Sexual Abuse by Health Care Professionals:
The Failure of Reform in Ontario

Sanda Rodgers*

Individually and collectively, those who drive the college processes
have chosen, in case after case, not to embrace fully what the RHPA
has to offer Ontario patients or to implement the policy of zero
tolerance of sexual abuse. We must therefore ask, ‘Whose interests are
being served?’

Feminist attempts to ensure rigorous legal response to sexual violence against
women and children have been characterized by persistent resistance and occasional victory. Feminist reform of law seeks to enhance women’s equality by
eliminating embedded legal bias and by deterring legally sanctioned violence. Hostile resistance to feminist law reform has been most clearly demonstrated both in litigation strategies and through concerted lobbying against amendments to the
Criminal Code sexual offence provisions. Similar battles have accompanied

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* Sanda Rodgers is the Shirley Greenberg Professor of Women and the Legal Profession in the Faculty of
Law, University of Ottawa. The author wishes to thank the Social Sciences and Humanities Research
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1 This article reviews the responses to sexual abuse by health care professionals with particular attention
to the provisions in the province of Ontario. A recent provincial audit of their implementation has
provided outstanding data from which to undertake an assessment of the impact of legislative change in
that province. The policies and provisions of the other provinces and of national health provider
organizations also are considered. (See II. Legislative and Policy Reforms, infra.) Special Task Force on
Sexual Abuse of Patients, What about accountability to the patient?: Final Report of the Special Task
Force on Sexual Abuse of Patients (Toronto: The Task Force, 2000) (Chair: Marilou McPhredran) [2000
Report] at 23.

2 For an overview see generally: Jennifer Scott & Sheila McIntyre, Women’s Legal Education and Action
Fund Submission to the Standing Committee on Justice and Legal Affairs Review of Bill C-46. (Ottawa:
LEAF, March 1997); Sheila McIntyre, “Tracking and Resisting Backlash Against Equality Gains in

3 See Women’s Legal Education and Action Fund, Equality and the Charter: Ten Years of Feminist
Advocacy Before the Supreme Court of Canada (Toronto: Emond Montgomery, 1996) particularly the
Queen.

668; R. v. Darrach, [2000] 2 S.C.R. 443. See also Rob Martin, “Proposed Sex Assault Bill an Expression
When One Out of Three is Enough” (1993) 42 U.N.B.L.J. 381; Don Stuart, “Mills: Dialogue with

5 Criminal Code of Canada, R.S.C. 1985, c. C-46, s. 276-7; An Act to amend the Criminal Code (sexual
assault) S.C. 1992, c. 38, s. 2; An Act to amend the Criminal Code (self-induced intoxication) S.C. 1995,
c. 32; An Act to amend the Criminal Code (production of records in sexual offence proceedings) S.C.
attempts to access claimant personal records in civil matters,\(^6\) the recognition of a cause of action for civil recovery of the injury caused by sexual abuse\(^7\) and by the tolling of limitation periods for the injuries caused by sexual violence.\(^8\)

Responding to sexual violence by health care professionals has been a part of this process.\(^9\) In 1991, the College of Physicians and Surgeons of Ontario (CPSO) established a Task Force to consider the incidence and impact of sexual abuse of patients by doctors.\(^10\) Chaired by feminist lawyer Marilou McPhedran, the Task Force was established following public criticism of the way in which the CPSO responded to patient complaints.\(^11\) As well, there was concern that even where the College imposed serious penalties on doctors found guilty of misconduct, on appeal the courts reduced the penalties imposed.\(^12\)

The Final Report of the Task Force on Sexual Abuse of Patients \(^{1991 Report}\)\(^13\) recommended a policy of zero tolerance toward sexual abuse and the development of policies, procedures and educational programmes to support that position. The \(^{1991 Report}\) recommended mandatory licence revocation for a minimum five year period in the most serious cases of sexual abuse. It suggested that all health care professionals be placed under an obligation to report abuse by another health care professional to that professional’s College. It recognised the unequal distribution of power, status and authority in all health caregiver-patient relationships. It noted that doctors have a particular opportunity to sexually exploit patients arising from the patients’ vulnerability and need for health care. It noted


\(^11\)The members of the first Task Force included McPhedran, Harvey Armstrong, Rachel Edney, Pat Marshall and Roz Roach. Rachel Edney was the only member of the original 1991 Report who was not involved in the 2000 Report.

\(^12\)Paul Taylor “4 key rulings involving MDs overruled medical body to appeal decision in case concerning abuse of 3-year-old” The Globe and Mail (28 January 1991) A4, \(^{1991 Report}\), supra note 10 at 189 “…[S]adly, there is little evidence that judges in Ontario are demonstrating a desire or an ability to respond to the reality particular to the victims of sexual abuse.”

\(^13\)Supra note 9.
that doctors occupy a position of trust and stand in a fiduciary relationship to their patients. It underscored that consent is never freely given in a sexual relationship between doctor and patient because of the power imbalance between them. The 1991 Report incorporated the view that no sexual activity between health care professional and patient is acceptable and that such activity always constitutes sexual abuse. It argued that no health care professional be allowed to engage in a sexual relationship with a former patient until two years had elapsed following the end of the professional relationship. Where the treating relationship was psychotherapeutic in nature, it proposed a lifetime embargo. In 1993, after broad consultation, Ontario implemented these recommendations in legislation applicable to doctors as well as to members of the 21 other regulated health professions. The legislation was proclaimed in force on December 31, 1993. The newly amended Regulated Health Professions Amendment Act (RHPA) contained a section which required the Health Professions Regulatory Advisory Council (HPRAC) to report to the Minister on the effectiveness of each College’s complaints and discipline procedures five years after the new provisions were declared in force.

As part of the review process, HPRAC retained PwC to prepare an evaluation of the various Colleges’ responses to the requirements of the legislation. The Minister of Health also re-appointed the earlier Task Force to provide an additional report, to be taken into consideration by HPRAC. PwC reported in 1999. The Task Force provided its report, What about Accountability to the Patient? (2000 Report) in November, 2000. HPRAC reported to the

15 Bill 100, Regulated Health Professions Amendment Act, 1993 S.O. 1993, c. 37 [RHPA]. In this Code, ss.1(3) describes “sexual abuse” of a patient by a member as,
(a) sexual intercourse or other forms of physical relationship between the member and the patient;
(b) touching of a sexual nature, of the patient by the member; or
(c) behaviour or remarks of a sexual nature by the member towards the patient. The mandatory penalty for “sexual abuse” requires that the Discipline panel:
2. Revoke the member’s certificate of registration if the sexual abuse consisted of, or included, any of the following,
   i. Sexual intercourse,
   ii. Genital to genital, genital to anal, oral to genital, or oral to anal contact,
   iii. Masturbation of the member by, or in the presence of, the patient,
   iv. Masturbation of the patient by the member,
   v. Encouragement of the patient by the member to masturbate in the presence of the member.

Subsection 72 (3)(a) states that revocation must be for a minimum period of five years where it is for sexual abuse described at section 2.
16 Ibid. s. 6(2)(b).
17 PwC Report was 27 volumes in length, with a specific report on the performance of each of the health disciplines governed by the legislation.
Minister in December, 2000 (*HPRAC Report*). This mandated five year review of the effectiveness of a legislative zero tolerance policy, and the data and reports generated, provide a unique opportunity to study the impact of legislative reform regarding sexual violence in the health care setting. It also provides a chance to consider and assess the recommendations of those charged with its evaluation in furthering or undermining those objectives.

This paper reviews the history of the documentation of abuse in the doctor-patient relationship which led to the reforms of the 1990s. It presents a preliminary assessment of the success of the Ontario legislation as an effective mechanism to promote freedom from abuse in the health care setting. I then consider the second wave of recommendations for legislative amendments arising out of the mandated five year review of the impact of the legislation. These will be assessed to determine whether their implementation is likely to improve the process of responding to health care abuse. In reviewing the impact of the legislation and its efficacy, I focus on complaints to the CPSO as it is the College with the largest membership, is still a male dominated profession and receives the highest number of complaints.

Experience with the first decade of the Ontario legislation suggests that its impact on preventing abuse by health care professionals has been deeply disappointing. The potential impact of the legislative changes has been significantly undermined by professional regulatory bodies and associations, by courts and by counsel for those professionals whose conduct is challenged. The provisions have been subjected to undermining in ways familiar from the history of the struggle against sexual violence and in ways that are specific to this new regulatory forum. Furthermore, the recommendations made to the Minister of Health and Long Term Care for Ontario by HPRAC will, if implemented, eviscerate rather than re-invigorate the legislation.

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20 This research is part of a larger study of the response of professional regulators and of the courts toward sexual abuse by their members. A second article (forthcoming) reviews the decisions of Discipline Committees and of the courts to discipline cases involving allegations of sexual abuse under the specific provisions of the Ontario RHPA.

21 The College of Physicians and Surgeons is the second largest regulated health profession with 26,500 members, of whom 72% are men. See College of Physicians and Surgeons “A Snapshot of the Profession” Members’ Dialogue (September/October 2003), online: College of Physicians and Surgeons of Ontario <http://www.cpso.on.ca/Publications/Discourse/0903/snapshot.htm>. The largest governing college is the College of Nurses of Ontario with 105,971 members, however, the majority of its membership is female (96.1% are women, see College of Nurses of Ontario, “CNO Membership Statistics 2003,” online: College of Nurses of Ontario <http://www.cno.org/docs/general/43069_stats2003.pdf>). While there are some few women professionals who abuse their patients, the overwhelming majority of abusers are men.
I. Incidence of Sexual Abuse in the Medical Setting

Attention to abusive misconduct by health care professionals is relatively recent and coincides with increased documentation of sexual violence against women generally. Studies that have reviewed violence perpetrated by some health care practitioners have investigated violent behaviour in two closely related forms; violence and harassment experienced by health care students and violence experienced by health care recipients. Whether during medical training or as patients, it is women who are overwhelmingly the target of violence and men who are overwhelmingly the perpetrators.

a. Abuse in the Medical School Experience

Since the 1980s, a number of surveys have demonstrated that medical and post graduate students experience harassment or abuse, some of it sexualized, at the hands of teaching staff during their undergraduate and post graduate education.22 The studies survey different groups and ask different questions, but the results in each case indicate a shockingly high incidence of abuse which has not diminished over the last fifteen years.23 When Canadian first and fourth year undergraduate medical students were asked about sexually abusive behaviour by educators, 46% of the women and 19% of men reported sexual harassment.24 In a

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23 See for example in the United States: Nanette Gartrell et al., “Psychiatric Residents’ Sexual Contact with Educators and Patients: Results of a National Survey” (1988) 145 Am J Psychiatry 690 [Gartrell] (6.3% female, 3.9% male psychiatric residents had sexual contact with educators, only 1% reported that educator resident sexual contact had been addressed during training); T. M. Wolf et al., “Perceived Mistreatment and Attitude Change by Graduating Medical Students: A Retrospective Study” (1991) 25:3 Medical Education 182 (51.7% of female medical students experienced some form of sexual harassment); DeWitt C. Baldwin Jr., Steven R. Daugherty & Edward J. Eckenfels, “Student Perceptions of Mistreatment and Harassment During Medical School: A Survey of Ten United States Schools” (1991) 155 Western Journal of Medicine. 140 [Baldwin] (55% of all students reported some form of sexual mistreatment ranging from sexist slurs to exchange of rewards for sexual contact. Thirty percent of women and 5.6% of men reported being directly propositioned for sexual favours); Patricia Ryan Recupero et al., “Sexual Harassment in Medical Education: Liability and Protection” (2004) 79 Academic Medicine 817.

24 Clinicians were the main perpetrators. “Sexual harassment” was defined as “unwanted sexual ad-
study of Canadian students training in psychiatric residencies, 9.7% of female residents reported sexual harassment and 4.1% reported a sexual relationship with an educator.\textsuperscript{25} A survey of Canadian medical students studying in seven residency programs revealed that 5.4% of female students reported assault by a male supervising physician, while 40% reported sexual harassment.\textsuperscript{26}

Furthermore, male students who experienced violence in the educational setting later self-reported that they engaged in violent behavior as practitioners, suggesting that they engaged in behavior that had been modeled for them during their education.\textsuperscript{27} Men who experienced abuse in their medical training reported subsequently abusing their patients at significantly higher levels than men who had not experienced abuse.\textsuperscript{28}

Medical students are not currently receiving an education designed to protect them or their patients from sexual abuse. Instead, the continuing failure of professional education to address issues of power and its abuse in the teaching relationship has led researchers to conclude that “[d]espite the righteous declarations and the invention of rules of conduct and procedures to handle complaints, the pattern of student abuse is largely unabated.”\textsuperscript{29}
In a 1990 study of psychiatry residents in their final year, more than half indicated that they had received little or no education regarding sexual issues between psychiatrists and patients. A study recently prepared for the CPSO reported that students at five Ontario medical schools continued to be insufficiently familiar with legislation or guidelines that govern physician-patient sexual relationships. Ten percent of the students surveyed believed that a sexual relationship with a patient was not sexual abuse if initiated by the patient, while 5% believed that sexual relationships between doctors and patients were a private matter if both were consenting adults. In its actions and in formal education, the teaching environment engenders a climate in which abuse of patients by health care professionals is unaddressed and unexceptional.

b. Abuser Reports of Violence

There have been a number of surveys of members of the health professions to determine the incidence of patient abuse. Earlier studies indicate higher rates of self-disclosure, probably because they generated greater professional candour. At the time, public and professional discussion had not yet focussed significantly on sexual exploitation. Later self-disclosure studies likely have been influenced by increased awareness that sexual relations with a patient is professional misconduct which may give rise to civil liability and to criminal prosecution.

5. Professional Relationships

It is expected that physicians involved in the education of medical students will:

c. maintain a professional relationship with medical students at all times, which includes:

• not exploiting the power differential that is inherent in the relationship;
• not becoming involved in situations involving potential conflicts of interest;
• not intimidating or harassing medical students emotionally, physically or sexually;

d. maintain a professional relationship with all other colleagues, which includes not intimidating or harassing them emotionally, physically or sexually.

The policy also requires that the educational institution create a supportive environment that encourages reporting of abuse or harassment of patients or colleagues. See also American Medical Association, “E-3.08 Sexual Harassment and Exploitation Between Medical Supervisors and Trainees,” online: American Medical Association <http://www.ama-assn.org/ama/pub/category/8336.html>. The failure to implement changes is also characteristic of the recommendations regarding sexual abuse by physicians of patients: “The professional literature itself has meandered through the topic areas and documents more in the way of inaction than of active and creative study leading toward solutions… Many preventive approaches that seem logical and reasonable are suggested year after year but never carried out”. G. R. Schoener et al., Psychotherapists’ Sexual Involvement with Clients: Intervention and Prevention (Minneapolis: Walk-In Counselling Center, 1990) at 49. See also College of Physicians and Surgeons of Ontario “Maintaining Boundaries with Patients” Members’ Dialogue (September/October 2004), online: College of Physicians and Surgeons of Ontario, <http://www.cpso.on.ca/Publications/Dialogue/0904/cover2.html>.

30 Blackshaw, ibid. Although the response rate to this questionnaire was relatively low at 23%, the results were similar to those obtained in a 1989 survey of Canadian residents in supra note 23, which had a response rate of 58%.


From 1973 through 1990, several major self-reporting surveys on the sexual abuse of patients were published in the United States.33 The earliest reported on a survey of 1000 physicians and had a 46% return rate. Five to 13% of various groups of physicians34 admitted to erotic contact or sexual intercourse with patients, while 5 to 7.5% acknowledged sexual intercourse.35 Ten years later, a study undertaken by the Committee on Women of the American Psychiatric Association found that 7.1% of responding male psychiatrists and 3.1% of females acknowledged sexual contact with patients. Eighty-seven percent had been involved with more than one patient. Four point four percent of women respondents and 0.9% of male respondents indicated previous sexual contact with their own therapists. Sixty-five percent of those responding had treated patients who had been sexually involved with a former therapist. Ninety-one percent of those patients were women.36 More recently, a survey of 10,000 family practitioners, internists, obstetrician-gynecologists and surgeons resulted in a response rate of 19% and the admission that 10% of the men and 4% of women had engaged in sexual contact with one or more patients, 42% with more than one patient.37
Studies done in Canada have generated similar results. A 1994 study by the Committee on Physician Sexual Misconduct of the College of Physicians and Surgeons of British Columbia generated a 72% reply rate. Three point five percent of respondents acknowledged sexual contact with a current patient and 7.3% with an ex-patient. The same year, the Society of Obstetricians and Gynecologists of Canada (SOGC) reported sexual involvement by 3% of male and 1% of female respondents. The response rate to the survey was 78%. A survey of Ontario emergency physicians in 1997 generated a return rate of 61.5% of whom 8.7% were aware of a colleague’s sexual involvement with a patient or former patient and where 88% of the involved physicians were identified as male. Six point two percent of the respondents reported their own sexual involvement with a current or former patient. Of these physicians, 6.5% were male and 4.9% female.

The data available from which to estimate the number of patients who experience sexual abuse by health care professionals is partial. If self-reporting rates accurately reflect the incidence of abuse, these studies expose a persistently pernicious rate of patient abuse. However, physician self-reporting of abuse can be assumed to result in under reporting. Whether the rate of reported abuse is accurate or under representative, the abuse of patients is endemic.

c. Survivor Reports of Violence

There are several sources for identifying the number of persons who are survivors of sexual violence by health care providers in Canada. The open-ended process of the Ontario Task Force in 1991 and the follow-up report in 2000, as well as other surveys, have generated detailed reports of abuse by health care professionals. A second source of abuse reports comes from those health care abuse survivors who complain directly to the abuser’s governing regulatory body. Legislative amendments and policy changes that impose a duty on health care professionals to report abusers to the governing College are a third source from which to approximate the level of abuse.

During public hearings held over a six month period in 1991, the Ontario Task Force heard 303 detailed reports from survivors of sexual abuse by physicians.

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38 Committee on Physician Sexual Misconduct, Crossing the Boundaries: Executive Summary (Vancouver: British Columbia College of Physicians and Surgeons, 1992) [B.C. Report].
41 Earl Berger & Nancy Staisey, “Initial analysis of a survey of Ontario women regarding sexual harassment and abuse by Ontario physicians” in Canada Health Monitor Survey No. #6 (Toronto: Price Waterhouse Canada, 1991) [Berger]. This study asked about experience of abuse by health professionals throughout the respondent’s life, supra note 1 McPhedran, supra note 9.
and other health care providers, sixteen involving male patients. At the same time the Canada Health Monitor found that 6% of Ontario women reported having experienced inappropriate behaviour or remarks by an Ontario physician, while 2% reported sexual contact or touching. Similar reports were received by the Canadian Mental Health Association in response to a questionnaire sent to consumers of mental health services in 1993. One hundred and fifteen persons reported abuse, four of whom were men. The second report prepared by the Ontario Task Force published in 2000 as part of an assessment of the impact of the legislative changes generated an additional 57 reports of sexual abuse, 11 from men. At the same time, a Health Insider survey conducted by PricewaterhouseCoopers reported that between 1994 and 1999, 2% of Ontario adults had experienced sexual abuse in the form of inappropriate words or behaviour of a sexual nature by a regulated health professional, while 1% had experienced inappropriate touching. Between 1987 and 1990, the College of Physicians and Surgeons received 150 reports of sexual abuse by doctors from patients. Between 1994 and 1998, that number had risen to a total of 661 complaints. The Ontario Task Force estimated that, taking into account under reporting, approximately 200,000 men and women in Ontario experienced sexual abuse by a health care professional between 1993 and 1998, after the enactment of a policy of zero tolerance of sexual misconduct applicable to all health care professionals.

It should be noted that the PricewaterhouseCoopers report on the number of complaints submitted to all of the regulated health professions recorded a 66% decline in the number of complaints submitted to the Colleges between 1994 and 1998, following the implementation of the RHPA mandatory provisions. However, it is impossible to conclude that this drop represents a corresponding reduction in the incidence of sexual misconduct and abuse. A myriad of other possible explanations for the statistical drop in reported complaints is possible, several of which are documented by the reports prepared for the HPRAC review of the legislation.

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43 Berger, supra note 41.
44 Canadian Mental Health Association, Women’s Voices Shall be Heard: Report on the Sexual Abuse of Women by Mental Health Service Providers (Winnipeg: Canadian Mental Health Association, 1993).
46 PwC Report, supra note 17, vol. 6. This study asked about experience of abuse over the previous five year period. The 2000 Report, supra note 1 of the Special Task Force cautions against concluding that there has been a reduction in the level of abuse based on the Health Insiders survey.
47 HPRAC Report, supra note 19. See also PwC Report, supra note 17.
48 Estimates suggest that generally only 40% of those who are sexually abused report the abuse. See Gary Catlin & Susan Murray, Canadian Victimization Survey (Ottawa: Solicitor General of Canada, 1985).
49 “The data compel us to say that sexual abuse by health professionals remains an important public safety problem whose importance is magnified when we consider the specific impact and severity of sexual abuse due to breach of trust.” 2000 Report, supra note 1 at 28.
50 PwC Report, supra note 17, vol. 6.
51 See text at I. receiving and responding to complaints
II. Legislative and Policy Reforms

In the early 1990s, the increased attention to sexual abuse of patients by health care professionals resulted in a series of important reports undertaken by the various provincial regulatory Colleges responsible for the medical profession. In Canada, the College of Physicians and Surgeons of Ontario established a Task Force to report to the College with specific recommendations concerning exploitation of patients by physicians. Alberta, British Columbia, Manitoba, Saskatchewan, and Quebec each undertook studies of their own.52 The Ontario study resulted in major legislative reform of the regulatory structure applicable to all of the health care professions in the Province. British Columbia and Prince Edward Island also implemented legislative changes applicable to physicians and surgeons in the province.53 Other provincial medical regulatory bodies implemented policy changes designed to supplement and inform the content of existing legislative structures responding to misconduct by members of the profession.

a. Legislative reforms

The most exhaustive changes were made to the governing legislation in Ontario. On December 31st, 1993, the Province of Ontario amended the *Regulated Health Professions Act, 1991*,54 introducing new provisions designed to address the sexual exploitation of patients by health care professionals. The Act provides the legislative framework for 21 health professions governed by its provisions.55 It establishes a structure for defining the educational qualifications of members, providing continuing supervision of members, and dealing with complaints and discipline. Its purpose is to provide for self-regulation by the professional's peers in the public interest. These functions are not new to the legislation. Nor is the recognition that sexual abuse of patients is unprofessional and constitutes misconduct subject to discipline. Prior to the amendments to the RPHA, the regulations defined professional misconduct to include sexual impropriety with a patient.
However, the new legislation offered specific provisions dealing with reporting of sexual abuse and mandatory penalties that were new.\footnote{The RPHA provides no definition of patient.}

The amendments introduced substantive and procedural revisions to the existing regulatory mechanism specifically designed to respond to sexual exploitation. The Task Force and other groups critical of the old legislation had called into question not only the disciplinary process of the College of Physicians and Surgeons and other Colleges, but also the response of courts to issues of sexual exploitation. Both the amendments to the RPHA and to the \textit{Procedural Code}, identify the purpose of the new provisions on sexual abuse as encouraging the reporting of abuse, providing funding for therapy and counselling for patients who have been sexually abused and, eradicating sexual abuse of patients. The key provisions of the \textit{Procedural Code} define “sexual abuse”, required mandatory reporting of abuse, introduced specific penalties and restrictive reinstatement provisions, and provided for intervener status to complainants in disciplinary proceedings and established a program of funding for survivors. The \textit{Procedural Code} provides detail with regard to sexual touching in the penalty sections. These list specific sexual conduct which is punishable by mandatory license revocation.

A key element of the \textit{Procedural Code} amendments is the mandatory obligation imposed on all health care professionals to report sexual abuse by other health care providers.\footnote{See also \textit{Medical Practitioners Act}, supra note 53 at ss. 65 requiring a report where a member has information concerning sexual conduct of another member. Where the information is obtained from the member’s patient, consent must be obtained from the patient or patient’s representative.} Section 85.1 requires the reporting of sexual abuse if the professional “has reasonable grounds, obtained in the course of practicing the profession, to believe that another member of the same or a different College has sexually abused a patient.” The failure to report is professional misconduct to which disciplinary consequences may attach.

The most important reform involved the penalties imposed for sexual abuse of patients. Under the new legislation, sexual abuse was explicitly labelled “professional misconduct”. The penalties available to a College on a finding of professional misconduct include fine; reprimand; terms, conditions, or limitations on the right to practice, for a specified or indefinite time; suspension; and licence revocation. Revocation was made mandatory for sexual intercourse; genital to genital, anal, or oral contact; masturbation; or encouragement to masturbate in the presence of the professional. While mandatory revocation applied only to these listed acts, revocation also was made available for other forms of sexual abuse. Where a professional’s licence was revoked for sexual abuse of any kind, there could be no application for reinstatement for five years.

The regulatory Colleges of the other provinces also have general policies that preclude sexual relations with patients, and characterize such behaviour as miscon-
duct for disciplinary purposes. Licence revocation could follow on a finding of misconduct.

b. Policies

In addition to legislative amendments specific to health care provider abuse, a number of major national organizations and a number of governing Colleges have taken a clear policy position that sexual contact between a doctor and a current patient is sexual abuse. In Canada these include the Canadian Medical Association, the Canadian Psychiatric Association, and the Society of Obstetricians and Gynecologists of Canada. In Ontario they include the College of Physicians and Surgeons of Ontario, the College of Chiropractors, and the Ontario Hospital Association. Of these, only the Ca-

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59 As have the American Psychiatric Association, “Patient/Therapist Sexual Contact,” online: American Psychiatric Association <http://www.psych.org/public_info/pt-sexcontact.cfm> (current or former patient) American Psychological Association, “Ethical Principles of Psychologists and Code of Conduct” (10.05-08 1 June 2003), online: American Psychological Association <http://www.apa.org/ethics/code2002.html#10_05> (current patients, former patients for a period of two years and then where it can be shown that there is no exploitation); American Medical Association, “E-8.14 Sexual Misconduct in the Practice of Medicine” (December 1989), online: American Medical Association <http://www.ama-assn.org/ama/pub/category/8503.html> (present patient or former patient where there is exploitation).
60 Canadian Medical Association, “The Patient-Physician Relationship and the Sexual Abuse of Patients” (1 June 1994), online: cma.ca <http://www.cma.ca/index.cfm/ci_id/3223/la_id/1.htm> [CMA Policy]: “The sexual abuse of patients is defined as any behaviour that transgresses the patient-physician relationship in a sexually exploitative manner by a physician’s words or actions.” This policy was first drafted in 1994 and updated in 2000, see “CMA Policy Summary: The Patient-Physician Relationship and the Sexual Abuse of Patients” (1994) 150 Canadian Medical Association Journal 1884.
61 Position Statement, supra note 29. The Canadian Psychiatric Association deems sexual activity of any kind between a psychiatrist and his or her patient to be sexual misconduct and unacceptable in any circumstances. Approved September 1995, replacing a 1985 statement.
63 Society of Obstetricians and Gynaecologists, “SOGC Policy Statement: Sexual Abuse by Physicians” (October 2003), online: SOGC <http://sogc.medical.org/sogcnet/sogc_docs/common/guide/pdfs/ps134.pdf> [SOGC Policy]: “The SOGC acknowledges and deplores the fact that incidents of physicians abusing patients do occur, and declares that such misconduct should not be tolerated. These incidents include ‘sexual impropriety’ due to poor clinical skills, chauvinism, or abuse of the power relationship, and outright systematic sexual abuse.” Approved March 2003, superseding Policy Statement No. 11, September 1992.
64 CPSO Governing Council Motion, May 21, 1991.
dian Psychiatric Association clearly precludes sexual contact with a previous patient.67

While not all of the provincial regulatory bodies made specific changes to the legislative scheme that governed professional misconduct, a significant number of those which did not do so adopted policy statements that were explicit in defining sexual abuse as professional misconduct warranting serious disciplinary measures.68 The regulatory Colleges of Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia and Saskatchewan have adopted policy statements that defined a broad range of sexual involvement between a doctor and patient as sexual abuse regardless of who initiated the conduct.69 All of the policies specified that a sexual or romantic relationship with former patients is unethical if there was potential for exploitation of trust, knowledge, emotions or influence and, in some cases, whenever the doctor-patient relationship consisted primarily of psychotherapy or counselling or the patient was a minor at the time.70 British Columbia and

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67 "The Canadian Psychiatric Association presumes sexual relationships with former patients to be unethical" (Position Statement, supra note 29). The SOGC policy, supra note 63 does not comment on relationships with previous patients. The CMA policy, supra note 60 suggests that relationships with former patients should be judged according to a number of factors, including: maturity, nature of the disorder, time passed, nature, intensity and duration of the service.

68 As have the Federation of State Medical Boards of the United States, Ad Hoc Committee on Physician Impairment, “Report on Sexual Boundary Issues” (1996), online: Federation of State Medical Boards <http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/sexual_boundary.html> (current or former patient) Council on Ethical and Judicial Affairs, “Sexual Misconduct in the Practice of Medicine, (1991) 266 Journal of the American Medical Association 2741 (current or former patient); American Psychiatric Association, supra note 58. American Psychological Association, supra note 59 (current patients, former patients for a period of two years and then only where it can be shown that there is no exploitation); American Medical Association, supra note 59 (present patient or former patient where there is exploitation).

69 College of Physicians and Surgeons of Alberta, supra note 52. The distinction between sexual involvement and sexual activity is not clear from the policy. The penalty is described as ranging from reprimand to revocation taking into account the harm to the patient, risk to others and possibility of re-offending. There is no minimum period of revocation. Applications for reinstatement will be considered where the physician provides a diagnosis, shows no psychopathy, there is an admission of guilt and treatment accepted, an honest reporting of feelings, he will work under supervision and will not practice psychotherapy, reinstatement is in the public interest, there is virtually no future risk and the practice will be under supervision. The College of Physicians and Surgeons of Nova Scotia adopted a similar policy in 1995. The Policy does not address issues of reinstatement. See also College of Physicians and Surgeons of New Brunswick, “Guidelines: Sexuality in the Physician/Patient Relationship” (September 1999), online: College of Physicians and Surgeons of New Brunswick <http://www.cpsnb.org/english/Guidelines/guidelines-3.html [New Brunswick Guidelines]>; College of Physicians and Surgeons of Manitoba, supra note 52, College of Physicians and Surgeons of British Columbia, Sexuality and the Doctor/Patient Relationship, http://www.cpsbc.bc.ca/policymanual/s/s3.htm. The B.C. College lists the criteria to be taken into account in determining penalty. These include, degree of aberrance, planning, multiple patients, inability to perceive the patients best interest, emotional dependency, disregard for harm, manipulation, failure to respond to third party intervention, lack of response to patient request to stop, recidivism.

70 Factors to be considered with regard to a relationship with a former patient include an understanding of the dynamics and boundary issues involved in doctor patient relationships, the intent of the termination and who terminated the relationship, knowledge of transference, and honesty in reporting feelings (CPSA
Nova Scotia imposed an obligation on College members to advise the College where the physician believed that a colleague may be guilty of sexual misconduct.

III. Legislative Reform: A Decade Later

a. The Task Force, PricewaterhouseCoopers and HPRAC Reports

The new RHPA, proclaimed in force on December 31, 1993, contained a provision that required the HPRAC to prepare an assessment of the effectiveness of the complaints and discipline processes of each of the 21 regulatory Colleges for the Minister of Health and Long-term Care of Ontario. In 1999, HPRAC undertook this assessment, contracting with PwC for a major evaluation of the complaints and discipline processes of all of the Colleges. PwC produced a twenty-seven volume assessment of the 21 regulated health professions, based upon self evaluations provided by the Colleges. At the same time, the Minister of Health requested a follow-up report of the 1991 Task Force originally constituted by the College of Physicians and Surgeons. The data produced by PwC Report, the 2000 Report and the HPRAC Report presented an extraordinary snapshot of the impact of major legislative reforms. They provided a deeply discouraging assessment of the ability of zero tolerance legislation to prevent, reduce or redress sexual abuse of patients by health care professionals.

Any initiative to respond to misconduct by health care professionals and in particular to sexual abuse, requires the significant and generous assistance of those patients who have been mistreated or abused by their health care provider. Where the mistreatment or abuse is sexual in nature, that courageous contribution is all the more difficult. The complainant receives no compensation either for the time she commits to the regulatory process nor for the injuries she experienced. The record that is produced through College processes is unavailable for other purposes. Participation may result in some satisfaction to the complainant if the health care provider is disciplined. Where the provider is not disciplined, or where the penalty imposed seems inappropriately lenient, it is unlikely that a positive experience is possible. Where there is press coverage of the complaint, the complainant may be viciously and publically demeaned, whether or not identified. Most often, com-

Policy, supra note 52). See also New Brunswick Guidelines, ibid. It is interesting to note that this test is more stringent than that set out by the Supreme Court of Canada in Norberg, supra note 7.

71 FRHPA, supra note 15, s 6(2)(b).

72 1991 Report, supra note 9, also see Rodgers, supra note 9.

73 No record of a proceeding under this Act, a health profession Act or the Drug and Pharmacies Regulation Act, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the Drug and Pharmacies Regulation Act or a proceeding relating to an order under section 11.1 or 11.2 of the Ontario Drug Benefit Act (RHPA, supra note 15, s. 36(3)).

74 Media coverage is often highly destructive and pornographic. The 2000 Report comments on a
plaintants indicate that their motivation for participating in the process is to protect others from future abuse. It is clear that they do so at great personal cost.

The evidence prior to the significant revisions to the RHPA suggested that patients who complained of sexual abuse by practitioners experienced re-abuse by the regulatory College processes and by the courts. The revisions to the governing legislation were optimistically designed specifically to recognize the complainant’s essential contribution to the process and to address the re-abuse experienced by complainants. It is, therefore, deeply dismaying that each of the three evaluative reports prepared by the Task Force, PwC and HPRAC concluded that the implementation of the legislative provisions has failed in this objective.

The list of disappointments described in the three reports is long. The reports served as the background for further recommendations for legislative and policy changes. Both HPRAC and the Task Force made a series of recommendations designed to improve the outcome of the disciplinary process. The HPRAC report is based on the data provided by PwC. The Task Force did not have access to those data in making its recommendations, but relied on the evidence that it gathered in discussion with individuals who had been involved in the complaints process since implementation of the provisions in 1993. In some cases the position taken by the Task Force is endorsed by the HPRAC recommendations, in others HPRAC specifically preferred its own solutions to a given issue and declined to support the position taken by the Task Force.

PwC was asked to determine whether or not each of the 21 regulatory Colleges showed evidence of compliance with the objectives of the legislative scheme. The objectives identified by PwC included the incidence of reporting of
sexual abuse, provision of therapy and counselling for those who experienced abuse, treating individuals with respect, assistance to individuals in exercising their legal rights, the eradication of abuse, and the advancement of the public interest. Although the PwC Report revealed that each College showed varying strengths and weaknesses in achieving the legislative objectives, overall there had been a failure of leadership, absence of a unified educational strategy for members of the public or the professions and limited change to the behaviour of members of the regulatory Colleges subsequent to the new legislation. Sixty-four percent of all College members reported to PwC that the legislation had not influenced their behaviour with patients. Seventy-five percent indicated that the legislation had not influenced their behaviour with colleagues. Few members of the public reported knowing how to complain, and those who did so were dissatisfied with the process. The reports highlighted weaknesses in receiving and responding to complaints in particular.

i. Receiving and responding to complaints

There are two sources of information regarding incompetence or misconduct, including sexual misconduct, by a health professional. A complaint may be filed by a member of the public or by another health professional complaining of the behaviour of a health care provider. Between 1994 and 2001 the CPSO considered 13,000 complaints of all kinds concerning its members. Of these 99% were dismissed or resolved internally without a disciplinary hearing.

The PwC Report revealed serious concerns with regard to the way both public and mandatory complaints of sexual abuse were handled by the Colleges. Mandatory reports arise from s. 85.1 of the Procedural Code which requires all members governed by the legislation to advise the appropriate College that a health care professional is sexually abusing a patient. The requirement that all regulated

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77 PwC Report, supra note 9, Vol. 3.
78 PwC performed a random telephone survey of 650 adults in Ontario. The survey identified 12 persons who had actually experienced abuse in the past five years. Of these, 3 had complained to the appropriate College. Of the 3 who complained, 2 were dissatisfied with the process. They found the complaints process to be re-traumatizing and unacceptably lengthy; they were ill informed by the College of the process and possible outcomes, obliged to provide for their own legal and emotional support and found the outcome unsatisfactory. College members who had been the subject of a complaint were of the view that the College failed to act in the member’s interests. They misunderstood the role of the College disciplinary process, assuming that the College should act in the interest of the individual member rather than in the public interest (PwC Report, supra note 9 at 3).
79 There are 28,000 members of the College in total.
80 Robert Cribb, Rita Daly & Laurie Monsebraaten “How system helps shield bad doctors: College admits flaws in process” Toronto Star (5 May 2001) A1. Data calculated by the Toronto Star indicated that 111 doctors have been found guilty of incompetence or misconduct, including sexual misconduct, with only 34 losing their license to practice. Of the 141 that had proceeded to a hearing between 1994 and 2001, 77 concerned sexual misconduct, 19 patient death and 10 psychological harm. It is difficult to reconcile the data with data generated by PwC. However, the years surveyed by PwC were 1994-1998. The Star data include 1994-2001.
81 Where the professional “has reasonable grounds, obtained in the course of practicing the profession, to
professionals file mandatory reports was a key component of the zero tolerance policy of the new RHPA. It was designed to shift the responsibility for reporting abuse, at least in part, from abuse survivors to professional colleagues, from individual patient to the profession.\textsuperscript{82} The 1999 PwC survey of members of all of the regulated professions determined that only 7\% of the 3560 who replied to the survey had made a mandatory report of sexual abuse by another professional. Three percent admitted choosing not to report sexual misconduct of which they were aware, despite their legal obligation to do so.\textsuperscript{83} It is perhaps not surprising that not all professionals required to forward a mandatory report did so, particularly in the first years following the legislative implementation of a new statutory obligation. Data provided to PwC by the Colleges revealed an aggregate total of 1012 mandatory reports filed between 1994 and 1998, of which 887 (87.6\%) were filed with the College of Physicians and Surgeons of Ontario.\textsuperscript{84} These numbers must be assessed taking into account under reporting.

The Colleges generally have put the information obtained through mandatory reports to no use. This is deeply troubling and undermines one of the key provisions of the legislation. Colleges reported that it is unlikely that a mandatory report would be the basis for an investigation where the name of the patient who had experienced the abusive behaviour was not provided. This failure confounds mandatory reports and individual complaints, requiring that the complainant be willing to identify herself and to proceed with the College process. Nor do the Colleges appear to be using reports filed under the mandatory provisions to track the possibility of multiple complaints against an individual member or as similar fact evidence to trigger an investigation or to provide support for an existing complaint.\textsuperscript{85}

The reports to PwC by the Colleges regarding complaints of sexual abuse made by individuals are equally startling and disturbing.\textsuperscript{86} There was a significant

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\textsuperscript{82} See Rodgers,\textsuperscript{supra note 9} for a critique of the provisions.

\textsuperscript{83} PwC Report,\textsuperscript{supra note 17, vol. 19: Eight thousand surveys were mailed to members of the regulated professions. The response rate was 42\%, of which 62\% came from women. Thirty-three percent had practised for more than 20 years, 21\% for less than 5 years. Reasons given for not reporting included that the health care professional did not believe the information was sufficient to make a report (43\%), or did not want to report a colleague (20\%). Of those who did not want to report, 26\% were women, while only 5\% were men.

\textsuperscript{84} Ibid.

\textsuperscript{85} Ibid. It should be noted that s. 75 of the Procedural Code allows for an investigation where a mandatory report has been received. See also s. 85.11 (2)(2) (1). See HPRAC recommendation with regard to obtaining the patient’s consent to disclose her identity and recommending that an investigation be undertaken where the Registrar has reasonable and probable grounds to believe the member has abused a patient (HPRAC Report,\textsuperscript{supra note 19}). Contrast this to the recommendations of the Task Force in the 2000 Report, recommendation 8.0 (empirical study), 10.0 mandatory reports to trigger investigation where there is a reasonable suspicion that there is a risk of harm to patients or upon two reports, recommendation 11. (enforce penalties for not reporting).

\textsuperscript{86} It should be noted that those most likely to be abused may be the least likely to report abuse.
drop-off between the filing of a complaint and a resolution on the merits by the Discipline Committee. In addition to the 887 mandatory reports received by the College of Physicians and Surgeons between 1994 and 1998, 448 independent individual complaints of sexual abuse were filed with the College. Of the 448 complaints, 213 were resolved or disposed of without referral to the Complaints Committee. This resulted from the withdrawal of the complaint, the resignation of the member or a formal or informal alternative dispute resolution process. Two hundred and forty-three complaints were considered by the Complaints Committee. Ninety-nine of these resulted in no action by the Committee, 80 received a written caution, and 51 an oral caution. Only 61, or 14%, were referred to the Discipline Committee for a disciplinary hearing. Only 23 of the 61 so referred, or 38%, resulted in a finding of guilt. Twenty-nine were found not guilty and 31 were withdrawn. As a percentage of total complaints of sexual abuse, only 5% of defendant doctors who were the subject of individual complaints were found guilty.

“Immigrants, non-English speaking persons, the physically and mentally challenged, persons with life threatening illnesses, and persons in counselling and psychotherapeutic relationships are more likely to be reluctant or challenged in their ability to make a complaint against a health professional” (HPRAC Report, supra note 19 at 2). See also 2000 Report, supra note 1. The RHPA requires a formal complaint (s. 25(4)). A few of the Colleges assist complaints by travelling to the complainant’s home, directing the complainant to resources for emotional support or offering information in more than one language. Only the College of Nurses engages in outreach to the public or to at risk or vulnerable groups. Three complainants indicated that the College of Physicians and Surgeons failed to support their special needs so that they could participate in the disciplinary process. These included a developmentally delayed complainant and two complainants who required financial assistance in order to attend the Discipline Committee hearing in Toronto (2000 Report, supra note 1).

87 The Complaints Committee may refer to the Executive Committee for incapacity, the Quality Assurance Committee for behaviour or remarks of a sexual nature, the Discipline Committee for misconduct or incompetence, require a member to appear before it to be cautioned or take any action that it considers appropriate and consistent with the RHPA. It may also dismiss the complaint if it is “frivolous, vexatious, made in bad faith or otherwise an abuse of process,” s. 26(4). “Among Colleges with 10 or more complaints and mandatory reports, the proportion of complaints… referred to the Discipline Committee ranges from 3.9% to 29.7%” (HPRAC Report, supra note 19 at 8). A referral may originate from either a complaint or from a mandatory report.

88 These are complaints against individual doctors. There may be multiple complainants.

89 There were 181 pre-complaint dispositions and 108 ratifications of a resolution otherwise achieved between the parties — the College and the doctor (PwC Report, supra note 17).

90 Four were the subject of ratification of a resolution reached through ADR, one of legal ratification, three were referred to the Quality Assurance Committee, four to the Executive Committee and two are indicated as “other” (PwC Report, supra note 17, vol. 22). The complainant may appeal to the Health Professions Appeal and Review Board.

91 PwC Report, supra note 17, vol. 22. There are small discrepancies in the numbers provided. PwC Report, supra note 17, vol. 6 lists 23 findings of guilt while PwC Report, supra note 17, vol. 22 lists 28. Additionally, not all complaints would have been resolved, even informally, during the time period being tracked by PwC.

92 PwC Report, supra note 17 vol. 22. The College reported to PwC that the caseload of the Discipline Committee grew exponentially following the changes in the legislation and that successful prosecutions decreased by 50% by the end of 1996.

93 Only the College of Nurses meets the time-line of 120 days for the disposal of complaints as set out in the legislation (PwC Report, supra note 17, vol. 6). HPRAC recommended extending this period to 150 days (HPRAC Report, supra note 19, rec 23).
by the Discipline Committee. The College identified 17 cases where the Disci-
pline Committee finding of sexual impropriety was appealed to the Divisional 
Court. Of these, 1 appeal was allowed, 6 were abandoned and 10 were upheld. Overall, the percentage of mandatory reports plus individual complaints that were 
referred to Discipline by all of the Colleges was only 5.53%.

The overwhelming attrition in the number of complaints that proceed to a full 
disciplinary hearing is the result of a number of factors, each disturbing in its own 
right. Any screening process can divert founded sexual abuse cases from the 
imposition of mandatory penalties. While the language of the RHPA indicates that 
it is the statutory obligation of the Complaints Committee to investigate, in fact, a 
preliminary investigation usually is carried out by staff of the College. PwC 
reports that 13 of the Colleges conduct some level of investigation prior to referral 
to the Complaints Committee. The College of Physicians and Surgeons is one of 
these. Whatever the stage at which the investigation is carried out, the nature of the 
investigation is key. According to the CPSO, investigatory standards that were 
designed in the 1990s to provide support to the complainant were re-assessed in 
1997 because it had become more difficult to achieve a successful prosecution at 
the Discipline Committee. An investigatory team comprised of women with 
experience and commitment to issues of sexual abuse was dismantled, investigators 
no longer acted as support persons for the complainant nor was the complainant 
any longer allowed significant control of the process, allegations involving possible 
clinical deficiencies were transferred to clinical investigation, the complainant’s 
medical records are now collected regardless of the possible prejudice to the

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94 Compare to the number of self reported cases of abuse (HPRAC Report, supra note 19).
95 PwC Report, supra note 17, vol. 22.
96 HPRAC Report, supra note 19.
97 In one case, described in the 2000 Report, the College of Physicians and Surgeons determined not to 
proceed to discipline. The Committee made the decision without having consulted an expert to assess the 
practice methodology of a young doctor who engaged in psychotherapy with a previously abused patient, 
then further abused her. Under the RHPA, a complainant may appeal the decision not to proceed to the 
Health Professions Appeal and Review Board (HPARB). The complainant appealed and the Board 
ordered the College to proceed (2000 Report, supra note 1 at 43). The Task Force reported that those who 
did appeal to the HPARB generally considered that the delays and treatment that they experienced were 
disrespectful and insensitive. There is also a significant backlog (2000 Report, supra note 1.) 
98 The failure to pursue complaints is the equivalent of the non-founding of sexual assault complaints in 
the criminal justice system.
99 HPRAC recommended that the investigatory role of the Complaints Committee be transferred to the 
Registrar with oversight maintained by the Complaints Committee. This would separate the investigatory 
role from the adjudicative role of the Complaints Committee, although somewhat diminishing the public 
oversight role played by the public member of each Complaints Committee (HPRAC Report, supra note 19). PwC reports that 13 of the Colleges conduct some level of investigation prior to referral to the 
Complaints Committee. The College of Physicians and Surgeons is one of these (PwC Report, supra note 17). See also Richard A. Steinecke, A Complete Guide to the Regulated Health Professions Act, looseleaf 
(Aurora, Canada Law Book, 1995).
100 This change is confirmed by the remarks of Ms. Susan Vella, 2000 Report, supra note 1 at 43: 
“Particularly in the past four to five years, the proverbial pendulum has swung back in favour of a tangible 
bias against patients: so much so that many lawyers, including myself, cannot recommend that patients 
ever go to the college.”
complainant, and matters now formally may be resolved prior to referral to the Complaints Committee. Of the 878 decisions issued by the Complaints Committee in 2000 on all matters of professional competence and conduct, 745 or 85% were dismissed outright or with a caution issued to the doctor. In fact, complaints regularly are resolved prior to referral to the Complaints Committee for investigation.

Some of the drop-off is attributable to the use of informal dispute resolution processes. Fifteen Colleges reported using such processes, although ten of those claimed that ADR would not be used in matters of sexual abuse and four that ADR would be used in sexual abuse cases only with regard to words, behaviour or gestures. Nonetheless, ten cases reported to PwC used an alternative dispute resolution process to resolve a sexual abuse complaint which was not forwarded to the Complaints Committee for investigation. The CPSO apparently used ADR to respond to four such complaints, of which only two were resolved. Yet, according to Dr. Bienstock, then president of the College, the College concluded that ADR was inappropriate for any matters of sexual misbehaviour.

One complainant’s dismal experience with ADR was described by the Task Force. At the suggestion of the CPSO, the complainant agreed to try mediation to resolve her complaint of sexual abuse. Prior to mediation, the College had agreed that should it fail, her complaint would proceed to a discipline hearing. During the mediation, the complainant was left alone with her abuser. When the mediation failed, the College reneged on its commitment to send the case to Discipline. The 2000 Report noted that the facts in this case were clearly different from what the college was saying publicly about its approach to mediation. The Task Force

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101 The 2000 Report recommended the use of a specially designated sexual abuse investigator, following the model used by the Canadian and Ontario Human Rights Commission. The HPRAC Report rejects the recommendation but makes alternative recommendations designed to increase the support available to the Complainant.

102 The College claims that such a strategy may be adopted where the Discipline Committee does not have the power to order as appropriate. “In these cases the College has worked actively on a course in appropriate boundaries and in the interim has been instrumental in arranging for a number of physicians to receive individual training in boundaries with experts. The College has also been instrumental in arranging for physicians to received (sic) therapy in appropriate cases.” Report on the College of Physicians and Surgeons of Ontario, vol 22, PwC at 12.

103 Robert Cribb, Rita Dalyand & Laurie Monsebraaten “Keeping patients in the dark: most patients will never know if a doctor’s record is spotless or tainted” Toronto Star (25 May 2001), online: The Toronto Star <http://www.thestar.com/static/archives/search.html>.

104 The College claims that no serious complaint of a sexual nature is resolved but that “…investigators may resolve issues that concern inappropriate comments or misunderstanding about proper physical examinations.” Supra note 102 at 17-18.

105 Ibid.

106 Ibid.


108 Ibid. at 60.
recommended that the RHPA be amended to preclude the use of ADR or mediation in complaints of sexual abuse.109

As well, the test used by the Complaints Committee in deciding whether to send a complaint forward to the Discipline Committee is of critical importance. According to the CPSO, the decision to send to Discipline is assessed on a number of factors: does the alleged conduct constitute professional misconduct; does it warrant a discipline hearing; does the CPSO have clear and convincing proof of professional misconduct.110 Other Colleges describe this as a requirement for *prima facie* evidence. HPRAC recommended a reasonable sufficiency of admissible evidence defined as any admissible evidence of professional misconduct, which if believed by a panel of the Discipline Committee, could result in a finding of professional misconduct.111 Both the existing and recommended tests set up multiple barriers to discipline: admissibility of evidence, credibility of the complainant and other witnesses and the appropriate burden of proof in disciplinary matters. This amounts to the making of determinations of both admissibility112 and of credibility at the informal, and again at the formal investigatory stage. It allows for stereotypical myths about the credibility of women and children, in sexual abuse matters in particular, to inform the decision whether or not to send to discipline. As well, at this point in the process such a reliance on myth will not be documented, as it more likely would be where formal written reasons are required. In my view, an alternative, appropriate construction would be to assume that the facts as claimed are capable of proof. In any case where the facts, as claimed, would make out a case for Discipline, the complaint should be referred to a Discipline Committee hearing. Even where a case is forwarded to the Disciplinary Committee for a hearing, a full

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110 The College of Nurses uses a two pronged test: is there prima facie evidence of sufficient quantity and quality that would meet the burden of proof for a finding of professional misconduct or incompetence; is it a very serious matter for the College — sufficient standard of proof is clear and cogent evidence, relying on *Matheson v. C.N.O.*, (1979), 27 O.R. (2d) 632 at 638. The *HPRAC Report* draws an analogy between the role of the Complaints Committee under current legislation and that of a preliminary inquiry judge. This inappropriate evidentiary burden was noted by the Task Force in 1991 and again in 2000. See also Sydney L. Robins, *Protecting Our Students: A review to identify & prevent sexual misconduct in Ontario schools* (Toronto: Ministry of the Attorney General, 2000) at 225: “There are obvious and important distinctions between criminal and administrative proceedings. It should be remembered that, in some areas, special and more relaxed evidentiary and procedural rules apply to administrative proceedings…” [Robins].

111 *HPRAC Report*, supra note 19 at 38.

112 The test for admissibility of hearsay evidence, for example, is relevant. Arguably, the threshold test in administrative matters is governed by more flexibility than in criminal matters. The *2000 Report*, supra note 1, in recommendation 13.0 suggested section 49 of the RHPA be repealed and that evidentiary rules be governed by the *Statutory Powers Procedure Act*. See also Robins.

“It is appropriate to apply a lower threshold of reality and necessity in civil and, most particularly, in administrative proceedings. This accords with the interests at stake in those proceedings….In the context of hearsay statements by student complainants or witnesses in sexual misconduct cases, it also accords with the position advanced throughout this chapter that, in striking the balance between competing interests, the rights of children or sexual complainants may acquire equal or greater prominence, particularly where the adverse party cannot lay claim to a right to make full answer and defence arising out of a potential deprivation of liberty.” *Supra* note 110 at 231.
hearing may never take place. In 2000, the Medical Post reported that the CPSO had concluded hearings in only four cases of sexual abuse under the Act. In each the doctor pleaded guilty and therefore a full hearing was not required.113

It should be noted that the Task Force 2000 Report recommended the creation of a new independent institution, the Public Access Centre, which would be responsible for receiving, investigating and deciding whether sexual abuse complaints against any member of a regulated College would be sent to a disciplinary hearing, with the disciplinary process continuing to reside at the individual College level. HPRAC rejected this model.114

It is clear that in considering the complaint, the levels of screening create opportunities for systemic bias to operate, particularly where the screener’s views on credibility effect progress to the next level of consideration. In effect, the College has injected a form of preliminary hearing not authorized by the statute. A second barrier arises from the apparent lack of clarity with regard to the role of the Complaints Committee. The third arises from the quasi-criminal evidentiary standards applied, despite the fact that the evidentiary rules in administrative proceedings generally are laxer than in judicial proceedings. As well, determinations of credibility of the complainant and the professional are properly the role of the Discipline Committee. The role of the Complaints Committee should be limited to screening out of obviously frivolous complaints. As well, some Colleges are inappropriately using ADR to divert complaints. This is inappropriate in situations of such unequal power and evades the public interest in de-licencing the offender and educating practitioners and members of the public. As well, it appears that improper considerations lead the Complaints Committee to divert complaints they believe are credible so as to avoid the mandatory revocation provisions prescribed by the Act.

The Colleges have failed to use information obtained through mandatory reports to trigger investigations or to provide additional support and documentation for complaints filed by individuals. To this must be added the documented barriers to filing a complaint115 and the understandable reluctance of those abused to file complaints. Those who do file are only a small brave marker of those who have been abused. The significant fall off created by such barriers, combined with the draconian screening and dismissal of those that are filed, results in only the barest minimum, and most likely those most contiguous with dominant male norms of “real rape”, ever being subjected to the disciplinary process. The legislation has failed to improve this situation.

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114 HPRAC Report, supra note 19.

115 These include individual feelings of denial, complicity, shame, self-doubt, trauma and loss and systemic institutional factors that suggest that the institution will favour its own members — here health care professionals.
ii. Supporting complainants through the process

The 1991 Report noted the increasing legalization, and more particularly criminalization, of the disciplinary process. Ten years later, after major revisions to the legislation designed to mitigate the impact on complainants, the trend toward criminalization has continued and accelerated, with the result that participating in the disciplinary process remains an experience of re-abuse. Complainants are not parties to the disciplinary hearing. Only the health care professional and his College have party status, despite the key role of the complainant in bringing the abuse to the attention of the College, participating in the investigation, likely appearing as a witness and undergoing cross-examination. Key 1993 amendments were designed to support complainants by allowing them intervener status should they choose to exercise it, and by providing funding for therapy to those who did participate. However, under the Act, the request to intervene is granted at the discretion of the Discipline Committee and even where granted, no financial support is provided to the intervener. This emptied the provision of meaningful content. The five year HPRAC review process resulted in a repeated call to provide complainants meaningful status at the hearing. Both HPRAC and the Task Force again recommended full party status, including the right to a support person at the hearing, to participate in pre-hearing proceedings, to generate agreed statements of fact, the right to resist disclosure of her personal records, to make statements and submit evidence, to cross examine the defendant and witnesses, and to be represented by legal counsel. Neither called for financial support to ensure meaningful access to the process.

The provision of funding for therapy also has proven illusory in its application by the Colleges. The provisions that provided for payment to support the costs of therapy for certain complainants were deeply limited when adopted. Under the legislation there is no funding for patients whose complaints do not proceed to a formal hearing for whatever reasons, including a plea bargain or because of the resignation of the member. There is no access to funding for a patient who served

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117 Any person whose “good character, propriety of conduct or competence of the person” (Procedural Code, supra note 54, s. 41.1(1)(a)) is at issue or whose participation would assist the panel may be granted status as a participant. The decision to allow participation is made at the discretion of the disciplinary panel itself and the extent of that participation is also to be determined by the panel. Procedural Code, supra note 54, ss. 41.1(1)(b), 41.1 (2). Recommendations that funding be provided to support the cost of legal representation were not implemented. See Rodgers, supra note 9 at 188.
118 PwC did not track the number of requests for intervener status sought or denied.
119 The HPRAC Report does not suggest that funding be provided. They specifically recommend that there be no power to recommend that costs be awarded to the complainant.
120 The HPRAC Report recommends a roster of independent practitioners who would be funded to offer support. The 2000 Task Force Report recommends that this function be housed at the PAC.
121 HPRAC Report, supra note 19.
123 Ibid. at 39: “There is no substitute for full party status.” See An Act to Amend the Medical Act, supra note 53, s. 30.1.
as a witness for the College and with regard to whom a finding of abuse was made, but who is not the complainant. Generally, interim funding will not be provided even where there is an agreed statement of facts that admits to behaviour that was abusive. Funding is available only for future therapy, past therapy required to support the complainant to enable her to proceed with the complaint will not qualify. There is no provision for associated costs such as transportation, medication or childcare.

At the time of the PwC follow-up survey, only five Colleges had approved any applications for funding for therapy. Three Colleges had a policy of allowing the guilty member to comment on the complainant’s application for funding prior to deciding whether to grant the request. Only 71% of all applications had been approved relative to the number of findings of guilt. While the legislation provided for funding up to $10,000, rarely had this level of support been awarded. The detailed paperwork involved deterred therapists from participating. The College of Physicians and Surgeons reported to PwC that it had received 38 applications of which it had approved 22 for a total allocation of $90,921.

The Task Force and HPRAC recommendations, if adopted, would partially remedy this situation, providing alternative criteria for eligibility that would include funding for therapy where there is an admission of sexual abuse of a patient by the professional, a criminal conviction, or a finding of sexual abuse that is short of a guilty determination with regard to the patient as complainant. They recommended that funding be retroactive and that it cover incidental expenses.

The HPRAC Report also made a number of new recommendations designed to provide protection from the re-abusing impact of participating in the disciplinary process. They recommended allowing a support person to attend the hearing so long as she or he is not a witness and is not disruptive. They also recommended the

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124 Dental Surgeons, Nurses, Physicians and Surgeons, Physiotherapists and Psychologists.
125 Chiropodists, Chiropractors and Massage Therapists (HPRAC Report, supra note 19).
126 The College of Physicians and Surgeons reported that they previously did so (PwC Report, supra note 17, vol. 22).
127 Ibid. vol. 6.
129 Ibid.
130 PwC Report, supra note 17 vol. 22.
131 The College of Occupational Therapists did provide access to funds prior to a finding of guilt. Some Colleges provided access to funds for an admission of guilt or upon criminal conviction (HPRAC Report, supra note 19).
132 Ibid. HPRAC recommends that funding can be retroactive. They do not comment on interim therapy. The 2000 Report recommends that s. 85.7(4) and (10) of the Procedural Code be amended to ensure interim funding be available (recommendation 15.1. Recommendation 22.0 also suggests that s 85.7 of the Procedural Code be clarified to extend to incidental costs including medication, childcare, travel and accommodation expenses, be retroactive and be available where there is an admission of guilt, a criminal conviction or the determination that there is sufficient evidence to support a reasonable belief that the patient was abused (2000 Report, supra note 1).
adoption of strategies to protect the complainant when giving her evidence before the Discipline Committee. HPRAC suggested adopting the provisions of the Evidence Act that provide protection to minors. These would be made applicable to all cases of sexual abuse considered under the RHPA regardless of the complainant’s age. However, the right to testify under these protections would be at the discretion of the Discipline Committee hearing the case.135

IV. Reconfiguring Reform: Retrenchment, with Publication

The data collected by PricewaterhouseCoopers at the behest of HPRAC, and the information collected by the 2000 Task Force, provided a deeply discouraging picture of the impact and implementation of the provisions of the new RHPA. None of the three reports was encouraging about what was found. The Colleges had failed vigorously to embrace the mechanisms available to them to respond to reports or complaints of abuse. They had been resistant to extending the spirit of the new legislation to acts of professional misconduct that pre-dated it, although arguably able to do so.134 They ignored information made available to them, dismissed complaints of abuse and provided limited support to those complainants who lent themselves to the disciplinary process.135 In response to the PwC data, HPRAC made a number of recommendations. The 2000 Task Force did the same, relying on information obtained from interviews they conducted. In some cases HPRAC supported the recommendations of the Task Force, in others it chose not to do so.

The 1993 legislation provided a definition of and penalties for the sexual abuse of a “patient.”136 “Patient” was undefined.137 Abusing professionals often claimed to have terminated the professional/patient relationship prior to engaging in sexually abusive conduct, arguing that therefore the embargo on sexual relations was inapplicable.138 The 1991 Report emphasized the continuing impact of influ-

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133 HPRAC Report, supra note 19.
135 Recently, in McClelland et al. v. Stewart et al. (2003), 229 D.L.R. (4th) 342 (B.C.S.C.), Madame Justice Smith refused to strike out a statement of claim alleging damages against the College of Physicians and Surgeons of British Columbia for negligence in failing to investigate complaints of sexual assault against a physician. She held that it was not obvious that the College owed no duty of care to the plaintiffs. It is possible that liability will be imposed where complaints are brought to the attention of a self regulatory agency which fails to take appropriate steps to investigate the allegations. See also Barreau du Québec c. McCullock-Finney, [2004] 2 S.C.R. 17.
137 Those who are not patients, but who are sexually abused by the professional may complain of “professional misconduct” under the other provisions of the RHPA. Brand v. College of Physicians and Surgeons of Saskatchewan (1990), 72 D.L.R. (4th) 446 (Sask. C.A.).
138 1991 Report, supra note 9 at 135 “Termination of the physician-patient relationship has often been used by a physician intent on sexually abusing to gain sexual access to patients or to rationalize the exploitation.”
ence and disproportionate power after termination of the professional relationship. It recommended generally that a two year post termination embargo on a sexual relationship with a previous patient would be appropriate, except in cases involving psychotherapy where a lifetime ban was recommended.\(^{139}\) Relying on guidelines developed by the American Medical Association and the experience with legislative requirements in Minnesota,\(^{140}\) they recommended that guidelines be developed and applied to professionals involved in treatment relationships even of a short term nature. They specifically declined to make an exception for emergency department physicians whose contact with a patient was short term or for physicians practising in smaller communities who argued that their potential pool of sexual partners would be unreasonably limited if they could not enter into relationships with their patients.\(^{141}\) In the 2000 Report, they again recommended that a specific two year embargo be included in the legislative provisions and that a sexual relationship with a previous patient never be acceptable where the patient was a minor when treated, was suffering from a judgment impairing disorder or where the treatment was of a psychotherapeutic nature.\(^{142}\)

In contrast, the HPRAC Report introduction begins by noting that:

…some health professionals and their patients do fall in love and become life partners. Under the RHPA this is sexual abuse if the professional relationship was not terminated for an appropriate period of time before the intimate relationship began. Such cases underscore how legislation alone cannot deal with all the complexities of the human spirit.\(^{143}\)

The HPRAC argument tracks that raised by a number of health professionals disciplined by their professional Colleges.\(^{144}\) In particular, it reflects the reasoning

\(^{139}\) Ibid.

\(^{140}\) Ibid. Evidence indicated that 60-80% of abusive relationships began within 6 months of termination, 98% within one year and the remaining within two years of termination.

\(^{141}\) Ibid. at 137: “We believe… that the nature of the physician-patient relationship, and the differential in power within it that provides the potential to abuse, does not differ between the ‘big city’ and ‘small town’.”

\(^{142}\) 2000 Report, supra note 1.

\(^{143}\) HPRAC Report, supra note 19 at 1.

\(^{144}\) Several other cases have considered mandatory revocation provisions. In College of Physiotherapists of Ontario v. Melusky, [1999] O.J. No. 148 (Div. Ct.), a physiotherapist terminated her professional relationship with her patient in order to commence a sexual relationship. She later re-established the professional relationship. The Discipline Committee considered the constitutionality of the revocation provisions and did not apply them, imposing a lesser penalty. On appeal to the Divisional Court, the Charter issue was not considered. In A.B. v. College of Physicians and Surgeons of Prince Edward Island, (2001) 205 Nfld. & P.E.I.R. 131(S.C.) a permanent prohibition of a sexual relationship with a former patient was struck down by the Court of Appeal. The relationship began some 8 years after termination of the doctor patient relationship but where the treatment was psychotherapeutic in nature. See Medical Act, R.S.P.E.I. 1998, c. M-5, ss. 38.1, 28.3. The mandatory revocation provisions themselves were not struck down. In N. v. College of Physicians and Surgeons of British Columbia (1997), 143 D.L.R. (4th) 463 (B.C.C.A.), the doctor patient relationship had terminated at the time of the sexual relationship. See
put forward on behalf of Dr. Anil Mussani, who claimed that the mandatory revocation provisions violated the Canadian Charter of Rights and Freedoms. In 1999, Dr. Mussani admitted entering into a sexual relationship with his patient AK and, at the same hearing, also was found guilty of having sexually abused a second patient NF. Allegations with regard to two other patients were withdrawn by the College, one at the behest of the College and the other when the fourth complainant did not appear to act as a witness. At the hearing Dr. Mussani raised constitutional objections to the mandatory revocation provisions of the legislation, arguing that they violated sections 2(b) (freedom of association), 7 (life, liberty and security) and 12 (cruel and unusual treatment or punishment) of the Charter. The mandatory revocation provisions were upheld as constitutional by the Discipline Committee, by the Ontario Divisional Court, and most recently by the Ontario Court of Appeal. Before the Court of Appeal both the Ontario Medical Association and the Ontario Nurses Association intervened in support of Mussani’s position. The Attorney General of Ontario and the College of Nurses of Ontario intervened in support of the position of the College of Physicians and Surgeons of Ontario defending the constitutionality of the mandatory five-year revocation provisions. The Ontario Court of Appeal clearly and decisively held that the mandatory revocation provisions did not violate sections 2(b), 7 or 12, that if they did they would be saved by section 1 and that if they were unconstitutional, revocation would be an appropriate penalty in the Mussani case. In particular, Mr. Justice Blair, Armstrong and Juriansz J.A. concurring,

also College of Physicians and Surgeons v. Wyatt, [2000] O.C.P.S.D. No. 10 where the Discipline Committee chose not to apply the mandatory revocation provisions to a doctor who established a sexual relationship with her female psychotherapy patient. The Discipline Committee imposed a penalty of 24 months suspension, 20 of which would be lifted if conditions were complied with. The penalty was for professional misconduct rather than sexual abuse.

Mussani began treating A.K. in 1985. She was 23. She confided difficulties in her marriage. He began providing counselling and psychotherapy, billing OHIP. Between 1990 and 1991 he treated her 90 times. At one point she worked in his office. The families became friends and travelled together. She, a physiotherapist, treated him. They began an affair in 1992. In 1994 she became pregnant and was unsure whether her husband or Mussani was the father. Mussani arranged an abortion. At no time did Mussani attempt to terminate the doctor patient relationship. She broke off the affair in 1994. College of Physicians and Surgeons of Ontario, “Discipline Committee Decisions 2001” Case Summaries, College of Physicians and Surgeons of Ontario <http://www.cpso.on.ca/Publications/Discsum/2001/disc01.07.html#5.%20Dr.%20Anil%20Mendi%20Mussani>.

The 1991 Report contained a legal opinion supporting the constitutionality of the Task Force’s recommendations. Since that time legislation responding to the Supreme Court of Canada’s invalidation of sexual assault Criminal Code law reforms has been found constitutional, despite providing more protection to the complainant than the accused.


emphasized the broad consultation that the province had engaged in prior to the implementation of the mandatory revocation provisions and the support that these provisions received from the health professions themselves, including the Ontario Medical Association and the Registered Nurses Association.

HPRAC also took the view that the two year prohibition on sexual relations with a prior patient recommended by the Task Force would be constitutionally suspect and subject to Charter challenge. They argued that patient contact varies depending on the nature of the profession, that applying the same penalty in dissimilar cases is "to lose a sense of proportionality" and that the principles of self governance make it appropriate that each College establish guidelines for their members which are "proportional and rationally connected to the clinical and professional circumstances...".

In echoing this position, HPRAC ignored the literature that describes the numbers of doctors who engage in abusive and exploitative behaviour after only short term contact with patients. They did not refer to those policies developed by many Colleges and professional organizations suggesting that a two year period generally is appropriate. They undermined the essential principle upon which the 1993 amendments were premised — that there is a fundamental power imbalance between the professional and the health care recipient which always operates to make sexual contact inappropriate, that the influence of that imbalance endures over time, that clarity in the legislation with regard to allowable and prohibited relationships is essential and helpful to professionals, that the extent of the injury varies depending on the personal history of the individual exploited, and that legislative integrity and mandatory reporting require a uniformity and a certainty of rules across health care professions. HPRAC choose not to respond to the failure of the Colleges effectively to react to continuing abuse of patients by professionals, which the HPRAC Report claimed to recognize. Instead, they signalled to the regulatory Colleges and to their members that variation, flexibility and limited term prohibitions are appropriate.

HPRAC preference for variable standards, increased flexibility and individualization in defining the professional-patient relationship is repeated in the recommendations made with regard to mandatory revocation for a minimum mandatory period. HPRAC recommended that the requirement of mandatory revocation for physical sexual abuse be maintained. However, HPRAC took the view that the period of revocation ought to be flexible to ensure that the disposition is proportional, or balanced to the circumstances of the misconduct and that the period of

149 HPRAC Report, supra note 19.
150 Ibid. at 24. The reasons for judgment of the Ontario Court of Appeal had not yet been issued at the time that HPRAC formulated its position. However, these arguments were addressed and rejected by the Court of Appeal. See para.63 seq., 84 seq.
151 Jenny Manzer “Penalties for sexual abuse need to be flexible: HPRAC: Health colleges should evaluate each case on merits” Medical Post (2 October 2001), online: Medical Post <http://www.medicalpost.com/mpcontent/article.jsp?content=/content/EXTRACT/RAWART/3733/08A.html>. 
revocation should vary depending on the facts of the case.\textsuperscript{152} Further to this retrogressive recommendation, HPRAC recommended reference to sentencing guidelines drawn from those found in the \textit{Criminal Code} or the \textit{Young Offenders Act},\textsuperscript{153} demonstrating not only the evisceration of the policy of zero tolerance but the constant drift towards the criminalization of the disciplinary process. The recommended elements to be considered in determining the period of revocation would include severity of abuse, proportionality, including gravity and responsibility, public protection, denunciation, impact on the victim, remorse, specific and general deterrence, potential for rehabilitation and any other factor considered appropriate.\textsuperscript{154} Application for reinstatement would be based on public safety, rehabilitation, practice restrictions and appropriateness of a probationary period. In contrast, the \textit{2000 Report} recommended that the mandatory period of revocation be maintained, would have extended mandatory revocation to \textit{recurrent} patterns of touching or sexual remarks,\textsuperscript{155} and recommended that principles in support of the minimum five year period be added to the legislation.\textsuperscript{156}

Although HPRAC recommended no revisions to the definition of sexual abuse, their position on the definition of “patient” and their support for discretionary penalties allowing variable periods of revocation seriously would weaken the legislation. Having undermined the principles, extent and impact of the legislative provisions, HPRAC did make some recommendations which would expand publication of information regarding sexual misconduct. Both the \textit{2000 Report} and HPRAC noted that the information made publicly available concerning members found guilty of sexual abuse was inappropriately limited, and recommended increased publication to ensure increased public protection.\textsuperscript{157} The HPRAC recommendations would require publication of all cautions and of complaints committee decisions that referred the matter to discipline or elsewhere, all remediation undertakings, resignations or non renewals arising out of a complaint or report of sexual abuse and publication of findings of guilt with regard to behaviour or remarks of a sexual nature.

Some of the recommendations, if adopted, will result in increased protection to the public. Others will provide limited additional protection to those involved in the disciplinary process as complainants or witnesses. HPRAC’s recommendations rely on increased public education and on the publication of more extensive

\textsuperscript{152} HPRAC Report, \textit{Supra} note 19 at 30.

\textsuperscript{153} \textit{Ibid.} at 31.

\textsuperscript{154} \textit{Ibid.} at 31-32.

\textsuperscript{155} The period of revocation in such circumstances would be variable.

\textsuperscript{156} Specific and general deterrence of members of the profession, denunciation of the conduct and the need to maintain confidence in the integrity of the profession.

\textsuperscript{157} The \textit{2000 Report} recommended that publication now required with regard to physical sexual abuse and sexual touching be extended to include publication of guilty findings where sexual behaviour and gestures are at issue. They recommended that all suspensions or resignations related to sexual abuse complaints be recorded and that any conditions imposed on a member with regard to any complaint of sexual abuse be noted in the public register.
information regarding sexual misconduct and abuse. Regrettably, the HPRAC recommendations also demonstrated significant retrenchment with regard to the fundamental tenets of zero tolerance: recognition of the power imbalance between health professionals and patients, and revocation for sexual abuse for a mandatory minimum period.

V. Conclusion

The attention to the sexual abuse of patients by health care professionals evidenced by the actions of the College of Physicians and Surgeons of Ontario and other provincial regulatory bodies, raised the hope that sexual abuse would be taken seriously, patients would be supported, the intra-professional silence surrounding known abusers would be penetrated by mandatory reporting requirements and meaningful penalties would be imposed. The mandated review provides us with evidence that none of these objectives is being realized. Worse, HPRAC, charged with reporting to the Ministry on the success or failure of the new provisions, seriously has undermined their future efficacy; choosing to reflect the opinion of those doctors and organizations most resistant to the provisions, rather than to respond to the empirical findings.

Sufficient evidence exists to demonstrate that some health care providers are serious, and often multiple, abusers. Students are abused during their medical training and male students who have been abused, go on to abuse their patients. Care providers self identify as abusers. Many others report having treated patients who have been abused by prior practitioners. Health care providers report professionals who are abusing patients. Patients report abuse. The evidence is there, as is the evidence that abuse is seriously under reported. The legislation provides the health disciplines with the tools necessary to respond to the abuse perpetrated by some members.

Instead, the College of Physicians and Surgeons and other Colleges, have failed to ensure that complainants are provided with the support necessary to assist them to survive the process of complaint, investigation and hearing. The drop off rate on complaints by the CPSO, and by other Colleges, is such that almost no complaints and few complaints of sexual misconduct and abuse proceed to a full hearing. Each stage of the process favours the professional and undermines the complainant. The legislation was designed to do otherwise. The five year assessment makes it clear that the RHPA is not being enforced.

In the face of express documented evidence of this failure, the HPRAC Report failed to respond with dismay, or to censure the Colleges or question their evasions. It condoned them. Rather, HPRAC choose to use the window of legislative review to side with those who would literally dismantle the heart of the legislation by restricting the scope of patient provider relationships captured by the RHPA and by eviscerating the penalty that would follow when the most serious breaches of the RHPA occur. The HPRAC recommendations would return our understanding of, and the legal response to, physician sexual abuse to the position prior to the
implementation of the new legislation — professional discretion unfettered by any understanding of the nature, dynamic and damage caused by sexual abuse.

The Ontario legislation, the result of broad consultation among the health care professions, organized feminist groups, caregivers and care users, provided an extraordinary opportunity to respond to the sexual abuse of women and children by health caregivers. A vigorous and vigilant re-commitment to the generous enforcement of the RHPA is required. The PwC Report and the 2000 Report significantly document the form that commitment should take. Retrenchment from the legislation will encourage retrenchment in those other provinces and by those other professions which have moved to respond to provider abuse.

The initiative to respond to sexual violence in health care is experiencing a period of assault and proposed retrenchment similar to that experienced by other feminist legal initiatives designed to respond to violence against women and children. The attack on the RHPA relies again on historic claims that a sexual relationship imposed within a relationship of unequal power is consensual. This is not the case. Abuse in the guise of care, enabled by professional status, access and patient vulnerability and dependency, is an insidious and terrible breach of trust and an unconscionable and violent abuse of power and authority.