions she stated as follows:

Speaker 1 (10:27):
So this happened July, 2022. When did you, I take it, did you make a report to the college about this?
Speaker 4 (10:38):
I did not make a report immediately. I filed a report April 23rd, 2023. Okay.
Speaker 1 (10:47):
And can you tell the panel members a little bit about why you didn't come forward immediately, but came forward? At that point?
Speaker 4 (10:54):
I had questioned if there was any merit to my complaints if I was overreacting, and I had sat on that for a while and it wasn't until seeing some reports come through in the paper about Dr. Horri's alleged misconduct with other patients that I felt I should just put it through to the College of Physicians. And if there was any merit, then it was up for them to decide.
Speaker 1 (11:30):
When you say you weren't sure if it had merit and if it had any merit, it was up to them to decide. What do you mean by that? About whether what you thought had happened, happened, or whether that was significant or what something else.
Speaker 4 (11:42):
What
Speaker 1 (11:43):
Do you mean by that?
Speaker 4 (11:46):
It didn't feel appropriate when I was there, but you second guess, am I overreacting? Am I right to feel the way that I do? And I think it's just being in a position where you trust your medical professionals, so you just assume they won't do that.

91. During cross examination she acknowledged that she had concerns about his character based on articles she had read and also stated the following:

Speaker 5 (16:23):
So the chaperone was within earshot of Dr. Horri, and there's no reason of which you're aware that the chaperone would not have been able to hear everything that Dr. Horri was saying that day?
Speaker 4 (16:38):
No reason that I can think of,

92. During the College's investigation Dr. Horri conceded that if he did what Patient 3 alleged that would be improper. Dr. Horri denies that he did and said what Patient 3 alleges.

93. The chaperone [redacted] testified, inter alia as follows:

Speaker 7 (00:49:25):
In all the exams that you've chaperoned, you have never heard Dr. Corey comment on the size of a woman's labia, right?

Speaker 3 (00:49:34):
No, I don't remember anything like that.
Speaker 7 (00:49:38):
And you've never heard him suggest to a patient that she should consider a surgical reduction of their labia, right?
Speaker 3 (00:49:49):
I don't remember like that.

. . .

Speaker 7 (00:50:16):
You never saw Dr. Horry grab a woman's labia, correct?
Speaker 3 (00:50:24):
No. And if you just checking, because there are times like some after pap, they want something that they have to check in there. Again, Dr. Horri ask them, okay, you can lay down and will check, we'll check.

. . .

Speaker 7 (00:54:28):
Okay. So we're back to the pap exam now. So when Dr. Horry removes the speculum, you said right away he puts the drape down, right?
Speaker 4 (00:54:41):
Yes.
Speaker 7 (00:54:43):
And that's so that the woman isn't exposed any longer than necessary, right?
Speaker 4 (00:54:48):
Yes. Yes.
Speaker 7 (00:54:50):
And so if he had then for some reason put his hands back near the woman's vulva again, that's something you probably would've noticed, right?
Speaker 3 (00:55:00):
Oh, yes. Yes. Because it's like no consent. There's no consent, it is not right. He always ask for consent, like, okay, if you will need to check, then lay down and then he'll check it again.

94. We have no basis to question the credibility of the Patient 3. Further we acknowledge that given the nature of what she says was done and said, it would be a memorable event which supports the reliability of her evidence. That said we are in a situation of conflicting evidence. Dr. Horri denies he did or said what is alleged. While Dr. Horri's evidence can be viewed as self-serving, he did acknowledge to the PIC that if he had done and said what is alleged that would be improper.

Conclusion on Charge 10

95. The evidence of the College's witness [redacted], while somewhat difficult to follow, is essentially to the effect that if she had seen or heard what is alleged, she would have known it was improper and raised it with her manager had it occurred. She testified she did not raise it with her manager. Like Patient 3, we have no basis to question the credibility of Ms. [redacted]. The burden of proof is on the College by clear, convincing and cogent evidence satisfying the balance of probabilities test. The evidence as a whole leaves us in the position that, while close to the line, we conclude Charge 11 has not been proven on the balance of probabilities.

Charge 12 Harassment of or encouragement of a potential witness to provide false information

96. The specific allegations in Charge 12 are that Dr. Horri harassed the witness, [redacted], and/or encouraged her to provide false information. We are satisfied that the allegation of harassment is not proven. There were two relatively short text exchanges between them on December 24 and December 27, 2022. At no point did Ms. [redacted] characterize the actions of Dr. Horri as harassment. She simply regarded the conversations as Dr. Horri, whom she knew well, venting. There is no evidence that she felt harassed by him or that these conversations caused her to do anything different than what she freely chose on her own to do.

97. The issue of whether Dr. Horri "encouraged" her to provide false information to the College is more nuanced. In response to Ms. [redacted]'s statement on December 27, 2022, to the effect that he was suggesting she lie to the College, his clear statement was: "Yes this is not the time to think about integrity". On any reasonable interpretation of this statement, he was then encouraging Ms. [redacted] to provide false information to the College about his practice with respect to chaperones in his office.

98. Having said that, the following issues arise, being:

    i. the cited section 7.2 (t) of the Bylaws has no application to the Charge;

ii. the cited section 7.2 (aa) has not been demonstrated to be clearly engaged and breached; and

iii. the words of Bylaw 7.2(l) "Not harass, intimidate or threaten a person with whom the physician is connected in their practice of medicine" does not contain the word "encourage".

99. These issues aside, Section 46(o) of the Act expressly provides that "unbecoming, improper, unprofessional or discreditable conduct" includes the physician doing any act or thing which the discipline committee considers to be such. We are of the opinion that telling an employee and potential witness in an investigation by the College that "this is not the time to think about integrity" is encouragement to do precisely that. While Ms. [redacted] was not influenced or distracted by Dr. Horri's encouragement, that does not detract from the fact that his statement was encouragement to her.

Conclusion on Charge 12

100. Integrity is one of the essential attributes of being a professional. Thus, to encourage a participant in an investigation, by the regulatory body of the profession, to have no regard to integrity, for the benefit of the professional under investigation, must necessarily be viewed as all of "unbecoming, improper, unprofessional or discreditable conduct". We find Charge 12 to be proven.

Charge 13 - Failure to Maintain Appropriate Medical Records

101. The charge relates to the medical records prepared in respect of:

i. Patient 1 for the dates of August 2 and October 4 of 2022,

ii. Patient 2 for the date of July 14, 2022; and

iii. Patient 3 for the dates of November 21 and 28, 2022.

102. The evidence of Dr. Doig establishes that:

i. On November 10, 2022 the August 2 and October 4, 2022, records for Patient 1 were changed as shown in Ex. C1 Tab 15;

ii. On May 8, 2023, the July 14, 2022, record for Patient 2 was changed as shown in Ex. C1 Tab 17; and

iii. On December 9 and/or 11, 2022, the November 21 and 28, 2022, records for Patient 3 were changed as shown in Ex. C1 Tab16.

103. Bylaw 8.1(b) states various actions to be unprofessional conduct including:

> (vi) Falsifying a record in respect of the examination or treatment of patient
> (ix) Failing to maintain the standard of practice of the profession

.

This charge brought does not allege falsifying the records contrary to bylaw 8.1(b)(vi). It simply alleges failure to maintain the standards of practice of the profession referencing bylaws 8.1(b)(ix) and 23.1. Thus, the essence of his alleged failure is grounded in the bylaw 23.1 statement of what are the minimum requirements for medical records.

104. Dr. Horri maintained his patient medical records in an electronic medical record system. The evidence of Dr. Doig established that as required by bylaw 23.1 (e) his system did maintain an audit trail that, inter alia, tracked any changes in the recorded information and preserved the original content of the record if subsequently changed or updated. It was the existence of such audit trail that permitted Dr. Doig to identify the changes or additions made and when they were made. Thus, the Committee finds no failure on Dr. Horri's part in relation to the requirements of bylaw 23.1 (e).

105. Bylaw 23.1 states, inter alia, the following to be minimum requirements for the records to be maintained:

> (a) All members of the College of Physicians and Surgeons of Saskatchewan shall keep, as a minimum requirement, the following records in connection with their practice:
>
> (ii) In respect of each patient contact, a legibly written or typewritten record setting out:
>
> . . .
>
> 2. a record of the assessment of the patient which includes the history obtained, particulars of the physical examination, the investigations ordered and where possible, the diagnosis; and
> 3. a record of the disposition of the patient including the treatment provided or prescriptions written by the member, professional advice given and particulars of any referral that may have been made. Prescribing information should include the name of medication, strength, dosage and any other directions for use.
>
> . . .
>
> (d) The records must be completed in a timely manner.

106. The above quoted provisions are the applicable provisions. Thus, the issue on this charge is whether Dr. Horri failed to adhere to the minimum requirement quoted above in the records he kept and/or whether these records were completed in a timely manner. Whether, as alleged in charges 6, 9 and 11, his changes to the medical records:

a. were made after he became aware of the he College's investigations; and
b. he provided the altered records without advising the College of what his original records were

constitutes unprofessional conduct is a distinct matter dealt with in charges 6, 9 and 11 above. The issue on Charge 13 is limited to whether there was a failure to meet the minimum standards stated in bylaw 23.1(a)(ii) and (d) quoted above.

107. The College outlines at pages 22 to 28 of their Brief the importance of accurate and timely prepared medical records. It notes that in *Skeels (Estate of) v Iwasnkiw* 2006 ABQB 335 the court said the following:

> [112] The lack of charting does not necessarily mean that procedures were not conducted, nor is the mere lack of charting prima facie evidence of negligence in the treatment. However, the lack of charting makes it more difficult for a court to determine matters of credibility where individuals who are trained to chart, did not do so. This failing, despite the opportunity to do so, makes it harder for a court to accept that the correct steps were followed and appropriate procedures were done as it would have been logical for them to be recorded had they been done: [citations omitted]
> [113] Professional notes, maintained contemporaneously, have long been admitted as prima facie proof of the truth of their content even when they contain opinion as well as objective information: *Ares v. Venn*er: 1970 CanLII 5 (SCC), [1970] S.C.R. 608. In this case, several blows were dealt to the reliability the courts place on note taking, and these warrant separate factual treatment.

108. As the Supreme Court of Canada observed in *Ares v. Venn*er, professional notes, if prepared routinely and contemporaneously, can be admitted as prima facie proof of their contents, even when they contain opinion as well as objective information. The minimum requirements of bylaw 23.1 (a)(ii) and (d) were set by CPSS to ensure not only that the record can sufficiently and accurately inform all health care professionals (including the record creating physician him/herself) as to what has occurred in the past to inform ongoing care decisions, but also to ensure the record is suitable for subsequent evidentiary purposes.

109. Dr. Horri's position, as advanced by his Counsel in their brief is as follows:

> 73. Medical record keeping is part of any physician's practice, and it is acknowledged that section 23.1 of the Regulatory Bylaws sets out standards of practice for physicians in maintaining their medical records. The Discipline Committee has various versions of the Regulatory Bylaws available, and it should be noted that the current version of the Regulatory Bylaws published March of 2025 specifically address how amendments to an Electronic Medical Record ("EMR") must be made and labelled; these specific expectations are *not* found in any of the version of the Regulatory Bylaws provided in Exhibit C-1.
>
> 74. Dr. Horri has acknowledged that his medical records were not always adequate; however, inadequate record keeping does not automatically result in a finding of professional misconduct. The *Sussman* case referred to above confirms that the mere fact that a physician may breach professional standards, such as for example record keeping expectations set out in the *Regulatory Bylaws*, does not automatically constitute professional misconduct. Rather, the degree of the breach of record keeping standards and the consequences should be analysed to determine if the conduct is sufficient to rise to the level of misconduct.
>
> 75. Important context for this analysis in Dr. Horri's case includes:
>
> i. There is no allegation that Dr. Horri did not document his visits at all, or that any of the visits recorded were fabricated;
> ii. There is no evidence that the documentation impacted patient care or outcomes;
> iii, In 2022, the *Regulatory Bylaws* did not contain any detailed requirements around the use of an EMR and how amendments or late entries need to be recorded, which detail has now been added in the current version of the *Regulatory Bylaws*;
> iv. It is commonly understood among physicians that EMR systems track every 'touch' to a patient record, and that those records are stored and available through the audit process;
> v. Dr. Strydom acknowledged that there is not always sufficient time to complete a record contemporaneously, and that, while not ideal, it is not unusual for a record to be completed days or even weeks following the attendance at issue; and
> vi. The mere fact that records are changed or completed later is not in itself misconduct. The fact that there are now requirements laid out in the *Regulatory Bylaws* for identifying changes demonstrates it is contemplated that physicians may need to make alterations to their records.
>
> 76. Dr. Horri submits that the changes made were in the nature of completing the records at issue, were relatively minor, and had no impact on patient care. The College has not demonstrated that Dr. Horri's records and changes made to those records rise to the level of misconduct.

110. In relations to Charges 6, 9 and 11, dealt with above, we found that Dr. Horri's alterations to his original records constituted unbecoming conduct in light of when and the circumstances under which these changes were made. While the changes may not have had an impact on patient care, the changes or additions cannot be viewed as being relatively minor given the finding that they constituted unbecoming conduct. That having been stated we view this Charge 13 as being focused on whether the records "kept" by Dr. Horri, met the minimum requirement of Bylaw 23.1 a(ii) and were "completed" in a timely manner as required by Bylaw 23.1(d).

111. Given the original and amended EMR's evidenced in Ex. C1 Tabs 15 to 17 and the evidence provided in witness testimony, we find, as regards Patient 1, the following:

i. The August 2, 2022, record for Patient 1 documented only her PAP smear with no mention being made of an armpit mass/lump being discussed, no record of Dr. Horri's examination thereof, and no provisional diagnosis nor treatment options being discussed.

ii. The November 10, 2022, amendments to the August 2, 2022, record were made more than 3 months later and only after Dr. Horri was aware of a complaint to the College.

iii. The changes or additions made 3 months after August 2, 2022, cannot, in light of the opinion evidence of Drs. Strydom and Geller, be viewed as having been "completed" in a timely manner. In the context of a typical busy family medicine practice, which Dr. Horri described his practice as being, there can be little confidence that the information he inserted into the record 3 months later was factually correct. This conclusion is reinforced by the fact that at the hearing of the complaints Dr. Horri's position was that he had no memory of what occurred on August 2, 2022.

iv. The original record of the October 4, 2022, surgery of Patient 1 utilized Dr. Horri's standard template for such a procedure. Notwithstanding selectable options in the template regarding the cc's of Xylocaine and Marcaine administered, the scalpel used, the number of sutures and the suture products these details were not provided in the original record. They were only inserted over a month after the procedure upon becoming aware of a complaint to the College.

112. We find that the noted shortcomings in these original and amended records regarding Patient 1constitute clear failure to keep records that satisfy the minimum requirements of Bylaw 23.1 (a)(ii) and the obligation under subsection (d) to complete such records in a timely manner. These failures have resulted in an incorrect and unreliable record of the patient's treatment with potential consequences to the patient's future medical care. As such, we find Dr. Horri's failure to meet minimum requirements to constitute unprofessional conduct.

113. As regards Patient 2, with reference to tab 16 of Exhibit C1, we find as follows:

i. On November 28, 2022, the patient was seen as follow up to a hospital attendance and ER discharge where she had complained of abdominal and pelvic pain. The initial record of this November 28, 2022, attendance is found at page 2 of Tab 16. The original record of a November 28, 2022, attendance utilizes a Dr. Horri template which is incomplete with a number of the template field options not completed.

ii. On December 9, 2022, Dr. Horri amended his original record notes for November 28, 2022, as evidenced by page 3 of Tab 16 and on December 11 added "rectal exam normal" as evidenced by page 4 of Tab 16. As of the December 9, 2022, it is not clear from the record if a breast exam was performed or not.

iii. The original record of a November 21, 2022, attendance (page 6, Tab 16) only references difficulty in hearing and ear wax syringing [not which ear]. There is no mention of the abdominal/pelvic pain that the patient also expressed concerns about that date and regarding which Dr. Horri asked her to book a complete physical.

iv. On December 9, 2022, amendments were made to the November 21, 2022, record that it was the right ear that was the ear syringed (page 7, Tab 16). Then on December 11, 2022, the record was further amended removing any reference syringing of the ear but maintaining advice to use wax softening drops (page 8 Tab 16).

114. We find, on the basis of the evidence of Drs. Strydom and Geller and that:

i. Patient 2 was a patient who saw Dr. Horri and other health care providers frequently believing that she had cancer and other conditions;

ii. She was well known to Dr. Horri; and

iii. The circumstances of her attendances and the timelines involved

it has not been proven on the balance of probabilities that the subject records were not completed in a timely manner. Given the timelines involved and Dr. Horri's knowledge

of this patient, the delays in completing the record should not in our opinion be viewed as unprofessional conduct.

115. While we conclude that the records, as originally completed, did not meet the minimum requirements of Bylaw 23.1(a)(ii), we are unable to go the further step and conclude that the evidence establishes, on the balance of probabilities, the noted deficiencies in the record keeping in respect of Patient 2 reached the level of unprofessional conduct by reason of failing to maintain the standard of practice of the profession.

116. The evidence of Drs. Strydom and Geller did not express clear opinions that in the context noted in paragraph 114 above that the Dr. Horri's record keeping failed to maintain the standard of practice of the profession. Given the evidence as a whole, we are unable to conclude that the failures have resulted in an incorrect and unreliable record of the patient's treatment with potential consequences to the patient's future medical care. Mistakes are a fact of life. In our opinion, Dr. Horri's failures to meet the minimum requirements for his record keeping did not, in the circumstances of Patient 2, elevate to the level of unprofessional conduct

117. As regards Patient 3, with reference to tab 17 of Exhibit C1, we find as follows:

i. The original record of this patient's July 14, 2022, attendance records only a routine PAP smear test and indicates "no medical concerns".

ii. The evidence of Patient 3, which we accept, is that she also raised the fact that she had learned her partner with whom she was sexually active had a sexually transmitted infection, she wished to test regarding the same, she was tested and that she was prescribed an antibiotic to treat same.

iii. There is no documentation of the Public Health system being advised of the STI transmission to the patient.

iv. While Dr. Horri amended the July 14, 2022, record on May 8, 2023, with some details on her history of past PAP tests, he made no amendments with respect to the matters dealt with in ii. above and added "[redacted] present during the procedure".

118. Based on the above findings, we conclude as follows in regard to the record of Patient 3:

a. The July 14, 2022, record fails in significant respect to meet the minimum requirements for a medical record established by Bylaw 23.1(a)(ii)(2) and (3). The attendance for, investigation of and prescribing of an antibiotic for an STI is an essential part of a medical record.

b. The July 8, 2023, identification of a chaperone present does not satisfy the requirement to prepare the record in a timely manner.

c. Given Dr. Horri's failure to include the information relating to the STI aspects detailed in paragraph 117(ii) above we conclude that he had no memory of the same and thus was unable to correct the record in that respect; as he would have been obliged to do if he had such knowledge. Since he then had no knowledge of the significant STI aspects of Patient 3's attendance, he would in all probability have had no recollection of the specified chaperone being present. Thus, we find that Dr. Horri inserted into the record on July 8, 2023, a statement regarding a chaperone being present that he could not be confident was correct.

119. We find that the noted shortcomings in these original and amended records regarding Patient 3 constitute a clear failure to keep records that satisfy the minimum requirements of Bylaw 23.1 (a)(ii) and the obligation under subsection (d) to complete such records in a timely manner. These failures have resulted in an incorrect and unreliable record of the patient's treatment with potential consequences to the patient's future medical care as well as failing to provide important information relating to the sexually transmitted infection which has public health concerns. As such, we find Dr. Horri's failure to constitute unprofessional conduct.

120. We find that in respect of Patient 3 Charge 13 has been proven on the balance of probabilities.

Conclusion on Charge 13

121. For the reasons set forth above we find the charges of unprofessional conduct in respect of Dr. Horri's record keeping in respect of Patients 1 and 3 made in Charge 13 are proven but are not proven in respect of Patient 2.

Summary of Findings on the Charges

122. As regards the 14 charges particularized in the Amended Notice of Hearing our findings are, for the reasons set forth above as follows:

a. Charge 1- we find the College has failed to prove Charge 1.

b. Charge 2 - we find the College has failed to prove Charge 2.

c. Charge 3 - we find it proven that Dr. Horri failed to maintain the standard of practice of the profession by failing to obtain an informed consent from Patient 1 in respect of the surgical intervention that proceeded on October 4, 2022.

d. Charge 4 - the "College advised they were not seeking a conviction on Charge 4.

e. Charge 7 - this Charge was withdrawn by the College.

f. Charges 5, 8 and 14 - we find, on the basis of Dr. Horri's failure to honour his undertaking given to the College, Charges 5, 8 and 14 of unbecoming, improper, unprofessional or discreditable conduct under s. 46(o) of the Act to have been proven.

g. Charges 6, 9 and 11- we find Charges 6, 9, and 11 are proven.

h. Charge 10 - we find the College has failed to prove Charge 10.

i. Charge 12 – we find the charge of "unbecoming, improper, unprofessional or discreditable conduct" under s. 46(o) of the Act to have been proven on the basis of Dr. Horri's encouragement to Ms. [redacted] to not think about integrity in her communications with the College.

j. Charge 13 - we find the charges of unprofessional conduct in respect of Dr. Horri's record keeping in respect of Patients 1 and 3 made in Charge 13 to be proven; but not proven in respect of Patient 2.

Decision delivered June 10, 2025

Brian Scherman | FOR: Dr. Rupesh Chawla | Maya Scott

Amended Notice of Hearing attached as Schedule A in the following 4 pages

CPSS College of Physicians and Surgeons of Saskatchewan

IN THE MATTER OF *The Medical Profession Act, 1981*, S.S. 1980-81, c. M-10.1 and

Dr. Mehdi Horri, Medical Practitioner

TO: Dr. Mehdi Horri, medical practitioner:

Amended Notice of Hearing

TAKE NOTICE that a hearing will be held before the Discipline Hearing Committee of the College of Physicians and Surgeons of Saskatchewan beginning on **March 31, 2025** at the hour of 9:00 a.m. at the Offices of the College of Physicians and Surgeons of Saskatchewan located at Second Floor - 2174 Airport Drive, Saskatoon Saskatchewan.

AND FURTHER TAKE NOTICE that at this hearing the Discipline Hearing Committee will hear the charges set out below.

AND FURTHER TAKE NOTICE that you may be represented by counsel at the above hearing.

AND FURTHER TAKE NOTICE that should you fail to appear for the above hearing, such order as may be deemed appropriate may be made in your absence.

AND FURTHER TAKE NOTICE that the hearing will be conducted into the following charges laid by the Council of the College of Physicians and Surgeons, namely:

CHARGE 1

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or (p) of *The Medical Profession Act, 1981* and/or bylaw 8.1(b)(ix) of the Regulatory bylaws of the College of Physicians and Surgeons of Saskatchewan, the particulars of which are that you Dr. Horri performed a surgical procedure in regard to [PATIENT #1] without adequate prior investigation and/or without obtaining an opinion from a surgeon, and/or thereby did not maintain the standard of practice of the profession.

CHARGE 2

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or (p) of The Medical Profession Act, 1981 and/or bylaw 8.1(b)(ix) of the Regulatory bylaws of the College of Physicians and Surgeons of Saskatchewan, the particulars of which are that you performed a surgical procedure in an office setting unsuited for the procedure and/or did not apply sufficient clinical knowledge or surgical skill to the performance of the procedure, and/or therefore did not maintain the standard of practice of the profession.

CHARGE 3

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or (p) of The Medical Profession Act, 1981 and/or bylaw 8.1(b)(ix) of the Regulatory bylaws of the College of Physicians and Surgeons of Saskatchewan, the particulars of which are that you did not obtain informed consent for the surgical procedure performed on [PATIENT #1] and/or therefore did not maintain the standard of practice of the profession.

CHARGE 4

You, Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or section 46(p) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(ix) of the Regulatory Bylaws of the College of Physicians and Surgeons of Saskatchewan, particulars whereof are that you did not provide adequate postoperative instructions and timely postoperative care to [PATIENT #1]and/or therefore did not maintain the standard of practice of the profession.

CHARGE 5

You, Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, in that you did not have a chaperone present during a procedure with female patient [PATIENT #1], contrary to your 2018 Undertaking with the College.

CHARGE 6

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or (p) of The Medical Profession Act, 1981 and/or bylaw 8.1(b)(vi) of the Regulatory bylaws of the College of Physicians and Surgeons of Saskatchewan, the particulars of which are that you altered medical records related to [PATIENT #1] after becoming aware of a College investigation into your conduct with that patient.

CHARGE 7

You, Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or 46(p) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(ix) of the College's Regulatory Bylaws in that you performed a rectal examination on [PATIENT #2] that was not medically indicated.

CHARGE 8

You, Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, in that you did not have a chaperone present during a procedure with female patient [PATIENT #2]., contrary to your 2018 Undertaking with the College.

CHARGE 9

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or (p) of The Medical Profession Act, 1981 and/or bylaw 8.1(b)(vi) of the Regulatory bylaws of the College of Physicians and Surgeons of Saskatchewan, the particulars of which are that you altered medical records related to [PATIENT #2] after becoming aware of a College investigation into your conduct with that patient.

CHARGE 10

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of sections 46(o) and/or 46(p) of The Medical Profession Act, 1981, and/or sections 7.1 and 7.2 of the Code of Conduct, the particulars of which are that you inappropriately touched and/or made comments on a female patient's genitals during an examination.

The evidence that will be led in support of this charge will include one or more of the following:

1) On or about July 14th, 2022, you had a patient encounter with [PATIENT #3], a female patient.
2) During the course of a pap smear procedure, you pinched the patient's labia between your fingers, moved the labia back and forth, and/or asked whether the patient had ever considered surgery to remove the excess, or words to that effect.
3) The specific touching you conducted was not medically indicated and/or not consented to by the patient.

CHARGE 11

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or (p) of The Medical Profession Act, 1981 and/or bylaw 8.1(b)(vi) of the Regulatory bylaws of the College of Physicians and Surgeons of Saskatchewan, the particulars of which are that you altered medical records related to [PATIENT #3] after becoming aware of a College investigation into your conduct with that patient.

CHARGE 12

You Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of sections 46(o) and/or 46(p) of The Medical Profession Act, 1981, sections 7.2(l), 7.2(t), and 7.2(aa) of the Code of Conduct, and/or bylaw 8.1(b)(xxii) the particulars of which are that you harassed and/or encouraged a potential witness in a College investigation into your conduct to provide false information.

The evidence that will be led in support of this charge will include one or more of the following:

1) On or about December 24th, 2022, you had been advised that the College was investigating your conduct and that a potential interim suspension of your ability to practise would be considered.

2) In a text message conversation on or about December 24th, 2022, you told a potential witness to the investigation that "all they need to hear is that I see my female patients with a chaperone. That's it andthat's all".

3) After further conversation by text message, the potential witness asked you "so lie?" and you responded: "Yes this is not the time to think about integrity."

4) On or about December 27th, 2022, you sent the potential witness information from your lawyer indicating that you may be suspended by the College, then asked the potential witness whether they "still think these people deserve honesty".

CHARGE 13

You, Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or section 46(p) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, and/or bylaw 8.1(b)(ix) and/or bylaw 23.1 of the Regulatory Bylaws of the College of Physicians and Surgeons of Saskatchewan, particulars whereof are that you failed to maintain appropriate medical records for your patients [PATIENT #1], [PATIENT #2], and/or [PATIENT #3].

CHARGE 14

You, Dr. Mehdi Horri are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) of The Medical Profession Act, 1981, S.S. 1980-81, c. M-10.1, in that between 2018 and 2023 inclusive you had encounters with female patients without a chaperone present, contrary to your 2018 Undertaking with the College.

DATED at Saskatoon, Saskatchewan, this 11th day of February, 2025.

Brian Scherman, K.C.
Chair, Discipline Hearing Committee