IN THE MATTER OF A HEARING BEFORE THE HEARING TRIBUNAL
OF THE COLLEGE OF PHYSIOTHERAPISTS OF ALBERTA
INTO THE CONDUCT OF MAHVEEN MOIZ
PURSUANT TO THE *HEALTH PROFESSIONS ACT*, RSA 2000, c. H-7

DECISION OF THE HEARING TRIBUNAL

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I. INTRODUCTION

[1] A hearing of the Hearing Tribunal of the Alberta College of Physiotherapy (the "**College**") was held on November 27, 2023 by videoconference.

[2] The members of the Hearing Tribunal were:

Sharla Butler, Regulated Member, Chair
Vikram Krishnan, Regulated Member
Catherine Freeman, Public Member
Barbara Rocchio, Public Member

[3] Also in attendance were:

Moyra McAllister, Complaints Director
Vita Wensel, Legal Counsel for the Complaints Director
Mahveen Moiz, Investigated Member (the "**Investigated Member**" or "**Ms. Moiz**")
Eric Appelt, Legal Counsel for the Investigated Member
Julie Gagnon, Independent Legal Counsel for the Hearing Tribunal
Thomas Feth, Student-at-Law, observer with Ms. Gagnon
Haylee O'Reilly, Hearings Administrator
Cheryl Blahut, Conduct Coordinator
Elizabeth Sebastianski, Court Reporter

II. PRELIMINARY MATTERS

[4] The parties confirmed that there were no objections to the members of the Hearing Tribunal or the Hearing Tribunal's jurisdiction to hear the matter. The parties confirmed there were no preliminary matters to be raised.

[5] The hearing was open to the public pursuant to section 78(1) of the *Health Professions Act*, RSA 2000, c. H-7 (the "**HPA**"). No application was made to close the hearing to the public. There were members of the public in attendance.

III. EXHIBITS

[6] Ms. Wensel, on behalf of the Complaints Director, advised that the parties had entered into an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct (the "**Agreed Statement of Facts**"). The following exhibits were entered during the course of the hearing:

Exhibit 1 – Agreed Statement of Facts
Exhibit 2 – Attachments to the Agreed Statement of Facts

- Tab 1 Curriculum Vitae of Mahveen Moiz
- Tab 2 Complaint Form of JA
- Tab 3 Complaint Form of DE
- Tab 4 Mahveen Moiz responses to complaints of JA and DE
- Tab 5 Interim Order, February 7, 2023
- Tab 6 CPA letter re complaints referred to hearing, May 31, 2023
- Tab 7 Amended Notice of Hearing and Notice to Attend, November 16, 2023
- Tab 8 *Health Professions Act*, RSA 2000, s. 1.3
- Tab 9 Expert Report of L. Maffey, June 21, 2023
- Tab 10 HQCA Report on Dry Needling
- Tab 11 Expert Report of Dr. Parent, July 21, 2023
- Tab 12 DE Consent Form, August 20, 2020
- Tab 13 DE Physiotherapy Assessment, August 20, 2020
- Tab 14 DE Appointment History, August 20, 2020 to December 18, 2021
- Tab 15 DE Treatment Records
- Tab 16 DE Incident Report
- Tab 17 JA Consent Form, June 4, 2022
- Tab 18 JA Treatment Records
- Tab 19 Text Messages between JA and Mahveen Moiz
- Tab 20 Text Messages between RA and Mahveen Moiz
- Tab 21 *Health Professions Act*, RSA 2000, s. 1(1)(pp)
- Tab 22 Code of Ethical Conduct for Alberta Physiotherapists
- Tab 23 Standards of Practice for Physiotherapists of Alberta (January 20, 2017)

Exhibit 3 – Joint Submission on Penalty

IV. ALLEGATIONS

[7] The allegations in the Amended Notice of Hearing and Notice to Attend as Witness (the "**Notice of Hearing**") are:

1. On or about December 18, 2021, you failed to administer dry needling in a competent manner to D.E., resulting in bilateral pneumothoraxes.

2. You failed to provide adequate or any information to D.E. after performing dry needling on her in relation to how to recognize or respond to potential adverse events, particulars of which include:

   a. Failed to advise D.E. of potential symptoms such as increasing pain, discomfort or shortness of breath that would assist D.E. in recognizing that an adverse event, including pneumothorax, may have occurred;
   b. Failed to provide D.E. with information regarding how to manage a potential adverse event;
   c. Failed to advise D.E. to seek medical treatment on an urgent basis if she experienced any symptoms that could constitute a pneumothorax.

3. On or about June 4, 2022, you proceeded to administer dry needling to J.A.'s left cervical and shoulder girdle region, despite the increased risk of pneumothorax as a result of the significant risk factors unique to J.A. arising from his medical history and physique.

4. On or about June 4, 2022, you failed to administer dry needling in a competent manner to J.A, resulting in pneumothorax.

5. You failed to provide adequate or any information to J.A. after performing dry needling on him in relation to how to recognize or respond to a potential adverse events, particulars of which include:

   a. Failed to advise J.A. of potential symptoms such as increasing pain, discomfort or shortness of breath that would assist J.A. in recognizing that an adverse event, including pneumothorax, may have occurred;
   b. Failed to provide J.A. with information regarding how to manage a potential adverse event;
   c. Failed to advise J.A. to seek medical treatment on an urgent basis if he experienced any symptoms that could constitute a pneumothorax.

6. On or about June 4-5, 2022, you failed to adequately advise JA and/or his mother RA that he may have suffered a serious complication that necessitated medical evaluation on an urgent basis as a result of potential pneumothorax.

IT IS FURTHER ALLEGED THAT your conduct constitutes "unprofessional conduct" as defined in s. 1(1)(pp)(i), (ii), and (xii) of the HPA. In particular, it is alleged that your conduct breaches one or more of the following:

- Code of Ethical Conduct for Alberta Physiotherapists: Responsibilities to the Client (A12, A13 and A15);
- Standards of Practice for Physiotherapists in Alberta: Performance of Restricted Activities;
- Standards of Practice for Physiotherapists in Alberta: Communication;
- Standards of Practice for Physiotherapists in Alberta: Client Assessment, Diagnosis, Interventions.

(referred to altogether as the "**Allegations**")

V. AGREEMENT AND ADMISSION OF UNPROFESSIONAL CONDUCT

[8] The parties presented the Agreed Statement of Facts to the Hearing Tribunal. The Investigated Member admitted to the conduct in the Allegations.

[9] The following agreed facts are taken from the Agreed Statement of Facts.

Background Relating to the Complaint

[10] The Investigated Member became a regulated member of the College on the provisional register in January 2014 and was subsequently registered on the general register in February 2016.

[11] On November 15, 2022, the College received a complaint ("**Complaint 1**") against the Investigated Member from R.A., the mother of J.A. J.A. was a former client of the Investigated Member and had attended treatment on one occasion with her. Complaint 1 alleged that after receiving dry needling during physiotherapy treatment on June 4, 2022 from the Investigated member, J.A suffered a pneumothorax. R.A. also raised other concerns regarding consent and the Investigated Member's response after J.A. started showing symptoms.

[12] On December 1, 2022, the College received a second complaint ("**Complaint 2**") against the Investigated Member from D.E, a former client of the Investigated Member. Complaint 2 alleged that after receiving dry needling during physiotherapy treatment on December 18, 2021 from the Investigated Member, D.E. suffered a bilateral pneumothorax. D.E. also raised concerns regarding consent and the Investigated Member's response to D.E.'s concerns after she was made aware of the injury.

[13] At all relevant times of Complaint 1, the Investigated Member was employed as a physiotherapist as Clinical Director and Co-Owner of One Physiotherapy & Mobility Clinic in Calgary, Alberta (referred to hereafter as "**Clinic 1**").

[14] At all relevant times of Complaint 2, the Investigated Member was an independent contractor acting as a physiotherapist at Beacon Hill Physiotherapy & Sports Medicine in Calgary, Alberta (referred to hereafter as "**Clinic 2**"). The Investigated Member remains co-owner and a practicing physiotherapist with Clinic 1 but no longer works at Clinic 2.

[15] Upon receipt of Complaint 2 and on December 20, 2022, the Complaints Director sought a direction pursuant to s. 65 of the HPA to restrict the Investigated Member from needling in areas where there was a high risk for pneumothorax. On February 7, 2023, the Chair of the Registration Committee issued an interim order in accordance with s. 65 (the "**Interim Order**") that the Investigated Member's practice of needling be restricted to "body parts distal to the glenohumeral joint and distal to the greater trochanter" until Complaint 1 and Complaint 2 were concluded.

Agreed Facts Related to Allegations

Dry Needling Practices

[16] Administering dry needling is a restricted activity, as defined in s. 1.3 of the HPA. Dry needling constitutes a restricted activity because it involves performing an invasive procedure on body tissue below the dermis.

[17] The Investigated Member completed dry needling training between 2016 and 2017, completing the Level 1 course in 2016 and the Level 2 course in 2017. Effective February 20, 2019, the Investigated Member was authorized by the College to use needles in her practice. The Investigated Member was permitted, at all material times, to engage in dry needling. There are many possible techniques for performing dry needling including trigger point dry needling, traditional acupuncture, and intramuscular stimulation ("**IMS**"). The Investigated Member practiced IMS needling.

[18] The Complaints Director obtained an expert report from Ms. Lorrie Maffey, a regulated member of the College and a musculoskeletal clinical specialist. Ms. Maffey noted in her report that there is no set needle size when a physiotherapist performs dry needling. Instead, a physiotherapist must use their skill, judgment and training regarding the client's anatomy, medical and physiological conditions, boney backdrop and target location.

[19] When completing dry needling, there is no set or standard needle length or gauges for specific muscles. A practitioner will complete landmarking on a client's body based on standard anatomy to determine where to place the needle, the direction of the needle and how deep to place the needle. Training is provided on techniques, risks, potential adverse events, obtaining consent and landmarking. However, a physiotherapist must demonstrate professional skill, judgment, and knowledge to perform dry needling competently.

[20] When considering anatomy, patients who are obese or very muscular may make it more difficult to identify the underlying anatomy and bony backdrop, and may cause

landmarking to be less reliable. Where a patient is very lean, tall, or small, normal landmarking may also be less reliable. Where a physiotherapist has less reliable landmarking due to a patient's physique, inserting a needle less or alternatively, minimally inserting the needle, may be appropriate and may avoid risks to the client.

Risks of Pneumothorax

[21] One of the most severe adverse outcomes of dry needling is pneumothorax. Pneumothorax is a potentially life-threatening complication where an abnormal collection of air in the space between the lung and chest wall occurs when a needle enters the lung tissue. Pneumothorax is commonly known as a collapsed lung. Symptoms of pneumothorax include shortness of breath on exertion, chest pain, dry cough, decreased breath sounds or wheezing, tightness in the chest, fast heart rate, fall in blood pressure, increased neck vein distension and fatigue. Pneumothorax generally requires urgent medical assessment through a chest x-ray. Treatment for pneumothorax generally includes monitoring with follow up x-rays. In some instances, it may require hospital admission.

[22] Due to the enhanced risk, physiotherapists practicing dry needling should identify and inform a client of risks and symptoms of pneumothorax as well as offer potential interventions, such as calling the physiotherapist clinic for mild symptoms, or seek urgent or emergency care for more severe symptoms, including respiratory changes. When receiving dry needling in the thorax region, the expert Ms. Maffey opined that clients should always be advised of the signs and symptoms of pneumothorax to monitor for within 48 hours of receiving dry needling, as the symptoms can be delayed.

The Investigated Member's Practice and Probability of Pneumothorax

[23] In her practice prior to the Complaints, the Investigated Member estimated that she completed dry needling on 60%-70% of her clients, seeing approximately 75-80 clients per week.

[24] The Complaints Director obtained an expert report from Dr. Eric Parent, a regulated member of the College and an Associate Professor in the department of Physical Therapy at the University of Alberta. Dr. Parent calculated, based on the approximate amount of treatment sessions where the Investigated Member performs IMS on clients in her practice, literature on pneumothorax and the three incidents of pneumothorax reported, that the probability of pneumothorax in the Investigated Member's practice was 72.7 times larger than the worst case reported in the literature, with a probability of 1:3,808 for the Investigated Member versus the worst-case report with a probability of 1:276,788.

[25] Furthermore, Dr. Parent concluded that, from his review of the data on the Investigated Member's practice compared to the literature, the probability of a pneumothorax observed in treatments using dry needling was higher than the literature estimates available, and also higher than all but two of the upper limits of wide 99% confidence

intervals around the estimates calculated. Dr. Parent also noted that the scenarios explored may have overestimated the number of dry needling therapy sessions delivered by the Investigated Member which in turn would result in underestimating the pneumothorax probability in her practice to date.

Client D.E.

[26] D.E. began seeing the Investigated Member for physiotherapy services in August 2020 for treating vertigo. On August 20, 2020, D.E. filled out intake forms that included a treatment consent form and a dry needling consent form.

[27] Between August 20, 2020 and December 18, 2021, D.E. attended a total of sixteen appointments with the Investigated Member. Throughout her treatment with the Investigated Member, D.E. had received dry needling on her back and neck.

[28] On December 18, 2021, D.E. attended Clinic 2 for an appointment with the Investigated Member. The Investigated Member performed some usual therapies regarding vertigo and then continued to perform dry needling. The Investigated Member asked D.E. whether anything in her medical history had changed as well as obtained and documented verbal consent for treatment. The Investigated Member performed dry needling on D.E.'s upper trapezius muscles, levator scapula muscle and suboccipital muscles. Specifically, she had D.E. lie in a prone position with her arms at her side to dry needle the upper trapezius and scapula muscle. The Investigated Member obtained D.E.'s verbal consent prior to proceeding with treatment.

[29] The Investigated Member felt and landmarked for the scapula border and then pinched D.E.'s upper trapezius muscle and lifted it up then placed the needle. She directed the needle in D.E.'s upper trapezius muscle while standing at the head of the bed. When needling the levator scapula muscle, she directed the needle towards the thorax, or in a parallel position.

[30] The Investigated Member used 40-millimeter needles for D.E.'s upper trapezius muscles and levator scapula muscle, which was her standard practice. The Investigated member did not document the length of needle nor the depth inserted in D.E.'s chart.

[31] The Investigated Member used a 30-millimetre needle for the suboccipital muscles, which similarly was her standard practice. The Investigated Member did not document the length of needle nor the depth inserted in D.E.'s chart. While receiving dry needing, D.E. reported feeling a pop.

[32] Prior to ending the appointment and despite D.E. experiencing a "pop" during dry needling, the Investigated Member did not provide any information to D.E. regarding potential adverse events, such as pneumothorax. No education or counselling to D.E. on the possibility of an adverse event, or what to do if symptoms occur, is documented by then Investigated Member in D.E.'s chart. The Investigated Member did not recall, nor

document, that anything unusual happened during D.E.'s appointment and instead she documented that D.E. tolerated the treatment well.

[33] D.E. returned home after the appointment and later felt her breath becoming shorter and shorter throughout the evening. D.E. woke up the next morning with chest pain and was transported to the hospital via ambulance. D.E. was diagnosed with bilateral pneumothoraxes, received treatment, and had to take approximately one month off work. Her lungs returned to normal capacity after six weeks. She experienced physical pain, panic, and financial stress due to the injury she suffered from the Investigated Member's dry needling. D.E. was 20 years old at the time of her injury.

Client J.A.

[34] J.A. had his first appointment with the Investigated Member on June 4, 2022. He attended the appointment to assist with pain in his shoulder. Prior to beginning his appointment with the Investigated Member, he filled out intake forms that included a treatment consent form and a dry needling consent form. On the consent form, J.A. indicated that he has […] […] and […]. The Investigated Member assessed J.A. at the beginning of the appointment. The chart was not completed and signed by the Investigated Member until August 9, 2022 as she completed scratch pad notes and then later transferred her charting into the Jane software system in August.

[35] J.A. had only received dry needling once before his appointment with the Investigated Member. The Investigated Member performed dry needling on J.A. despite his reported health conditions and slender and lean physique. Specifically, he was 6 foot 4 inches and approximately 185 pounds. During the appointment, the Investigated Member's treatment focused on J.A.'s cervical and shoulder girdle regions, due to his pain in those areas. Specifically, she performed dry needling on his upper fibre trapezius muscles, levator scapula muscle, deltoid muscle, rhomboid muscles and latissimus dorsi muscle.

[36] While receiving dry needing, J.A. was in pain but decided to tough it out. Although […] […] is an inflammatory disease that does not affect the bony backdrop of a spine, […] has the potential of causing issues with the bony structure of the spine.

[37] The Investigated Member checked J.A.'s posture, tone and scoliosis prior to performing dry needling. However, despite J.A. indicating his medical conditions on his intake form and his slender physique which both caused a significantly increased risk of pneumothorax, the Investigated Member performed dry needling on numerous locations in the cervical and shoulder girdle regions, near the lungs.

[38] J.A. was positioned in the prone position with his head down while receiving dry needling, with some changes to his arm position throughout the needling.

[39] The Investigated Member felt and landmarked for the scapula border and then pinched J.A.'s upper trapezius muscle and lifted it up then placed the needle. She directed the

needle in J.A.'s upper trapezius muscle towards the supraclavicular fossa area with a 40-milimetre needle. She completed needling on the upper trapezius muscles bilaterally.

[40] Regarding the levator scapula muscle, the Investigated Member landmarked from the upper scapula, lifted and pinched, using a 40-milimetre needle and needled parallel to the lungs. Regarding the deltoid muscle, the Investigated Member pinched between the anterior and posterior head of the deltoid and using a 40-millimeter needle at an unknown depth. Regarding the rhomboid muscles, the Investigated Member had J.A. place his hand in the small of his back and landmarked based on the scapula border for the rhomboid and inserted a 40-millimetre needle at a lessor, but unknown, depth. Regarding the latissimus dorsi muscle, the Investigated Member had J.A.'s hand hang on the side of the bed, landmarked the scapula and pinched the latissimus dorsi. She used a 40-millimeter needle at an unknown depth.

[41] The Investigated Member did not document the length of needle nor the depth inserted in J.A.'s chart. However, she documented that J.A. twitched when needling the rhomboid and latissimus dorsi muscles.

[42] The Investigated Member did not recall, nor document, that anything unusual happened during J.A.'s dry needling. She then continued to perform fascial stretch therapy, cupping, and moist heat therapy.

[43] Closer to the end of his appointment, J.A. felt pain in his chest while he was receiving moist heat therapy with hot packs but did not say anything.

[44] Prior to ending the appointment, the Investigated Member did not provide any information to J.A. regarding recognizing or responding to potential adverse events, such as pneumothorax. No education or counselling to J.A. on the possibility of an adverse event, or what to do if symptoms occur, is documented by the Investigated Member in J.A.'s chart.

[45] The only post-treatment care advice documented by the Investigated Member was gentle mobility, hydration and stretching.

[46] J.A. left the appointment and on his drive home, he continued to feel the pain in his back increase. He later felt it was becoming difficult to breathe in addition to his pain. Later that day, J.A. showered at home and felt that things were floating inside his chest and developed a dry and persistent cough.

[47] J.A. then obtained the Investigated Member's contact information. He called Clinic 1, leaving a voicemail for the Investigated Member, seeking her assistance, indicating that he was nervous, describing his symptoms and asked what was going on. J.A. later learned that pneumothorax was a potential outcome from dry needling, and later that day, J.A. went to urgent care and updated his mother.

[48] On or about June 4, 2022, R.A. texted the Investigated Member with J.A.'s symptoms, including that he had shortness of breath, dry cough, pain in upper back and right chest and sharp pain with deep breaths. She also advised the Investigated Member that J.A. had gone to urgent care. The Investigated Member responded to R.A. indicating that J.A. should get "himself checked out" but that in her experience "it's nothing which is serious" as well as commented on potential emotional release and to ice his neck and shoulder and to take pain relief medication.

[49] They continued to text each other where R.A. advised that urgent care believed it was pneumothorax, asking the Investigated Member if the needles would have come near the lung. The Investigated Member responded that sometimes patients "twitch or move" during treatment and bruising near the "parietal layer can happen." She also indicated that it resolves itself in 2-3 days and they provide pain medication.

[50] While J.A. was still at urgent care, he received a text from the Investigated Member. In her message, she indicated she had heard from R.A. and apologized for missing his voicemail and that he was experiencing symptoms. She indicated that it could be because of his left shoulder blade resting higher and that his "lung field was shifted".

[51] J.A. was then transferred and admitted to the hospital in the early morning on June 5, 2022 and was diagnosed with a large pneumothorax on his left side. Due to the pneumothorax, J.A. took approximately eight days off work and then returned on modified duties for approximately two weeks. He was also told that he could not fly in an airplane nor dive into water for three months. He experienced a stressful hospital admission, physical pain, ongoing fatigue, and financial stress due to the injury he suffered from the Investigated Member's dry needling. J.A. was 19 years old at the time of his injury.

Acknowledgement of Unprofessional Conduct

[52] The Investigated Member admitted to the conduct as set out in the Notice of Hearing. The Investigated Member further acknowledged that her conduct amounted to unprofessional conduct within the meaning of s. 1(1)(pp) of the HPA.

[53] Specifically, the Investigated Member acknowledged her conduct constitutes a lack of knowledge, skill or judgment in the provision of professional services (s. 1(1)(pp)(i)); and contravenes the College's Code of Ethical Conduct (also referred to as the "**Code**"), and Standards of Practice (also referred to as the "**Standards**"), specifically:

- Code of Ethical Conduct for Alberta Physiotherapists: Responsibilities to the Client (A12, A13 and A15);

- Standards of Practice for Physiotherapists in Alberta: Performance of Restricted Activities;

- Standards of Practice for Physiotherapists in Alberta: Communication;
- Standards of Practice for Physiotherapists in Alberta: Client Assessment, Diagnosis, Interventions; and

Is conduct that harms the integrity of the regulation profession (s. 1(1)(pp)(xii)).

VI. SUBMISSIONS OF THE PARTIES

Submissions on Behalf of the Complaints Director

[54] Ms. Wensel submitted that the Hearing Tribunal's tasks at this stage are to determine if the facts underlying the Allegations have been established, and if so, whether this conduct amounts to unprofessional conduct under the HPA. If yes to both, then the Hearing Tribunal must determine the appropriate sanction.

[55] Ms. Wensel also submitted that the Hearing Tribunal should accept the Agreed Statement of Facts and noted that it had been admitted to and agreed to by the Investigated Member.

[56] Ms. Wensel then presented the Agreed Statement of Facts. She submitted that the Investigated Member (1) failed to administer dry needling to D.E in a competent manner; (2) failed to provide adequate or any information to D.E. after performing dry needling in relation to potential adverse events; (3) failed to administer dry needling to J.A. in a competent manner; (4) administered dry needling to J.A. despite the increased risk of pneumothorax as a result of J.A.'s significant risk factors; (5) failed to provide adequate or any information to J.A. after performing dry needling in relation to potential adverse events; and (6) failed to adequately advise J.A. or his mother R.A. that he may have suffered a serious complication as a result of potential pneumothorax.

[57] Ms. Wensel then submitted the Complaints Director's position that the Allegations before the Hearing Tribunal were factually proven and that the conduct constitutes unprofessional conduct. She noted there is no dispute between the parties about the facts or whether the conduct constitutes unprofessional conduct. She noted the Agreed Statement of Facts sets out the facts the parties agreed occurred and that the conduct admitted to is unprofessional conduct. She noted the Investigated Member has admitted to all six of the allegations.

[58] Ms. Wensel's concluded by noting that the Investigated Member's conduct constitutes "unprofessional conduct" as defined in s. 1(1)(pp)(i), (ii), and (xii) of the HPA. In particular, Ms. Wensel submitted that the Investigated Member displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services, and contravened the Code of Ethical Conduct for Alberta Physiotherapists as well as contravened the relevant Standards of Practice for Physiotherapists in Alberta as set out in the Notice of Hearing and Agreed Statement of Facts.

Submissions by the Investigated Member

[59] Mr. Appelt echoed Ms. Wensel's submissions regarding the Hearing Tribunal's tasks and potential findings. Mr. Appelt acknowledged that Ms. Wensel accurately set out the material facts in the Agreed Statement of Facts, and confirmed that the Investigated Member acknowledges that those Allegations have been made out factually.

[60] Secondly, Mr. Appelt noted that the facts do trigger or fall within the definition of unprofessional conduct for the purpose of the HPA. He concluded by asking that the Agreed Statement of Facts be accepted by the Hearing Tribunal.

VII. DECISION OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

[61] Following submissions on the Agreed Statement of Facts, the Hearing Tribunal adjourned to deliberate.

[62] The Hearing Tribunal found that the Allegations in the Notice of Hearing are proven. The Hearing Tribunal found that the conduct in the Allegations constitute unprofessional conduct, as admitted by the Investigated Member and agreed to by both of the parties as in the Agreed Statement of Facts.

[63] Further, the Hearing Tribunal found that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the HPA. In particular, the Hearing Tribunal found the following definitions of unprofessional conduct were met:

(i) displaying a lack of knowledge of or a lack of skill or judgment in the provision of professional services;

(ii) contravention of the HPA, a Code of Ethics or Standards of Practice; and

(xii) conduct that harms the integrity of the regulated profession.

VIII. REASONS AND FINDINGS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

[64] The Hearing Tribunal considered Ms. Wensel's submissions and Mr. Appelt's submissions, and noted that Mr. Appelt had no objections to Ms. Wensel's submissions. Further, the Hearing Tribunal considered that the Investigated Member agreed with the facts as they were outlined in the Agreed Statement of Facts and that she acknowledged the conduct occurred. For these reasons, the Hearing Tribunal was satisfied, on a balance of probabilities, that the conduct in the Allegations did occur.

[65] The Hearing Tribunal found that the Investigated Member showed a lack of judgment and skill in the provision of professional services, constituting unprofessional conduct as defined in s. 1(1)(pp)(i) of the HPA.

[66] Physiotherapists who perform dry needling, must be competent in doing so. It was the Investigated Member's responsibility to ensure that, and consider whether, she was competent to do so. Given the Investigated Member's academic credentials and previous experience with dry needling, knowledge did not appear to be the issue in this case. Rather, the Investigated Member demonstrated a lack of judgment and skill in performing dry needling in these instances.

[67] On December 18, 2021, the Investigated Member performed dry needling on D.E. in an incompetent manner demonstrating a lack of judgment and skill by (a) using needles that were too long, specifically above 25-milimetres on D.E's upper trapezius muscles and levator scapula muscle; (b) inserting the needles at an unknown depth, and where the proper depth was 10 to 25-milimetres on upper trapezius, levator scapula and suboccipital muscles, which are all thin muscles; (c) in considering the opinion of Ms. Maffey regarding the direction and placement of needles, placing and/or directing the needle in a manner that put the lungs and lung tissue at risk, when performing dry needling on the upper trapezius muscle; and (d) inadequately considering D.E's anatomy, boney backdrop and the target location.

[68] On June 4, 2022, the Investigated Member performed dry needling on J.A. in an incompetent manner demonstrating a lack of judgment and skill by (a) using needles that were too long, specifically when she used a 40-milimetre needle on J.A. without considering his lean physique and the thin muscles; (b) inserting the needles at an unknown depth on the upper fibre trapezius muscles, levator scapula muscle, deltoid muscle, rhomboid muscles and latissimus dorsi muscle; (c) considering the opinion of Ms. Maffey regarding the direction and placement of needles, placing and/or directing the needle in a manner that put the lungs and lung tissue at risk, when performing dry needling on the upper trapezius muscle; and (d) inadequately considering J.A's anatomy, bony backdrop and increased risks due to […] […]. The Investigated Member also performed dry needling on J.A. despite his reported health conditions and slender and lean physique.

[69] The above constitutes unprofessional conduct as defined in s. 1(1)(pp)(i) of the HPA.

[70] The Hearing Tribunal also noted the particular vulnerabilities of the two patients as well as the serious potential health consequences of pneumothorax. Both patients were young, were unfamiliar the potential adverse effects of dry needling, and experienced adverse consequences as a result of pneumothorax.

[71] The Hearing Tribunal further noted that the Interim Order granted by the Registration Committee Chair on February 7, 2023, setting out restrictions on the Investigated Member's ability to provide needling, was an indicator of the seriousness of the conduct. The College had already flagged the Investigated Member's practice.

[72] The Hearing Tribunal also found that the Investigated Member contravened the code of ethics and standards of practice for physiotherapists in Alberta. The breaches were

serious enough to constitute unprofessional conduct as defined in s. 1(1)(pp)(ii) of the HPA.

[73] Regarding the dry needling performed on both D.E. and J.A. resulting in pneumothorax, the Investigated Member contravened the Code. Specifically, the Investigated Member contravened the Code, Responsibilities to the Client, A12, by failing to practice in a safe, competent, accountable, and responsible manner during the provision of services. As described above, the Investigated Member performed dry needling on D.E. on December 18, 2021 in an incompetent manner. As also described above, the Investigated Member performed dry needling on J.A. on June 4, 2022, in an incompetent manner. The Investigated Member also contravened the Code, Responsibilities to the Client, A15, by failing to practice the profession of physiotherapy according to her own competence and limitations.

[74] The Investigated Member also contravened the Code, Responsibilities to the Client, A13, by failing to take all reasonable steps to prevent harm to clients. The Investigated Member used needles that were too long, inserted those needles at an unknown depth, and placing or directing the needle in a manner that put the lungs and lung tissue at risk, causing both D.E. and J.A. to experience harm from pneumothorax. The Investigated Member did not take reasonable steps to mitigate the potential harm.

[75] The Investigated Member also breached the Standards, specifically, Performance of Restricted Activities, by failing to perform restricted activities that she was competent and authorized to perform and when client assessment findings support their use. As mentioned above, the Investigated Member performed dry needling on J.A. despite his reported health conditions and slender and lean physique.

[76] The Hearing Tribunal also found that the Investigated Member's admitted conduct post-needling also constitutes unprofessional conduct.

[77] After performing dry needling on D.E. on December 18, 2021 in the thorax region, the Investigated Member did not provide any information to D.E. regarding recognizing or responding to potential adverse events, such as pneumothorax. Specifically, the Investigated Member did not (a) advise or counsel D.E about potential symptoms such as increasing pain, discomfort, or shortness of breath; (b) advise or counsel D.E. about how to manage a potential adverse event, for example, by calling the clinic; nor (c) advise or counsel D.E. about seeking medical treatment on an urgent basis if she experienced symptoms, such as symptoms of pneumothorax, for example, by going to the hospital or urgent care.

[78] After performing dry needling on J.A. on June 4, 2022, the Investigated Member did not provide any information to J.A. regarding recognizing or responding to potential adverse events, such as pneumothorax. Specifically, after performing dry needling on J.A. on June 4, 2022, the Investigated Member did not (a) advise or counsel J.A. about potential symptoms such as increasing pain, discomfort, or shortness of breath; (b) advise or

counsel J.A. about how to manage a potential adverse event, for example by calling the clinic; nor (c) advise or counsel J.A. about seeking medical treatment on an urgent basis if he experienced symptoms, such as symptoms of pneumothorax, for example, by going to the hospital or urgent care. The only post-treatment care advice documented by the Investigated Member was gentle mobility, hydration and stretching.

[79] Although the Investigated Member provided some information to R.A. during their text correspondence after learning about J.A.'s post-needling symptoms, the information was inadequate considering the serious adverse event and potential impacts of pneumothorax, which the Investigated Member had learned in her training as well as based on D.E.'s reported concerns only six months prior. The Investigated Member downplayed the potentially serious and life-threatening complications as a result of a pneumothorax and failed to advise R.A. and J.A. that J.A. required assessment on an urgent basis.

[80] The Hearing Tribunal therefore also found that the Investigated Member contravened the Standards, specifically, Client Assessment, Diagnosis, Interventions, by failing to demonstrate proficiency in client assessment, diagnosis, and interventions to deliver quality client-centered services to both D.E. and J.A. with respect to dry needling. The Investigated Member also contravened the Standards, specifically, Communication, by failing to communicate clearly, effectively, professionally, and in a timely manner to both D.E. and J.A. with respect to performing dry needling and failing to provide information to them regarding potential adverse events. The Investigated Member's failure to advise J.A., directly or through his mother R.A., that J.A. required assessment on an urgent basis, was also a breach of these Standards.

[81] The Hearing Tribunal also found that the public would view the Investigated Member's conduct quite poorly, and that her conduct undermines the trust of the public in the profession of physiotherapy. The Hearing Tribunal therefore found that the conduct in the Allegations harms the integrity of the profession and is unprofessional conduct pursuant to s. 1(1)(pp)(xii) of the HPA.

[82] The profession must take the conduct seriously, since a failure to do so undermines the integrity of the profession as a whole.

IX. JOINT SUBMISSION ON PENALTY

[83] After finding that the conduct admitted to amounts to unprofessional conduct, the Hearing Tribunal indicated it would hear submissions on sanction.

[84] The parties presented a Joint Submission on Penalty to the Hearing Tribunal.

Submissions on behalf of the Complaints Director

[85] Ms. Wensel submitted that there is a very high threshold for rejecting a joint submission on sanction, as per the Supreme Court of Canada's decision in *R v Anthony-Cook*, 2016 SCC 43. She submitted that the standard for rejecting a joint submission is if it is so unhinged from the circumstances of the conduct that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, to believe the proper functioning of the justice system had broken down.

[86] Ms. Wensel also highlighted how the Investigated Member had accepted responsibility and given up her right to contest the allegations in the hearing.

[87] Ms. Wensel then provided an overview of the Joint Submission on Penalty. Ms. Wensel mentioned some of the proposed penalties in the joint submission, including that: the Investigated Member would receive a reprimand and the Hearing Tribunal's decision would serve as a reprimand; the Investigated Member would complete additional courses, including the PBI Risk Management Course; the Investigated Member would receive temporary supervision; a practice restriction would remain on the Investigated Member until certain requirements were met; and the Investigated Member would pay 25% of the total costs of the investigation and hearing to a maximum of $10,000.00.

[88] Ms. Wensel submitted that the following relevant factors from the case of *Jaswal v. Newfoundland Medical Board*, [1996] 42 Admin L.R. (2d) 233 ("*Jaswal*") should be considered in deciding the penalty:

a. *Nature and gravity of the proven allegations*: Ms. Wensel acknowledged that, in this case, the conduct was quite serious. Two young patients were sent to the hospital with pneumothorax which is a serious condition.

b. *Age and experience of the member*: Ms. Wensel noted that the Investigated Member had experience performing dry needling for several years.

c. *The previous character of the member*: Ms. Wensel acknowledged that there was no past conduct to consider and that, traditionally, this would be a mitigating factor.

d. *The age and mental condition of the offended patient*: Ms. Wensel noted both patients, D.E. and J.A., were quite young and uninformed about the potential consequences of dry needling. They were both in a vulnerable position.

e. *The number of times the offence was proven to have occurred*: Ms. Wensel noted that the dry needling incident occurred with more than one client, and that there were three pneumothoraxes altogether. This was an aggravating factor in that it occurred more than once and to more than one client.

f. *The role of the member in acknowledging what occurred*: Ms. Wensel noted that the Investigated Member admitted to the conduct and accepted responsibility. This saved both patients from testifying. This was a significantly mitigating factor.

g. *Whether the member has suffered other serious financial or other penalties*: Ms. Wensel mentioned that the Investigated Member did not lose her employment, and remains a co-owner of her clinic. However, there has been considerable impact from the Interim Order. Ms. Wensel noted that the Investigated Member has been bound by relatively restrictive conditions related to dry needling for nine months which affects her practice and business. Ms. Wensel submitted that this should be considered.

h. *The impact of the incident on the patient*: According to Ms. Wensel, D.E. was furious about the incident and J.A. felt the incident was anxiety-producing. Both patients required visits to the hospital, missed work, and suffered financial consequences due to pneumothorax.

i. *The presence or absence of any mitigating circumstances*: Ultimately, Ms. Wensel acknowledged the Investigated Member's acceptance of responsibility and that there was no evidence of previous conduct.

j. *The need to promote specific and general deterrence*: Ms. Wensel's position was that the reprimand and the hearing process were sufficient to deter the Investigated Member. Additionally, the penalty would support general deterrence. The proposed penalty would send the message that, if another practitioner commits the same conduct, there can and will be ongoing restrictions to practice via mandated supervision, for example.

k. *The need to maintain the public's confidence in the integrity of the profession*: Ms. Wensel acknowledged that it was clear there was trust lost in the practice of physiotherapy through the conduct.

l. *The degree to which the offensive conduct was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct*: Ms. Wensel noted it was clear the conduct fell outside the accepted standards. She submitted that bringing the Investigated Member in line with accepted standards would help with improving confidence in the profession.

[89] Ms. Wensel also provided submissions on costs. She discussed the parties' agreement on costs in the context of *Jinnah v Alberta Dental Association and College*, 2022 ABCA 336 ("*Jinnah*"). In *Jinnah*, the Alberta Court of Appeal stated that a compelling reason must exist to impose costs on a member who commits unprofessional conduct. At paragraphs 139 to 144, the Court set out four such reasons to impose costs:

(1) A member who engages in serious unprofessional conduct;

(2) A member who is a serial offender engages in unprofessional conduct on two or more occasions;

(3) A member who fails to cooperate with investigators and forces the College to expend more resources than is necessary to ascertain the facts related to a complaint; and

(4) A member who engages in hearing misconduct.

[90] Ms. Wensel submitted that, as per the Court's reasoning in *Jinnah*, costs should not be awarded in every case. Regulators should bear costs unless there is a compelling reason to do so. It is the task of the Hearing Tribunal to determine if costs are warranted, and what the amount of costs should be.

[91] Ms. Wensel submitted that a marked departure from the ordinary standard of care is an example of serious unprofessional conduct as contemplated in *Jinnah* that will justify an order of costs. She submitted that costs in this case were warranted because of the serious unprofessional conduct. The Investigated Member's care fell markedly below the ordinary standard.

[92] According to Ms. Wensel, the amount of 25% of the total costs of the investigation and hearing to a maximum of $10,000.00 was appropriate and does not stray outside the reasoning in *Jinnah*. She also noted the anticipated estimate costs of the hearing process as of October 2023 was around $47,000.00.

[93] Ultimately, Ms. Wensel noted this was an appropriate penalty considering public protection and the vulnerability of patients.

<u>Submissions by the Investigated Member</u>

[94] Mr. Appelt submitted that he believed the Joint Submission on Penalty was appropriate. He noted the two parties had worked hard to come to this agreement. He also noted the 13 non-exhaustive factors in *Jaswal* and provided some additional submissions in addition to Ms. Wensel's submissions on these factors.

[95] Mr. Appelt confirmed that the Investigated Member had not been the subject of previous complaints or practice restrictions. She generally had positive performance reviews which assisted with establishing her new clinic. This absence of prior complaints, considered alongside her strong academic background, were mitigating factors according to Mr. Appelt.

[96] The other consequences to the Investigated Member were also noted. Mr. Appelt explained how the interim condition imposed on the Investigated Member's practice in February 2023 affected her business. The Interim Order created restrictions preventing the Investigated Member from needling the thorax of her patients. This caused a loss of income. The Investigated Member estimated that 75-80% of her clients would undergo

dry needling to the thorax area prior to the restrictions being imposed. Mr. Appelt also mentioned that the Investigated Member suffered reputational harm which also led to a loss of business.

[97] Mr. Appelt then provided additional submissions on the *Jaswal* factors before concluding by explaining that he agreed with the submissions of Ms. Wensel. He asked that the Hearing Tribunal accept the Joint Submission on Penalty.

X. DECISION OF THE HEARING TRIBUNAL ON PENALTY

[98] Following submissions on the Joint Submission on Penalty, the Hearing Tribunal adjourned to deliberate.

[99] The Hearing Tribunal carefully considered the submissions of the parties. The Hearing Tribunal determined that it would accept the Joint Submission on Penalty presented by the parties.

XI. REASONS AND FINDINGS OF THE HEARING TRIBUNAL ON PENALTY

[100] The Hearing Tribunal found that the proposed penalties were appropriate and reasonable and would protect the public interest. The Hearing Tribunal also noted that, when parties propose a joint submission, a high level of deference is owed. The Hearing Tribunal agreed with the submissions of Ms. Wensel that there were significant mitigating and aggravating factors affecting what constitutes an appropriate and reasonable sanction.

[101] First, a reprimand was appropriate and reasonable. The Hearing Tribunal noted that a reprimand would help accomplish the objectives of specific and general deterrence. It would make clear to the Investigated Member, and others, that the conduct is serious and unacceptable.

[102] The Hearing Tribunal also agreed with the parties that it was appropriate for the Investigated Member to complete additional courses, including the PBI Risk Management Course and at least one other course on dry needling, as set out in the Joint Submission on Penalty. The Hearing Tribunal noted its findings that the Investigated Member had demonstrated a lack of judgment and skill in performing dry needling on D.E. and J.A., resulting in pneumothorax. While the Investigated Member was quite experienced in dry needling and there were no instances of prior conduct, pneumothorax occurred with more than one client and there were three altogether. The Investigated Member's practice also had an increased risk of causing pneumothorax. Additional education would assist the Investigated Member with preventing similar incidents in the future. This would help ensure public protection.

[103] A period of supervised practice, and restriction on the Investigated Member's practice permit, is also appropriate. The Investigated Member's conduct was serious and had significant consequences for two vulnerable patients. Temporary supervision and

restriction are appropriate to prevent further harm to members of the public while the Investigated Member takes steps to improve her needling practice. A restriction has already been in place since February 2023 via the Interim Order.

[104] The Hearing Tribunal next considered the matter of costs and the submissions of the parties. The Hearing Tribunal found that an order of costs is appropriate and reasonable in the circumstances of this case. The Hearing Tribunal considered the seriousness of the unprofessional conduct and that the public may lose confidence in the profession if responsibility for some portion of costs does not fall on the Investigated Member. The Hearing Tribunal noted that in accordance with the principles in *Jinnah*, this is a case where a significant order of costs can be made given the serious unprofessional conduct in the Allegations.

[105] Costs speak to accountability. There has been serious unprofessional conduct in this case. The Investigated Member departed markedly from the ordinary standard of care in causing patients to suffer pneumothorax through dry needling. The Investigated Member should therefore bare some of the costs.

[106] The Hearing Tribunal acknowledged that the Investigated Member was cooperative in coming to an agreement with the Complaints Director. The Investigated Member took responsibility for her actions and the parties, as well as D.E. and J.A., were thus able to avoid a lengthy hearing stage. These mitigating factors were considered by the Hearing Tribunal. The Hearing Tribunal concluded that a costs order of 25% of investigation and hearing costs, to a maximum of $10,000.00, was appropriate and reasonable in the circumstances, having taken into consideration the mitigating factors. The Investigated Member did not lose her employment, and remains a co-owner of her clinic, which assists her ability to pay. The 12-month timeline for paying costs is reasonable.

XII. ORDERS OF THE HEARING TRIBUNAL

[107] The Hearing Tribunal hereby orders, as follows:

1. Ms. Moiz shall receive a reprimand and the Hearing Tribunal's decision shall serve as a reprimand.

2. Ms. Moiz shall complete, at her own cost, the PBI Risk Management Course available online at https://pbieducation.com/risk-management/. Ms. Moiz shall provide the Complaints Director with a certificate confirming successful completion of the course within six (6) months of service of the Hearing Tribunal's written decision.

3. Ms. Moiz shall complete, at her own cost, one of the below courses and provide the Complaints Director with a certificate confirming successful completion of one of the courses within twelve (12) months of service of the Hearing Tribunal's written decision:

a. Foundations Health Education AN-IMS1 (Available online at https://www.foundationsedu.ca/courses-workshops/)

b. SMART Seminars Certification in Biomedical Dry Needling (Available online at https://www.smartseminars.org/projects)

c. UBC Gunn IMS (Certification) Course (Available online at https://www.gunnims.com/gunn-ims-course-calendar.html)

d. Functional Dry Needling Level 2 (Evidence in Motion) (Available online at https://evidenceinmotion.com/course/functional-dry-needling-level-2/)s

e. Dry Needling Program – Level II (Acupuncture Canada) (available online at https://acupuncturecanada.org/education-certification/courses/dry-needling- program-level-ii/).

4. Should Ms. Moiz be unable to comply with the selected courses in paragraph 2 or 3 within the deadlines identified above due to scheduling difficulties, she may apply to the Complaints Director for an extension, by submitting a written request prior to the deadline. Extensions may be granted in the sole discretion of the Complaints Director.

5. After Ms. Moiz completes the courses identified in paragraphs 2 and 3, she shall successfully complete supervision (hereafter the "Supervised Practice"), subject to the following conditions:

a. The Supervised Practice will be facilitated and approved by the Complaints Director;

b. Ms. Moiz must agree to and sign a supervision agreement (the "Supervision Agreement") outlining the criteria to be met by Ms. Moiz by the end of the Supervised Practice period;

c. Ms. Moiz is responsible for any fees or costs associated with the completion of the Supervised Practice and as requested by the Approved Supervisor;

d. The Approved Supervisor will be mutually agreed upon by the Complaints Director and Ms. Moiz, and must be a physiotherapist who is qualified to perform dry needling and has previous experience acting in a supervisory or mentorship role;

e. Ms. Moiz is responsible for finding an Approved Supervisor and must make reasonable efforts to find an Approved Supervisor. If Ms. Moiz is unable to find an Approved Supervisor, she may seek assistance from the Complaints Director in finding an Approved Supervisor, demonstrating all reasonable

efforts taken by her and the reasons for not finding an Approved Supervisor to date;

f. The Supervised Practice will proceed as follows:

i. The Approved Supervisor will be provided with a copy of the Agreed Statement of Facts, all attachments, and the Hearing Tribunal's written decision, and confirm their review of the same;

ii. Ms. Moiz will attend at the Approved Supervisor's place of business for a minimum of 8 sessions of 3 hours duration (24 hours in total) (the "Session" or collectively, "Sessions"). The Sessions will take place over a minimum period of 8 weeks but must be completed within 16 weeks;

iii. During the Supervised Practice, Ms. Moiz will observe the Approved Supervisor while they treat patients who attend for dry needling;

iv. After the Approved Supervisor is satisfied that Ms. Moiz has engaged in an adequate period of observation, the Approved Supervisor will, in their discretion, permit Ms. Moiz to administer dry needling to patients, including in the neck and trunk area (posterior, anterior and lateral from C4 to L2);

v. All dry needling performed by Ms. Moiz will be undertaken under direct supervision by the Approved Supervisor;

vi. During each Session with Ms. Moiz, the Approved Supervisor and Ms. Moiz will engage in discussion and feedback on the observation and supervision completed, with specific reference to any areas of improvement identified for Ms. Moiz relating to her dry needling practice;

vii. After each Session with Ms. Moiz, the Approved Supervisor will complete an hourly log, indicating the number of hours of supervision completed by Ms. Moiz;

viii. After each Session directly supervising Ms. Moiz, the Approved Supervisor will complete a Skills Checklist with regard to Ms. Moiz's practice, provided by the College.

6. Upon completing the period of the Supervised Practice outlined in paragraph 5, the Approved Supervisor must provide the Complaints Director:

a. Copies of all documentation in connection with the period of the Supervised Practice, as referred to in paragraph 5;

b. A written report summarizing the results of the period of the Supervised Practice, including:

i. Whether the Approved Supervisor has any concerns with respect to Ms. Moiz's ability to practice dry needling independently as a physiotherapist, specifically to the neck and trunk area (posterior, anterior and lateral from C4 to L2);

ii. Whether Ms. Moiz has met "At Expected Level" or above in all categories in the Skills Checklist, provided by the College, in the last 3 Sessions;

iii. If applicable, whether the Approved Supervisor recommends an extension of the Supervised Practice in order to address the concerns outlined in paragraph 6.b.i.

7. If the Approved Supervisor has concerns about Ms. Moiz's practice and/or if she fails to meet the "At Expected Level" in any of the categories outlined in the Skills Checklist, the Complaints Director may in their sole discretion extend the Supervised Practice for a reasonable period of time.

8. If the Approved Supervisor has no concerns regarding Ms. Moiz' ability to practice dry needling independently and if she meets the "At Expected Level" or above in the last 3 sessions, the restriction on Ms. Moiz' practice permit will be removed.

9. Subject to paragraph 10, Ms. Moiz's practice restriction "Authorization to provide needling is restricted to body parts distal to the glenohumeral [shoulder] joint and distal to the greater trochanter [hip joint]" will remain in place until:

a. Ms. Moiz provides proof to the Complaints Director that she has successfully completed the requirements set out above at paragraphs 2-3, and

b. The Complaints Director has received the written report referenced in paragraph 6.b and the Approved Supervisor has confirmed that Ms. Moiz meets the "At Expected Level" or above in the last 3 sessions.

10. The restriction on Ms. Moiz's practice permit will not be in effect while Ms. Moiz practices under the direct supervision of the Approved Supervisor.

11. The orders set out above at paragraphs 2-5 will appear as conditions on Ms. Moiz's practice permit and on the public register and will be removed once the orders are completed.

12. Should Ms. Moiz be unable to comply with any of the deadlines for completion of the orders identified above, she may apply to the Complaints Director for an extension, by submitting a written request prior to the deadline. Extensions may be granted in the sole discretion of the Complaints Director.

13. Should Ms. Moiz fail to comply with any of the orders above within the deadline specified or within the period of the extended deadline granted by the Complaints Director, the Complaints Director may do any or all of the following:

    a. Treat Ms. Moiz's non-compliance as information for a complaint under s. 56 of the Act,

    b. In the case of failure to complete the courses, Supervised Practice or pay costs within the timelines referred to above, or within the amended deadline agreed to by the Complaints Director, Ms. Moiz's practice permit will be suspended until she has complied with the outstanding order(s); or

    c. Refer the matter back to a hearing tribunal for further direction.

14. Ms. Moiz shall pay twenty-five percent (25%) of the total costs of the investigation and hearing, to a maximum of $10,000 (the "Costs'') and on the following terms:

    a. the Costs are due twelve (12) months after the date that Ms. Moiz receives a copy of the Hearing Tribunal's written decision;

    b. the Costs must be paid to the College, whether or not Ms. Moiz holds an active practice permit with the College; and

    c. the Costs are a debt owed to the College and if not paid by the deadline indicated, may be recovered by the College as an action of debt.

DATED this _6th_ day of February, 2024.

Signed by the Chair on behalf of the Hearing Tribunal

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Sharla Butler, PT, Chair