

ZERO TOLERANCE SOME OF THE TIME? DOCTORS, DISCIPLINE AND SEXUAL ABUSE IN ONTARIO

Sanda Rodgers*

Confirming “the College’s commitment to the safety of the public by affirming the philosophy of Zero Tolerance of sexual abuse, and in accordance with that philosophy, developing policies, procedures, practices, and education programmes that support it.”¹

The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members.²

Introduction

In the early 1990s, many provincial regulatory Colleges governing the practice of medicine began to reexamine their response to doctors’ sexual abuse of patients. College investigations revealed that the abuse of patients did oc-

* Shirley E. Greenberg Chair in Women and the Legal Profession, Faculty of Common Law, University of Ottawa, Ontario. This study is the third in a series on the impact of zero tolerance legislation on health care providers. In this essay I am concerned with the impact of the legislation on the College of Physicians and Surgeons of Ontario (CPSO) Disciplinary Committee. For an analysis of the implementation of the legislation see Sanda Rodgers, “Health Care Providers and Sexual Assault: Feminist Law Reform?” (1995) 8 C.J.W.L. 159 [Rodgers 1995]. For a study of the five-year assessment of the impact of the Ontario legislation and proposals for amendment see Sanda Rodgers, “Sexual Abuse by Health Care Professionals: The Failure of Reform in Ontario” (2004) 12 Health L. J. 71 [Rodgers 2004]. I am grateful to the Law Foundation of Ontario for support for this project and to Sarah Turney for research assistance.

1 College of Physicians and Surgeons of Ontario, Council Motion: 27 May 1991.

2 *Regulated Health Professions Act*, S.O. 1991, c. 18, as am. by S.O. 1993, c. 37, Sch. 2 [*Procedural Code*].

cur, and that it could not be explained as occasional or anomalous. In fact, the abuse of patients was well documented, although relatively little had been done to respond to the abuse or to protect patients. In the decade that followed, many of the regulatory Colleges commendably undertook specific initiatives to respond to physician sexual abuse, often in the face of the outraged resistance of their members.³ In 1991, the College of Physicians and Surgeons of Ontario (CPSO) established a Task Force on the sexual exploitation of patients.⁴ Alberta, British Columbia, Manitoba, Saskatchewan and Quebec each undertook studies of their own.⁵

The study undertaken in Ontario demonstrated categorically that the response by the CPSO to patient complaints of sexual abuse was experienced

- 3 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 Sexual Offence Law" (2000) 20 Canadian Women's Studies 72. See also *Seaboyer and Gayme v. The Queen*, [1991] 2 S.C.R. 577; *R. v. Mills*, [1999] 3 S.C.R. 668; *R. v. Darrach*, [2000] 2 S.C.R. 443. See also Rob Martin, "Proposed sex assault Bill an expression of feminist hatred" *The Lawyers' Weekly* 11:36 (31 January 1992) 9; Alan D. Gold, "Flawed, Fallacious But Feminist: When One Out of Three is Enough" (1993) 42 U.N.B.L.J. 381; Don Stuart, "Mills: Dialogue with Parliament and Equality by Assertion at What Cost?" (2000) 28 C.R. (5th) 275; Ontario Criminal Lawyers' Association, "Submissions on Bill C-49" (1992) Ontario Criminal Lawyers' Association 13:2 (August 1992) 7.
- 4 Task Force on the Sexual Abuse of Patients, *The Final Report of the Task Force on Sexual Abuse of Patients* (Toronto: College of Physicians & Surgeons of Ontario, 1991) [1991 Report].
- 5 College of Physicians and Surgeons of Manitoba, *Sexual Misconduct in the Doctor/Patient Relationship: Guideline No. 119* (2002), online: College of Physicians and Surgeons of Manitoba <http://www.umanitoba.ca/colleges/cps/Guidelines_and_Statements/119.html>; Joint Committee Re Sexual Abuse of Patients by Physicians, *Report* (Saskatoon: College of Physicians and Surgeons of Saskatchewan, undated); College of Physicians and Surgeons of Alberta, *CPSA Policy: Doctor/Patient Sexual Involvement* (1992), online: College of Physicians and Surgeons of Alberta <http://www.cpsa.ab.ca/publicationsresources/attachments_policies/Doctor%20Patient%20Sexual%20Involvement.pdf>; Committee on Physician Sexual Misconduct, *Crossing the Boundaries: The Report of the Committee on Physician Sexual Misconduct* (Vancouver: College of Physicians and Surgeons of British Columbia, 1992).

as re-abusing by the complainants. Penalties imposed by CPSO disciplinary committees were seen as inappropriately lenient, and as manifesting overarching identification with the accused physicians. Minimal penalties were rightly understood by the complainants, and those concerned about sexual violence in all of its forms, as little more than a slap on the abuser's professional wrist. At the same time, when the discipline committee did respond seriously to physician sexual abuse and imposed significant penalties on abusers, the Ontario courts regularly overturned the penalties, substituting less onerous ones and undermining the efforts of the CPSO to respond seriously to sexual abuse.⁶

In Ontario, the CPSO wrote reports, produced detailed policies and engaged in educational initiatives for both their professional members and for the public. The CPSO took important steps to increase the information available about abuse in the health care context and to open up the disciplinary process to public scrutiny. Policies, discussions and disciplinary decisions of CPSO committees were posted on its website, as were the disciplinary histories of individual doctors. The Province of Ontario and the CPSO demonstrated a commitment to eradicating physician sexual abuse that has been unmatched elsewhere. Ontario undertook major legislative reform of the regulatory structure applicable to all health care professions, introducing legislative changes to the *Regulated Health Professions Act*⁷ designed to implement zero tolerance of sexual abuse and to impose license revocation as a mandatory penalty for the most serious cases of abuse.⁸ Broad changes were

6 1991 Report, *supra* note 4. See also 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 4 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."

7 *Regulated Health Professions Act*, S.O. 1991, c.18, as am. by S.O. 1993, c.37 [*Health Professions Act*]. Schedule 2 to this *Act* sets out the *Procedural Code* which is deemed by s. 4 of the *Act* to be part of each health profession *Act* enacted by the Province. The amendments dealing with sexual assault are found primarily in the *Procedural Code*. See Bill 100, *An Act to amend the Regulated Health Professions Act*, S.O. 1991, c. 18, as am. by S.O. 1993, c. 37. They define sexual abuse and impose mandatory license revocation for a minimum period of 5 years for the most serious forms of sexual abuse. S. 72(3)(a).

8 British Columbia and Prince Edward Island also implemented legislative

made to the *Act*, introducing new provisions designed to address the sexual exploitation of patients by health care professionals.⁹

Recognition that sexual abuse of patients is unprofessional and constitutes misconduct was not new. Prior legislation defined professional misconduct to include sexual impropriety with a patient. However, the revised legislation included specific measures defining "sexual abuse," imposing an obligation on all health care professionals to report sexual abuse by other health care providers,¹⁰ introducing specific penalties and restrictive reinstatement provisions, and listing specific forms of sexual misconduct punishable by mandatory license revocation.

The most important reform was the mandatory revocation penalty imposed for sexual abuse of patients. License 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 the listed acts, it could be imposed for other forms of sexual abuse. Under the new provisions, where a professional's license was revoked for sexual abuse of any kind, no application for reinstatement could be made for a minimum period of five years. The legislation was proclaimed in force at the end of 1993. A statutory mandated

changes applicable to physicians and surgeons in those provinces: *Medical Practitioners Act*, R.S.B.C. 1996, c. 285, ss. 28, 59-60, 65 [*Medical Practitioners Act*]; *An Act to Amend the Medical Act*, S.P.E.I. 1997, c. 30, s. 13. For pending amendments in BC see also online: <http://www.health.gov.bc.ca/leg/pdfs/HPA_Unofficial_Consolidation_June_6_2007.pdf>.

9 Originally, the *Act* provided the legislative framework for 21, now 25, health professions governed by its provisions. These include audiologists, chiroprodists, chiropractors, dental hygienists, dental surgeons, dental technologists, denturists, dietitians, homeopaths, kinisiologists, massage therapists, medical laboratory technicians, medical radiation technologists, midwives, naturalpaths, nurses, occupational therapists, opticians, optometrists, pharmacists, physicians and surgeons, physiotherapists, psychologists, respiratory therapists, and those practising traditional Chinese medicines.

10 For a definition see *Procedural Code* (s. 1(3)) and Bill 171, *Health System Improvements Act, 2007*, 2nd Sess., 38th Leg., Ontario, 2007, Sch. M [Bill 171]. For mandatory reporting see s. 85(1) and (2). For mandatory consequences see s. 51 (5). See also *Medical Practitioners Act* s. 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.

five-year review was required by the legislation. Begun in 1999, the results of the review were made public in 2003.

A decade of experience with the zero tolerance provisions, the data provided by the five-year review and the increased access to information provided by the CPSO website make this an opportune time to consider the impact of these reforms. How have the CPSO and the disciplinary process responded to the objectives of the legislation? What has been the impact of the new legislative provisions on disciplinary penalties?

Medicine and the other healthcare professions are self-regulating professions. The regulatory structure under the *Act* establishes both a Complaints and a Discipline Committee. The members of each are drawn from the elected members of Council, and it is the members of each committee, supported by CPSO staff, who are responsible for the work of these committees. All elected members are doctors. Government appointed members are drawn from the broader community and bring varying expertise to their tasks. All members, and all committee members, receive some training with regard to the functions they serve.¹¹

In this paper I examine the decisions of the CPSO Complaints and Discipline Committees concerning sexual abuse between 1994 and 2005 to determine the impact of the new provisions of the *Act* on CPSO proceedings. I rely on two primary sources of information. The first is that provided to PricewaterhouseCoopers by the CPSO as part of the mandated five-year review. The second is my own review of post – 1993 discipline decisions involving allegations of sexual abuse and available on the CPSO website, whether in summary or complete form. In some cases, decisions that appear in summary form only are available in full from other databases. Occasionally other sources are specifically referred to. Where this is the case the source of the information is noted. While the information available from these sources is not coterminous, in each case it supports the same conclusions.¹²

My review reveals several locations of institutional resistance which interfere with the protection of the public and which undermine the intent of

11 See ss. 25 and 38 of the *Procedural Code* re: appointment of a complaints or discipline committee panel. The name of the Complaints Committee has been changed to the Inquiries, Complaints and Reports Committee by the *Health System Improvements Act, 2007*. During the period under review in this text the committees were known under their old names, Complaints Committee and Discipline Committee. This usage is maintained in this text.

12 See also *infra* note 17.

the zero tolerance legislation. These include the persistent and unacknowledged requirement that the complainant be independently corroborated; the persistent criminalization of the disciplinary process; and the pathologizing of the complainant and the exculpation of the offender through defense reliance on psychiatric "expertise." The decisions also reveal a narrow technical reading of the provisions of both the *Act* and CPSO guidelines, which undermines both the letter and the spirit of the legislative reforms.

I conclude that despite important legislative changes designed to ensure that sexual abuse is taken seriously and that those who transgress legislatively defined sexual boundaries are de-licensed, only 5.53% of cases involving allegations of sexual abuse considered between 1994 and 2005 ever reached the disciplinary stage. In those that did proceed to discipline, there is an unacknowledged reliance by both the Complaints Committee and the Discipline Committee on corroboration in the form of eyewitnesses or multiple victims. This imposition of a need for corroboration replicates and reinforces the stereotypes of unreliable and retributive women complainants so often found in the response to male sexual violence.

I also document an increasing criminalization of the disciplinary process and of the rules applicable to hearings. Both of these departures from the rules of civil procedure create increased and inappropriate barriers to protection of the public and undermine the objectives of zero tolerance legislation. Quasi-criminal burden of proof requirements are apparent in the decisions of the discipline committee and in attempts by counsel for accused doctors to access complainants' private and personal records. There is ample evidence of the psychiatrization of complainants for the purpose of discreditation, while similar techniques are used to exonerate abusing physicians.

I am not suggesting here that this resistance is either deliberate or that it represents intentional CPSO policy. Rather, it is the result of the very nature of the regulatory self-disciplinary process and its procedures and the fragmentation that occurs when each decision is understood to stand alone, rather than is considered as a part of a possible pattern. It is hoped that this study and what it reveals about the impact of the aggregate of decisions to pursue complaints will be of assistance to the CPSO as it furthers its commitment to a zero tolerance policy.

I. Barriers to Complaints of Sexual Misconduct

The 1993 legislative reforms required that a complaint of sexual misconduct be received by the CPSO, investigated and considered by the Complaints Committee and, should the Complaints Committee consider it warranted, be forwarded to the Discipline Committee for a full adversarial hearing and the imposition of an appropriate penalty. Such penalties included both discretionary and mandatory license revocation. Prior to the 1993 amendments, little evidence was available to assess the attrition rate of complaints that never proceeded either to the Complaints Committee, or from there to a hearing at the Disciplinary Committee. This left both the investigative stage and the referral by the Complaints Committee to the Discipline Committee exempt from scrutiny. While some Discipline Committee decisions were publicly available, they were difficult to access and often were made available in summary form only. The five-year assessment, the increased availability of CPSO statistics, and more complete summaries or full discipline Committee decisions now provide an opportunity to assess the actual impact of the change in attitude towards physician sexual abuse, as expressed in the *Act* and as implemented by the CPSO.

Mandatory Reporting

There are two ways in which information concerning physician sexual misconduct can come to the attention of the CPSO. The first is through a mandatory report made by another health care professional. The *Act requires* all health professionals in any one of the 21 regulated health professions to advise the appropriate regulatory college where she or he has knowledge of a colleague's sexual abuse of a patient.¹³ Between 1994 and 1998, the period studied in the five-year evaluation undertaken by Ontario, the 21 regulated health Colleges received a combined total of 1012 mandatory reports of sexual misconduct by a health care professional. Eight hundred eighty-seven (87.6%) involved doctors.¹⁴ It is clear that the mandatory reports received

13 S. 85.1 mandates reporting where the professional has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient. Best efforts must be made to advise the patient that the report will be made and to receive the patient's permission to disclose her name. In the absence of consent, the patient cannot be named.

14 PricewaterhouseCoopers, *Evaluation of the Effectiveness of the Health Professional*

are only a small percentage of those that should be made. Few members of the health professions comply with the mandatory reporting provisions. A 1999 PricewaterhouseCoopers survey of the 21 regulated health professions in Ontario found that only 7% of the 3560 professionals who replied to the survey had made a mandatory report where they knew of sexual abuse by a professional colleague. An additional 3% admitted that they failed to report sexual misconduct, despite knowing of their legal obligation to do so.¹⁵ The actual number who not only failed to report, but failed to admit their breach is unknown.

Furthermore, the PwC report found that the Colleges that received the mandatory reports indicated that they often did nothing with the information. The CPSO admitted that it was unlikely that a mandatory report would be the basis for an investigation of a health care professional unless the name of the abused patient was provided. They also indicated that they did not use mandatory reports to track the possibility of multiple complaints against a member, nor as similar fact evidence to trigger an investigation or to provide support for an existing complaint.¹⁶

Colleges' Complaints and Discipline Procedures with Respect to Professional Misconduct of a Sexual Nature and Status of the Colleges' Patient Relation Program (Toronto: PricewaterhouseCoopers, 1999) [PwC Report]. The PwC Report was 27 volumes in length, with a specific report on the performance of each of the health disciplines governed by the legislation. These numbers must be assessed taking into account under reporting. See *Table 2: Statistical Summary – Complaints and Mandatory Reports*.

- 15 *PwC Report*, volume 6, *ibid.* at 21: 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%).
- 16 *Ibid.* at 16. It should be noted that s. 75 of the *Act* allows for an investigation where a mandatory report has been received. See also s. 85.11 (2)(2) (1). See the recommendations of the Health Professions Regulatory Advisory Council, 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. Health Professions Regulatory Advisory Council, *Final Report to the Minister of Health and Long-term Care: Effectiveness of Colleges' Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature* (Toronto: Ministry of Health,

Complaints From the Public

The failure by the Colleges generally and by the CPSO specifically to use information obtained from mandatory reports is not the only barrier in the way of an effective implementation of the sexual misconduct provisions. The second source of sexual misconduct complaints is members of the public.¹⁷ Between 1994 and 2001 the CPSO alone received a total of 13,000 complaints of physician misconduct of all kinds, including sexual misconduct.¹⁸ The CPSO reported that 99% of these complaints were dismissed or were resolved internally without proceeding to a disciplinary hearing.¹⁹

2000), online: Health Professions Regulatory Advisory Council <<http://www.hprac.org/downloads/cAndD/ComplaintsAndDisciplineReport.pdf>> [HPRAC Report]. Contrast this to the recommendations of the 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] that mandatory reports should trigger an investigation where there is a reasonable suspicion that there is a risk of harm to patients *or upon two reports* at 39-40 [emphasis added].

17 It should be noted that those most likely to be abused may be the least likely to report abuse: "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, *ibid.* at 3. See also 2000 Report, *ibid.* at xii. The Act requires a formal complaint (s. 25(4)). A few of the Colleges assist complainants by travelling to their homes, 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, *ibid.* at 17-18.

18 There are 28,000 members of the College in total.

19 Robert Cribb, Rita Daly & Laurie Monsebraaten, "How system helps shield bad doctors: College admits flaws in process" *Toronto Star* (5 May 2001), online: *Toronto Star* <http://www.thestar.com/NASApp/cs/ContentServer?pagename=thestar/Layout/Article_T>. 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 licenses to practice. Of the 141

Many obstacles impede an individual patient from personally filing a complaint of physician sexual misconduct. These include individual feelings of denial, complicity, shame, self-doubt, trauma and loss as well as a concern that the institution will favour its own members. These barriers suggest that those patients who do file complaints are only a small percentage of those who have been abused. The CPSO reported that between 1993 and 1998, 448 independent individual complaints of sexual abuse were filed with the College.²⁰ Of these, 213 were never referred by CPSO staff to the Complaints Committee. This was the result of a withdrawal of the complaint, the resignation of the member or a formal or informal alternative dispute resolution process.²¹ Two hundred and forty-three²² complaints were forwarded to the Complaints Committee. Of these, 99 received no action by the Committee; 80 doctors received a written caution; and 51 doctors received an oral caution.²³ Only 61 doctors, or 14% (61/448), were referred to the Discipline Commit-

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. Most recent data from the CPSO indicate that in 2005 73% of complaints received by the Complaints Committee, including sexual abuse complaints, resulted in no action. CPSO, *Annual Report* (Toronto: College of Physicians and Surgeons of Ontario, 2005) at 10 [*Annual Report*].

- 20 These are complaints against individual doctors. There may be multiple complainants. In 2005 there were 705 complaints on all matters of professional competence and conduct, 73% resulting in no action. Four percent were forwarded to discipline. *Annual Report, ibid.*
- 21 There were 181 pre-complaint dispositions and 108 ratifications of a resolution otherwise achieved between the parties – the College and the doctor (*PwC Report, vol. 22, supra* note 14 at 29).
- 22 These numbers are discrepant with those above. The discrepancy arises in the numbers provided by the CPSO to PwC and relied on by PwC in its report. For the first set of numbers see vol. 6: Summary of Key Findings. For the second set of numbers see vol. 22: Report on the College of Physicians and Surgeons of Ontario, *ibid.*
- 23 Four were the subject of ratification of a resolution reached through ADR, 1 of legal ratification, 3 were referred to the Quality Assurance Committee, 4 to the Executive Committee, and 2 are indicated as “other.” Vol.22, *ibid.* at 30. The complainant may appeal to the Health Professions Appeal and Review Board.

tee for a disciplinary hearing.²⁴ Of these, 23, or 38% (23/61), were found guilty by the Discipline Committee.²⁵ Twenty-nine (29/61) were found not guilty and 31 cases were withdrawn.²⁶ Overall, only 5% (23/448) of defendant doctors who were the subject of complaints of sexual abuse went on to be found guilty by the Discipline Committee.²⁷ On appeal of these decisions of the Discipline Committee to the courts, 6 were abandoned, 10 upheld and in one the appeal was allowed.²⁸

Thus, added to the failure of professionals to meet their mandatory reporting obligations and the failure of the CPSO to follow up on those reports when received, is a significant drop off rate between the filing of a complaint by an individual and any resolution on the merits by the Discipline Committee.²⁹ Overall, the percentage of mandatory reports plus individual complaints referred to discipline was 5.53% of all complaints of sexual abuse that the CPSO received.³⁰

24 *Ibid.* at table 2: Statistical Summary – Complaints and Mandatory Reports. There are small discrepancies in the numbers provided. Volume 6 of the *Report* lists 23 findings of guilt. Volume 22 lists 28. Additionally, not all complaints would have been resolved, even informally, during the time period being tracked by PwC.

25 *Ibid.* at table 3: Statistical Summary of Referrals to Discipline. 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.

26 *Ibid.* at 31.

27 *HPRAC Report*, *supra* note 16 at 16.

28 *PwC Report*, vol. 22, *supra* note 14 at 10.

29 The Complaints Committee may refer a doctor subject to a complaint to the Executive Committee for incapacity, or to the Discipline Committee for misconduct or incompetence, or require a member to appear before it to be cautioned or take any action that it considers appropriate and consistent with the *Act*. It may not refer a doctor to the Quality Assurance Committee for behaviour or remarks considered sexual but may refer a member to attend a continuing education or remediation program (Bill 171, *supra* note 10 at s. 30). 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 patient complaints and mandatory reports, the proportion of complaints referred to the Discipline Committee ranges from 3.9% to 29.7%. *HPRAC Report*, *supra* note 16 at 9.

30 *HPRAC Report*, *ibid.* at 16.

This is a significant level of attrition.³¹ It likely understates the real problem. The reluctance to file, high withdrawal rates and the negative consequences of filing experienced by complainants combined with the failure to pursue mandatory complaints created a significant fall off. When combined with the informal screening and dismissal of complaints that are filed, these all combine to result in few complaints being subjected to the disciplinary process. Despite the implementation of zero tolerance legislation, this situation has not improved.

II. Barriers to Getting Heard by the Discipline Committee

What accounts for the 47.5% (213/448) of all complaints that never make it to the Complaints Committee and for the 74.9% (182/ 243) of those that never make it from the Complaints Committee to the Discipline Committee? The non-founding of these complaints is the result of a number of factors, each disturbing in its own right.³² The imposition of any screening process diverts sexual abuse cases.

31 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 *Act*, 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. 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. *Supra* note 16 at 43, 36.

32 The failure to pursue complaints is the equivalent of the non-founding of sexual assault complaints in the criminal justice system. The non-founding of complaints does not mean that they are *unfounded*, but rather that active steps have been taken to disqualify them from proceeding. In contrast, criminal law statistics indicate a non-founding rate of 6% of sex assaults reported to police. Of those reported, 40% result in charges; 66% result in a conviction. Ontario Women's Directorate, *Sexual Assault Reporting Issues*, online: <<http://www.citizenship.gov.on.ca/owd/english/publications/sexual-assault/reporting.htm#1> 28 June 2007>; Statistics Canada, "The Violence Against Women Survey" (Ottawa: Ministry of Industry, 1993).

The language of the *Act* indicates that it is the statutory obligation of the *Complaints Committee* to investigate any complaint formally received. In fact, a preliminary investigation usually is carried out by staff of the CPSO and not by the Committee.³³ The CPSO reported that complaints were regularly “resolved” prior to referral to the Complaints Committee for investigation.³⁴ Some of the drop-off is attributable to the use of informal dispute resolution processes to respond to complaints not forwarded to the Complaints Committee for investigation.³⁵

Whether the investigation is formally carried out by the Complaints Committee as required by the legislation, or is carried out informally, the nature of the investigation is key. In its report to PwC, the CPSO admitted that investigatory standards that it had implemented specifically to assist the complainant were abandoned in 1997. The motive for discarding complainant friendly strategies was the perception that they were responsible for difficulties the CPSO was experiencing in concluding successful disciplinary prosecutions.³⁶ The supportive mechanisms had included an investigatory

33 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. Recommendations 20,21. PwC reports that 13 of the Colleges conducted some level of investigation prior to referral to the Complaints Committee. The College of Physicians and Surgeons is one of these. *Supra* note 14 at 15. See also Richard A. Steinecke, *A Complete Guide to the Regulated Health Professions Act* (Aurora: Canada Law Book, 1995).

34 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 14 at 17-18.

35 *Supra* note 14 at 17. The CPSO used ADR to respond to four complaints, of which only two were resolved. This occurred despite the position of Dr. Bienstock, then president of the College, that ADR was inappropriate for *any* matters of sexual misbehaviour. This was recently formalized by amendments to the *Act* which now stipulate that ADR may not be recommended in cases of sexual abuse (Bill 171, *supra* note 10 at s. 25 (1)).

36 This change is confirmed by the remarks of Ms. Susan Vella, *2000 Report, supra* note 16 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

team of women with experience and commitment to issues of sexual abuse. This was dismantled. In addition, investigators were advised no longer to act as support persons for the complainant. Nor was the complainant any longer allowed significant control of the process. In addition, allegations of sexual abuse that could be characterized as clinical deficiencies were re-characterized as such and transferred to clinical investigation.³⁷ As well, changes were made to the manner in which the complainant's medical records were collected. They are now collected regardless of the possible prejudice to the complainant.³⁸ Furthermore, the CPSO determined formally that complaints could be resolved prior to referral to the Complaints Committee, although the language of the *Act* contains no such provision.

The 86% fall off rate for those cases that do reach the Complaints Committee but do not get referred on to disciplinary adjudication is equally disturbing. The function of the Complaints Committee as preliminary assessor of the complaint has been the subject of some comment in the courts. The comment predates the 1993 revisions to the legislation, and reflects an arguably inappropriate solicitousness to professional reputation. Reliance on these cases by the CPSO and its judicial committees post-1993 arguably is out of step with the legislative intention as expressed in the 1993 major revisions to the regulatory structure, particularly with regard to sexual misconduct.

In 1979 in *Re Matheson and College of Nurses of Ontario*³⁹ the Ontario Divisional Court reviewed the screening role of the Complaints Committee, and concluded that the power to refer to discipline should be used "sparingly, where it feels a serious case is involved."⁴⁰ It continued:

that many lawyers, including myself, cannot recommend that patients ever go to the college."

37 For example, allegations of inappropriate sexual touching of a patient's breast might be characterized as inadequate training in performing a breast examination rather than as sexual misconduct.

38 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. *Supra* note 16 at 11-12.

39 (1979), 27 O.R. (2d) 632.

40 *Ibid.* at para.15

Our view is that the Discipline Committee has rather restricted functions, either to find someone guilty of professional misconduct or incompetence, both being very grave conclusions. Even though the sanctions that it may employ include relatively minor ones, the mere fact that a nurse comes before the Discipline Committee is a serious sanction in itself....⁴¹

In 1992 in *Brett v. Board of Directors of Physiotherapy*,⁴² the Ontario Divisional Court suggested that a two-pronged test be applied by the Complaints Committee to decide whether a case should be forwarded to discipline. The proposed test required that the Complaints Committee determine whether 1) there is some evidentiary basis for a prosecution and 2) this an appropriate case to send on for trial. In a comment on *Brett*, Steinecke, Maciura and LeBlanc explained that the Committee is required to assume “that the information against the practitioner is believable for the limited purpose of deciding whether there is a case that might meet the onus of proof.” This test is much more generous to the complainant than the one set out in *Re Matheson*, and is more in accord with the spirit of the *Act*. Steinecke, Maciura and LeBlanc commented on an inclination of some Complaints Committee panels to impose greater barriers on the decision to forward a case to the Discipline Committee. They reported that in some cases, the Complaints Committee has required that there be “a reasonable prospect of success,” raising the bar even higher. In their view, this inappropriately incorporates criminal law terminology and burden of proof. They suggested that the Complaints Committee should consider whether it is appropriate in all circumstances to send the complaint to a disciplinary hearing, requiring the Complaints Committee to “set aside the assumption ... that the complaint will be believed” and focusing on whether the allegations are serious, requiring a hearing by their very nature, or whether an alternative other than discipline would protect the public interest.⁴³ Clearly, there is some lack of clarity and varying degrees of attention to the accused and to the complainant in these varia-

41 *Ibid.*

42 (1992), 9 O.R. (3d) 613.

43 Steinecke Maciura LeBlanc, “Complaints Cases That Have Withstood the Test of Time” (February 2002), online:

Steinecke Maciura LeBlanc Barristers and Solicitors

<<http://www.sml-law.com/publications/newsletters-detail.asp?DocID=32>>.

tions on the appropriate measure to be used in determining whether to send a case forward to discipline.

The test used by the Committee in deciding whether to send a complaint forward to the Discipline Committee is of critical importance to the profession's response to sexual misconduct. According to the CPSO, the decision to send to discipline is assessed on a number of factors: whether the alleged conduct constitutes professional misconduct, whether it warrants a discipline hearing and whether the CPSO has clear and convincing proof of professional misconduct.⁴⁴ This is tantamount to a requirement for *prima facie* evidence. HPRAC recommended an alternative and more flexible test than that which the CPSO claims is in use. The HPRAC test would require 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."⁴⁵ The existing test sets up multiple barriers before any complaint is referred for a disciplinary hearing, including: 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 admissibility,⁴⁶ credibility and of probity at the informal, and again at the formal, investigatory stage.

44 *Matheson v. C.N.O.*, (1979), 27 O.R. (2d) 632 at 638. 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. The sufficient standard of proof is clear and cogent evidence. 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, *supra* note 16 at 37. 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...."

45 *Supra* note 16 at 38.

46 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*, in recommendation 13.0, *supra* note 16 at 40, suggested section 49 of the *Act* be repealed and that evidentiary rules

It is clear that in considering complaints of any kind, multiple levels of screening create opportunities for systemic bias to operate. They allow 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 a complaint to discipline. At this point in the disciplinary process such a reliance on myth will be completely undocumented and therefore not subject to scrutiny. In contrast, if that reliance occurred as part of the discipline hearing it is at least possible that it would be documented in the decision: formal written reasons are required. A purposive approach which balanced the public interest in combating sexual abuse with fairness to the accused could be met by presuming that the facts as claimed are capable of proof for the purposes of proceeding to the discipline committee. At the disciplinary stage full procedural fairness is available and the accused's interests are protected. In all cases where the claimed facts could make out a case for discipline, the complaint should be referred to a Discipline Committee hearing.

This is particularly problematic where views on credibility preclude access to the Complaints Committee and therefore to the Discipline Committee, or bar referral from Complaints to Discipline. In effect, the CPSO has created a form of preliminary hearing not authorized by statute. A second barrier arises from the 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. Determinations of credibility of the complainant and the accused are properly the role of the Discipline Committee. The task of the Complaints Committee should be limited to screening out obviously frivolous complaints. It must be noted

be governed by the *Statutory Powers Procedure Act*. See also Robins, *supra* note 44 at 231-2:

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.

that even where a case is forwarded to the Discipline Committee for a hearing, a full hearing may never occur. If the doctor pleads guilty, or there is an agreed statement of facts, a full hearing likely never will take place.⁴⁷ Screening out complaints so that they never reach a disciplinary hearing evades the public interest in de-licensing the offender and in educating practitioners and members of the public. It is also possible that improper considerations may lead the Complaints Committee to divert complaints they believe are credible so as to avoid the mandatory revocation provisions prescribed by the *Act*. A close review of the decisions of the Discipline Committee since 1993 demonstrates clearly that these concerns are justified.

III. Discipline Committee Decisions 1993-2005

The website of the CPSO now contains all of the decisions of the Discipline Committee where the doctor was found guilty of an offence after 1993. Where no guilty finding is made, the case is not listed on the website.⁴⁸ Where the decision of the Discipline Committee has been overturned by an appellate court, the case is removed from the list. If the member retains his license to practice but has been disciplined, or if the member is subject to a discipline proceeding which has not yet been completed but where he is subject to interim license restrictions, this information is also available on the website through a search of the physician's name.⁴⁹ Not all decisions are made available in full on the website; many are provided as summaries only. However, there is an increase in publicly accessible information. As well, there is a significant increase in the number of full decisions now publicly available.

The CPSO has published the outcomes of the disciplinary hearings against 120 doctors⁵⁰ in sex misconduct cases decided after 1993. These fall into two categories. One group involves acts of misconduct that occurred prior to the amendments but where the hearing occurred after 1993. In these, the 1993 new definition of sexual abuse and the mandatory license revocation provi-

47 Jenny Manzer, "Is Health Professions Act all bark and no bite?" *Medical Post* (14 May 2000) 36, online: Medical Post <<http://www.medicalpost.com/mcontent/article.jsp?content=/content/EXTRACT/RAWA>>.

48 Some, not all, are available through Quicklaw.

49 In addition, some but not all of the disciplinary decisions of the college committee are available on Quicklaw, database CPSO.

50 For the purposes of this study multiple cases brought separately against a single doctor are counted as one.

sions did not apply. While revocation is not mandatory, however, it may be imposed for serious professional misconduct. The second group involves acts of misconduct that occurred after the amendments. Mandatory revocation is required for certain categories of sexual abuse. Both the pre- and post-1993 cases include acts of sexual misconduct that may fall short of requiring license revocation. Each case decided after 1993 was heard by the Discipline Committee in an environment in which it was clear that sexual abuse was being taken seriously by the CPSO and by the Province.

A review of the post-1993 decisions of the Discipline Committee demonstrates a number of striking features. These decisions suggest that the disciplinary hearings fall short of the achievements represented by the 1993 legislation.

Requiring Corroboration

In the criminal law context, male centered assumptions about women's sexuality and morality and about male sexual entitlement have informed the criminal law on sexual assault. This has resulted in evidentiary rules unique to sexual assault offences. These have included definitions of rape that required penile penetration, that non-consent be demonstrated by violent resistance, and rules regarding the doctrine of recent complaint. Among these, the rules regarding the need for corroboration have been the most longstanding, pernicious and intractable, rendering past sexual history relevant to present consent or refusal and insisting on warnings concerning the danger of convicting on the otherwise uncorroborated evidence of a woman or child. All of these have been the subject of political, legislative and judicial reform, and of backlash to reform.⁵¹ Legislatures and courts have found them, variously, to be irrational, discriminatory and unconstitutional. Too often, despite explicit legislative repeal or judicial direction that such requirements are no longer valid, reliance on these legal markers of resistance resurfaces in slightly altered forms. It is not surprising therefore to find their resurgence in the context of physician's sexual misconduct. This is demonstrated by the response of CPSO staff members and committees to complaints of sexual abuse perpetrated by physicians. The persistence of discriminatory stereotypes and resistance to the full implementation of zero tolerance provisions demonstrates the survival of these assumptions and stereotypes and

51 McIntyre, *supra* note 3.

their replication in the regulatory context. This is despite a strong legislative message that sexual abuse by professionals should not be tolerated.⁵²

Extraordinary requirements with regard to corroboration have been a continuing and pernicious marker of law's resistance to the eradication of male sexual violence against women and to legal and social recognition of the full equality and personhood of women. The most striking subversion of the implementation of a policy of zero tolerance in the regulatory context is the apparent persistence of an unwritten and uncommented upon requirement for independent corroboration of the complaint, and resistance to proceeding where the only evidence of sexual abuse is provided by the woman herself. This is despite the fact that nowhere in the *Act* is there reference to any formal requirement for corroboration and despite the explicit repeal of such requirements in the criminal context.

It is clear from the data provided above that many complaints never formally make it to the Complaints Committee and, of those that do, only a few are forwarded to the Discipline Committee. The most striking feature of those that are forwarded is the presence of independent corroboration of the complaint. The corollary is, of course, that in the absence of corroboration the cases do not come forward at all – either because they never make it to the Complaints Committee or because the Complaints Committee fails to forward them to Discipline. Furthermore, the relatively high failure rate at Discipline of the few cases that do go forward without corroboration further demonstrates the persistent resistance to allowing a finding on uncorroborated evidence.

In the cases that are heard by the Discipline Committee corroboration takes a number of forms. The most decisive form of corroboration comes from a successful criminal conviction, or a disciplinary finding against the physician in another jurisdiction, for acts that constitute sexual abuse.⁵³ In such cases, the existence of a formal finding of criminal responsibility or dis-

52 This was noted by the Task Force prior to the amendments to the legislation. "It would seem that tribunals are most likely to render a finding of not guilty (a) where a physician denies the conduct and offers evidence as to good character in the community; and (b) where there is a lack of corroboration for the complaint," *supra* note 16 at 186. It is entirely discouraging to find that this has not changed.

53 For a summary of the tribunal decisions individually referred to below see generally: *Summary of Discipline Committee Decisions*, online: CPSO <http://www.cpso.on.ca/Info_Public/Dis_sum/disc_sumtoc.htm/>. See e.g. *Campbell* (2007); *Singh* (1991); *Verma* (2001).

ciplinary penalty constitutes the grounds for misconduct, without the need for a full investigation or full disciplinary hearing. The CPSO need not consider whether the claim of sexual abuse can be proven where it has been proven through another legal process understood to be reliable by the CPSO and made formally so by the terms of the *Act*.

The most striking form of corroboration is through the admission by an accused that the complaint of sexual abuse is true. This may take the form of his voluntary resignation, a guilty plea or an admission that the abuse occurred by way of an agreed statement of facts or consent order. A second group of cases includes *both* the physician's guilty plea and additional independent corroboration. The third group demonstrates corroboration alone.

Even where the doctor pleads not guilty, most cases forwarded to the Discipline Committee include corroborative evidence of the complainant's claim. This takes a number of forms. Occasionally the abuse is actually documented in the doctor's own files concerning the patient. More frequently there is tangible evidence, including letters of apology, cards, telephone calls, video and audio tapes, email messages, gifts, photos, hotel bills, or independent witnesses who were present when the complainant and accused were together. Multiple complainants and similar fact evidence also provide corroboration.

Forms of Corroboration: Pleading Guilty

Of the 120 cases of doctors⁵⁴ who were disciplined for sexual misbehavior decided between 1993 and 2005, 37 were resolved by the guilty plea of the accused.

Pleading guilty to acts of abuse occurring after 1993: Eighteen cases involved events that took place after the 1993 zero tolerance amendments, meaning that mandatory license revocation was a possible penalty. Of the 18 doctors who offered guilty pleas, 11 had their licenses revoked,⁵⁵ or were allowed to retire⁵⁶ or to resign.⁵⁷ In 2 of the 18 cases there is specific reference to a

54 Some doctors were the subject of multiple complaints.

55 See e.g. *Ahmed* (2002); *Carriere* (2001); *Dobbin* (2002); *Emmett* (2002); *McHugh* (2005); *Seidman* (2003); *Umar Khitab* (2003); *Waller* (2003); *Waxman* (2002).

56 *Richardson* (2002).

57 *Douglas-Murray* did not strictly require mandatory revocation, although the doctor had been reprimanded for similar abuse in 1992; the current complaint involved 6 patients and two had been abused subsequent to the 1992 reprimand. *Douglas-Murray* (1996).

plea bargain in which the CPSO withdrew the allegations of sexual abuse, proceeding with the misconduct allegation only.⁵⁸ Of the remaining 7 cases, 4 involved sexual intercourse with a *former* patient.⁵⁹ In those 4 cases, the penalties imposed ranged from a 2-month suspension⁶⁰ through 18 months reduced to 9 months.⁶¹

Pleading guilty to acts of abuse occurring before 1993: In almost all of the pre-1993 cases in which the doctor admitted, by his guilty plea or other agreed statement of facts, that sexual abuse had occurred, the penalties imposed were minimal. This was despite the zero tolerance message of the legislation, despite the fact that the hearing took place after the amendments to the legislation and despite the fact that license revocation was available to the Discipline Committee. Furthermore, for the most part, the penalties imposed for pre-1993 misconduct of the most egregious kind were hardly greater than those imposed for lesser offences.

Nineteen cases involved guilty pleas to acts that occurred prior to the 1993 zero tolerance amendments, although the cases were heard after the amendments had come into force. Fourteen involved allegations of sexual intercourse or other sexual abuse *that would have required mandatory revocation* if the abuse had occurred after 1993. Despite the guilty pleas, only 5 of the 14 resulted in license revocation.⁶² While license revocation was not mandatory under the terms of the pre-1993 *Act*, the Discipline Committee did have the discretion to impose revocation based on the facts of the complaint. The penalties imposed in the 9 remaining cases were minimal. Seven resulted in penalties ranging from one to six months suspension.⁶³ One resulted in a 24-month suspension of license to practice.⁶⁴ One doctor was allowed to resign.⁶⁵

58 Shiozaki (2004); Silva Ruelle (2003).

59 Bothwell (2003); Hurst (1997); Ives (2002); Noreiga (2003).

60 Bothwell (2000); Hurst (1997).

61 See e.g. Ives (2002), 9 months reduced to 5 months; Noreiga (2003), 18 months reduced to 9 months.

62 Crainford (1998); McNamara (2003); Rosen (2002); Scott (1995); Sole (1999).

63 Comeau (2001); Dube (2001); Irvine (1996); Lazare (1999); Oosterhalt (1995); Turton (1994); Yong-Set (1998).

64 Genereaux (1994). Genereaux's license was revoked two years later for abetting a suicide.

65 Caverhill (1994).

Five additional cases involved guilty pleas to pre-1993 misconduct that would not have required mandatory revocation under the new *Act*.⁶⁶ In these cases, the penalties ranged from 3 to 12 months. In each of the cases, the suspension was reduced if the doctor agreed to undergo therapy, undertook training in ethics or in the nature of boundary violations or, in some cases, agreed to the use of a chaperone when seeing female patients.⁶⁷

Forms of Corroboration: Guilty Plea Plus Additional Corroboration

Twenty-four of the cases involved both a guilty plea and additional corroborative evidence.

Acts of abuse occurring after 1993: Seventeen of these cases related to acts of abuse that arose after 1993.⁶⁸ Nine of those involved acts that triggered the mandatory revocation provisions.⁶⁹ One additional case resulted in revocation, although the mandatory penalty was not strictly required by the *Act*,⁷⁰ and 7 involved lesser offences and resulted in lesser penalties.⁷¹

Acts of abuse occurring before 1993: Seven cases that concerned abuse prior to 1993 involved both a guilty plea and additional corroboration. Four of these resulted in revocation.⁷² A fifth would have resulted in revocation but the academic license had been cancelled when the doctor was fired from his

66 *Davis* (1993) hugs, kisses, comments; *Dore* (1999) relationship outside of office; *Fernandez* (1997), comments; *Johnson* (1995) hugs, kisses; *Li* (1996) breast exams.

67 See *infra* at *Exculpating and rehabilitating the abusing physician*.

68 A very few cases show corroboration and no guilty plea, but involved an admission of the facts of the sexual relationship and raised a legal defense such as reliance on consent or a claim that the sexual relationship occurred outside of any doctor-patient relationship. In such cases the College likely proceeded based on the admission of facts and the corroborating evidence. *Musanni* admitted the facts of the complaint but challenged the constitutionality of the mandatory revocation provisions.

69 *Blondin* (2002); *Campbell* (2001); *Gatrall* (2002); *Gillen* (2003); *Frith* (2002); *Jeeves* (2003); *Kulkarni* (1996); *Waller* (2003); *White* (2005).

70 *Kernerman* (2004).

71 *Bergstrom* (2000); *Bingham* (2003); *Bothwell* (2003); *Levy* (2003); *Nguyen* (2003); *Wesley* (2002).

72 *Bull* (2000); *Brawley* (1995); *Kavouris* (2004); *Pell* (1994); *Weinberg* (1995).

residency program for the abusive actions.⁷³ The sixth had been criminally convicted of sexual assault against a patient.⁷⁴ He was suspended for only 90 days and required to engage a chaperone. The seventh, Dr. Beresford, 68, who pressured his psychiatric patient to engage in a sexual relationship, had his practice restricted to male patients.⁷⁵

Not guilty pleas

The remaining cases involved a not guilty plea by the doctor.⁷⁶ Despite the denial of guilt, at least 30 of these cases showed clear corroborative evidence in direct contradiction of the not guilty plea. The corroboration took the form of multiple complainants, criminal convictions, similar fact evidence or tangible evidence such as photos, phone calls and hotel receipts.⁷⁷

In only 16 of the cases which were forwarded to the Discipline Committee by the Complaints Committee between 1993 and 2005 in which a not guilty plea was entered, was there no clear evidence of corroboration.⁷⁸ Thus of the 120 doctors whose cases were forwarded to the Discipline Committee, all but 16⁷⁹ came forward with clear corroborative proof : either a guilty

73 *Valencia* (1995).

74 *Nagahara* (1996).

75 *Beresford* (1994).

76 There are some cases that do not fit completely into the guilty or equivalent / not guilty dichotomy. For example, there are some cases where no one appears for the doctor. Cases that do not clearly include a guilty plea or clear equivalent have been categorized as not guilty.

77 *Abelsohn* (2004); *Bocking* (1995); *Boodoosingh* (1993); *Bradford* (1995); *Carll* (2002); *Caughell* (1999); *Clemes* (2001); *Deitl* (1996); *Deluco* (2005); *Dobrowski* (2004); *Frelick* (1996); *Gabrielle* (1995); *Howatt* (2000); *Johnson* (1993); *Im* (2003); *Koffman* (2003); *Lambert* (2002); *Leibl* (2001); *Markman* (1999); *McRae* (1994); *Miceli* (2002); *Mussani* (2001); *Rafaj* (2000); *Ramesar* (2000); *Rosenberg* (2003); *Sidhu* (2002); *Totsoni-Flynn* (2002); *Verma* (2001); *Verma* (2003); *Williams* (1996).

78 *BVZ*, [1995] OCPDS No. 4; *ERM*, [1995] OCPDS No. 30; *FLS*, [1998] OCPDS No. 9; *FYF*, [2002] OCPDS No. 17; *Jabouin*, [1995]; *KLG*, [1998] OCPDS No. 3; *LJL*, [1995] OCPDS No. 33; *MYS*, [1996] OCPDS No. 20; *O'Connor*, [1997]; *OKS*, [1995] OCPDS No. 18; *PVM*, [1995] OCPDS No. 2; *QLN*, [1996] OCPDS No. 2; *RBA*, [1996] OCPDS No. 27; *STO*, [1997] OCPDS No. 3; *SDE*, [1995] OCPDS No. 14; *ZHJ*, [1994] OCPDS No. 29.

79 *Alfred* (1994); *BVZ*, [1995] OCPDS No. 4; *ERM*, [1995] OCPDS No. 30; *ETM*,

plea or its equivalent, with or without additional corroborative evidence; or a claim of not guilty but clear evidence belying that claim. Few cases were forwarded in the complete absence of corroborative evidence. Of those that were, almost all resulted in findings of not guilty.

It is clear that the cases which were forwarded to the Discipline Committee were those where a successful prosecution could be most assuredly predicted – confirming the admission that the CPSO tightened the evidentiary requirements at the screening stage and reduced its willingness to bring cases forward that represented a risk of unsuccessful prosecution. The review of the cases that were brought forward makes it clear that the CPSO took few risks. This resulted in a higher rate of prosecutorial success and avoided the possible political and financial costs associated with failure for members of the CPSO.

Despite the over representation of corroborated complaints among the cases actually heard by the Discipline Committee, cases of sexual abuse where corroboration is present are in fact anomalous. Sexual abuse by definition occurs out of the sight of others,⁸⁰ making the easy availability of corroborative evidence unlikely and the over representation of corroboration among the cases that are sent forward that much more notable. This is perhaps particularly true of the abuse that occurs between doctor and patient. Arguably, the CPSO is avoiding cases in which only the complainant's voice speaks authoritatively of the abuse. In so doing it recapitulates both the non-founding of sexual assault complaints prevalent in the criminal law context⁸¹ and the historical resistance to women's uncorroborated claims of

[1995] OCPD No. 8; *FLS*, [1998] OCPD No. 9; *FYF*, [2002] OCPD No. 17; *Henderson* (2004); *Jabouin* (1995); *Jagoo* (1998); *KIG*, [1998] OCPD No. 3; *LJL*, [1995] OCPD No. 33; *Longdon* (1995); *Lurie* (2004); *MYS*, [1996] OCPD No. 20; *O'Connor* (1997); *OKS*, [1995] OCPD No. 18; *Pilo* (1994); *PVM*, [1995] OCPD No. 2; *QLN*, [1996] OCPD No. 2; *RBA*, [1996] OCPD No. 27; *Ross* (2004); *SDE*, [1995] OCPD No. 14; *Sharma* (2003); *Singh* (1995); *Smith* (2003); *STO*, [1997] OCPD No. 3; *UUO*, [1996] OCPD No. 13; *Wyatt* (2001); *ZHJ*, [1994] OCPD No. 29.

80 See 1991 Report, *supra* note 4 at 80 : "Witnesses to such acts of sexual abuse are rare. The legal processes used to determine the veracity of complaints of sexual abuse must be responsive to the reality of this kind of abuse if abusers are to be found and stopped."

81 Scott Clark & Dorothy Hepworth, "Effects of Reform Legislation on the Processing of Sexual Assault Cases" in Julian V. Roberts & Renate M. Mohr, eds., *Con-*

assault. As a result, it leaves many cases of abuse unaddressed and the abusers undeterred.

Avoiding the provisions of the legislation

The mandatory revocation provisions apply only to the sexual abuse of “patients.” The term “patient” is not defined by the legislation. In 1992, the CPSO issued guidelines with regard to doctor-patient “dating.”⁸² Policies also are in place that prescribe the steps that are to be taken where the doctor wishes to terminate the doctor-patient relationship.⁸³ Because these are guidelines, their content is advisory only.

The guidelines recommend that “dating” relationships are prohibited during treatment and for a year following the termination of treatment. They specify that this one-year period may be extended or shortened, depending on the nature of the treating relationship, taking into account the nature of the treatment, its duration, the degree of emotional dependency and other circumstances. If the treatment has involved psychoanalysis or psychotherapy, or if this is a significant component of the treatment, “dating” relationships continue to be proscribed even after termination of treatment.

The definition of “patient” is key to the rigorous enforcement of the legislation and the failure to define it forms the basis on which the requirements of the *Act* are avoided in certain cases. In a number of cases, the outcome of the Discipline Committee decision has foundered on the termination of the doctor-patient relationship, followed immediately by engaging in what otherwise would be sexual abuse.

The penalties imposed by the Discipline Committee where the doctor terminated the treatment relationship and immediately entered into a sexual relationship with the patient have been minimal. This is true even though the dynamics of the abuse are virtually identical and require mandatory revocation when occurring within the doctor-patient relationship. Abrupt

fronting Sexual Assault: A Decade of Legal and Social Change (Toronto: University of Toronto Press, 1994).

82 See CPSO, “Physician-Patient Dating” (May 1992), online: CPSO <www.cpso.on.ca/Policies/dating.htm>; see also CPSO, “Maintaining Boundaries with Patients” *Members’ Dialogue* (September/October 2004), online: CPSO, <<http://www.cpso.on.ca/Publications/Dialogue/0904/cover2.htm>>.

83 See CPSO, “Ending the Physician-Patient Relationship” Policy #4-00 (September 2000), online: CPSO <<http://www.cpso.on.ca/Policies/dating.htm>>.

termination of the doctor-patient relationship specifically to evade the legislation has been sufficient to avoid license revocation, even for psychotherapy.⁸⁴ Even when hasty termination of the doctor-patient relationship is for ulterior motives and violates CPSO directives and guidelines on doctor-patient termination, the penalties are modest. The doctor artfully fragments the abusive and exploitative relationship. The grooming of the victim of abuse is implausibly divided into notionally unrelated acts that occur prior to or after technical termination. Acts that form part of the continuum of abuse are understood as separate acts. The arbitrary or manipulated timing of the acts as pre- or post-termination becomes key with regard to the imposition of the mandatory revocation penalty.

One example will suffice. Dr. David Levy provided psychotherapy to patients with eating disorders. He began treating the complainant in 1993.⁸⁵ During treatment Dr. Levy disclosed information about his personal life, encouraged her to use his health club membership, conducted therapy sessions while jogging and skating with her, took her out for drinks and for meals, bought her flowers and sent her personal cards and letters.

In October 1995, the doctor-patient relationship was terminated and Dr. Levy advised her that she could contact him for further treatment if necessary. From that time on he contacted her continually, seeking a personal relationship. In March 1996 they entered into a sexual relationship, which terminated in November 1998. The Discipline Committee treated the abuse

84 Most of these cases involve psychotherapy offered by general practitioners and sexual relationships that began within months of the termination of the doctor-patient relationship. Because the physician-patient relationship had been terminated the penalties imposed in most cases were minimal. See e.g. *Bothwell* (2003); *Dore* (1999); *Dube* (2001). All received a one-month suspension and were required to take a boundaries course. *Henderson* (2004) received a three-month suspension and was required to take a boundaries course. See also *Hurst* (1998); *Ives* (2002); *Kavouris* (2004). In *Kavouris* see the complainant's impact statement: "I feel as if Dr. Kavouris preyed on me. He knew my vulnerabilities and he took advantage of that I trusted him for 7 years, as a 'doctor,' as OUR family doctor. He knew that he could sell me anything and I would buy it, that I believed in him more than anyone." See also *Levy* (2003); *Lurie* (2004); *Richardson* (2002); *Shiozaki* (2004); *Totsoni-Flynn* (2002); *Wyatt* (2001).

85 *The College of Physicians and Surgeons of Ontario v. Dr. Lance David Levy*, online: CPSO <http://www.cpso.on.ca/Info_Public/Dis_sum/WEBDISC/2003/LevyL.pdf>.

as occurring after the termination of the doctor-patient relationship and suspended Levy's license for one year. Four months of that period were lifted if he met a number of conditions, including completing a boundaries course and undergoing a psychiatric assessment.

To treat as unrelated prior to termination and the abuse that occurred after termination as unrelated for the purposes of discipline, and the relationship as not triggering the mandatory revocation provisions because not technically occurring between doctor and patient, is clearly to circumvent the zero tolerance spirit of the legislation.

In a small number of other cases it appears that CPSO committees stretch the provisions of the *Act* to avoid the imposition of penalties that otherwise would follow. It is impossible to be certain how many cases are deliberately diverted from the anticipated requirements of the *Act* at the inquiry stage or by the Complaints Committee. However, there are a number where the extent the Discipline Committee will go to avoid the imposition of mandatory penalties is visible on the face of the decision. In particular, the Discipline Committee appears to have a soft spot for those (abusive) relationships with patients that are formalized by marriage or that show some measure of longevity.⁸⁶

CPSO v. Wyatt is one such case.⁸⁷ Dr. Wyatt treated the complainant B from 1988-1994, providing general care as well as psychotherapy. She began treating B's partner, A, in 1992. She provided A with psychotherapy as she did B, and provided them both with couple counseling. She began an intimate relationship with A in July 1994, one month after terminating the doctor-patient relationship with A and in the same month in which she terminated the doctor-patient relationship with B. In August and September 1995, Dr. Wyatt disclosed her relationship with A to three therapists, two of whom also were her patients. All three therapists notified the CPSO. The blurring of the roles of therapist and patient is not commented upon by the Committee.

In the view of the Discipline Committee, the termination of the doctor-patient relationship with A and with B removed Dr. Wyatt from the provi-

86 See generally *A.B. v. College of Physicians and Surgeons Prince Edward Island*, [2001] PEJ No. 89; *N. v. College of Physicians and Surgeons British Columbia*, [1997] 143 D.L.R. (4th) 463; *Melunsky v. College of Physiotherapists of Ontario*, [1999] O.J. No 148.

87 *CPSO v. Wyatt*, [2000] O.C.P.S.D. No. 10.

sions requiring revocation. This was despite the fact that the period between doctor-patient termination and the beginning of the personal relationship was merely a month, despite the psychotherapeutic nature of the relationship and despite CPSO guidelines on terminating the psychotherapeutic doctor-patient relationship. Referring to the Guidelines on physician-patient relationships following psychotherapy, the Discipline Committee concluded that a "severe" penalty was called for, but declined to impose revocation.

The Committee relied heavily on the evidence of the expert witness for Dr. Wyatt. The expert testified that Dr. Wyatt had disclosed an earlier sexual relationship with another previous patient. Nonetheless, in his view she exhibited no signs of an "impulse control disorder" or "emotional breakdown", nor any evidence of exploitation or of "predatory" behaviour. The Committee was influenced by the fact that Dr. Wyatt had contacted the CPSO for advice in advance and disclosed the relationship and that, *at the date of the hearing*, the relationship had continued for a five-year period. A 24-month suspension was imposed with 20 months lifted so long as Dr. Wyatt undertook a boundaries course, continued in psychotherapy and refrained from practising psychotherapy. The result effectively was a four month suspension from practice.

It is hard to believe that the CPSO takes sexual abuse of patients seriously when the technical and exploitative termination of a doctor-patient relationship which included long term psychotherapy distinguishes behaviour giving rise to a 5 year mandatory revocation from that which results in the most minor of penalties. What is clear is that the Discipline Committee, despite lip service to the need for a severe penalty, fails to understand the fiduciary obligations of the doctor or the exploitative and abusive nature of physician sexual abuse, especially in a psychotherapeutic relationship.⁸⁸

Similarly, in *CPSO v. Abelson*⁸⁹ the Committee again went to great lengths to avoid the mandatory revocation provisions. It also resisted imposing revo-

88 This pattern continues. For a very recent example, outside of the period of this study, see *Schogt* (2006), online: CPSO <<http://www.cpso.on.ca/Publications/Dialogue/dialtoc.htm>> at 43. The psychotherapeutic relationship extended from 1992 to 2001, involving sessions several times a week. The doctor terminated the doctor-patient relationship and entered into a personal relationship. The CPSO withdrew the allegation of sexual abuse and the Discipline Committee imposed a 9-month suspension for misconduct, with 3 months lifted for participation in a boundaries and ethics course.

89 *CPSO v. Abelson*, (2004). This hearing was the subject of a series of newspaper

cation as a discretionary matter. Dr. Abelsohn, a general practitioner, provided psychotherapy over a two and a half year period to a "difficult" patient. In addition to inappropriate hugging and other physical behaviour during the therapy, on six occasions the patient masturbated in Dr. Abelsohn's presence. Even after terminating the treatment relationship, Dr. Abelsohn continued to meet his patient in public places.

The Discipline Committee concluded that sexual abuse as defined by the *Act* occurred *on more than thirty occasions*. In the view of the Committee this behaviour did not trigger mandatory revocation, although it did give rise to suspension of the doctor's license. The Committee split on whether Dr. Abelsohn had "encouraged the patient to masturbate in his presence," behaviour that would have required mandatory revocation.⁹⁰ Two Committee members concluded that he did so. Two members concluded that he did not. It was the view of those members that because of the mandatory penalty, the "level of encouragement [required to trigger the mandatory revocation provisions] was high." In their view, mandatory revocation was required only for the worst type of predatory sexual behaviour motivated by the desire for sexual gratification. Encouragement required active "inducement, incitement, inspiring with courage, emboldening or energizing." They concluded that *allowing* the behaviour to occur did not necessarily mean that it was *encouraged*. This split precluded imposition of the mandatory penalty. Instead, the Committee imposed a *one-year* suspension and a prohibition on practising psychotherapy in the future.

Wherever mandatory revocation can be construed as not strictly required by the terms of the *Act*, the penalties that are imposed by the Discipline Committee are minimal. This is demonstrated in those cases that involve facts arising before the change in the *Act*, by complaints where exploitative and abusive conduct is artificially characterized as occurring after termination of the doctor-patient relationship, by those cases whose narrow interpretation of the mandatory provisions themselves appears contrary to legislative intent or whose facts are simply described as extraordinary. More particularly, the Discipline Committee decisions demonstrate a romanticiza-

columns supportive of Dr. Abelsohn and highly critical of the complainant. See online: CPSO <http://www.cpso.on.ca/Info_Public/Dis_sum/WEBDISC/2004/AbelsohnAR.pdf>.

90 This despite the fact that a fundamental tenet of the sexual abuse provisions is that the doctor is always responsible for the abuse regardless of any seductive or otherwise sexualized behaviour by the patient.

tion of doctor-patient sexual abuse in some cases. In others they reveal a misunderstanding of the nature of physician sexual abuse as perpetrated by demonized individualized predators seeking sexual gratification. They fail to understand physician sexual misconduct as an abuse of power in a relationship of heightened vulnerability and disproportionate power.

Criminalizing the disciplinary process: the standard of proof

In addition to the informal but persistent reliance on corroboration, the decisions of the Disciplinary Committee rely on an elevated standard of proof. The *Act* provides that the rules governing civil actions are applicable to the admissibility of evidence in disciplinary proceedings.⁹¹ The burden of proof lies on the CPSO to establish that the case for professional discipline is made out. The civil standard of proof generally is described as requiring proof “on the balance of probabilities.” However, because professional reputation and livelihood are at stake, the language of the burden of proof to be met creeps toward the criminal; at the same time the tribunals regularly acknowledge that the criminal standard of “beyond a reasonable doubt” does not apply.⁹²

Re Bernstein v. College of Physicians and Surgeons of Ontario, decided long before the significant 1993 changes to the legislative regime, is the primary continuing source for this heightened standard of proof in disciplinary cases.⁹³ The case involved disciplinary proceedings against Dr. Bernstein for his

91 Re Admissibility of evidence: “Despite the *Statutory Powers Procedure Act*, nothing is admissible at a hearing that would be inadmissible in a court in a civil action and the findings of a panel shall be based exclusively on evidence admitted before it. 1991, c. 18, Sched. 2, s. 49. However, no evidence admitted in a disciplinary proceeding before the Complaints or Discipline Committee is admissible in a civil proceeding.” See Steinecke, *supra* note 33 at 1170. See also *Re Gillen and the College of Physicians and Surgeons of Ontario* (1989), 68 O.R. (2nd) 278; *Board of Ophthalmic Dispensers v. Toth*, [1990] O.J. No. 1802 at 1. “The correct standard is that applicable in civil cases, i.e. proof on a balance of probabilities, with the qualification that before that standard can be said to have been met one must have regard for the proposition that the more serious the allegation to be proved, the more cogent must be the evidence.”

92 Steinecke argues that earlier cases holding that the standard of proof is “beyond a reasonable doubt” are probably wrongly decided. While it is clear that the criminal standard technically does not apply, the earlier jurisprudence and the persistence of an enhanced requirement for proof continue. *Ibid.*

93 (1977), 15 O.R. (2d) 447.

alleged sexual abuse of a patient. In considering the allegations against Dr. Bernstein, the Ontario Divisional Court specifically considered the precise nature of the onus of proof on the CPSO. Counsel for the CPSO argued that the burden of proof “as in civil cases, [is] to establish the guilt by a fair and reasonable preponderance of credible testimony, [and that the Committee was] entitled to act upon the balance of probabilities.” Counsel for Dr. Bernstein submitted that in light of the grave nature of the issue, the proof offered needed to be “weighty, cogent and reliable...” and that the standard of proof required of the CPSO was proof that was “clear and convincing and based on cogent evidence... [on] a fair and reasonable preponderance of credible testimony.”

In *Re Bernstein*, the Divisional Court referred to comments made by Laskin JA (later Laskin CJSCC) in *Re Glassman and Council of the College of Physicians and Surgeons* that while there is a precise formula for the standard of proof in criminal cases, no such precision is available in civil cases.⁹⁴ They further quoted Laskin JA that: “[a] man’s professional reputation, threatened by allegations of misconduct against which he pledges his credit as a witness, should be upheld unless there be very strong evidence shattering his defense of that reputation” and that the degree to which the tribunal must be satisfied will “depend upon the totality of the circumstances on which this judgment is formed including the gravity of the consequences of the finding” and “the seriousness of the charge ... to be considered ...[in what] might ...amount to a sentence of professional death against a doctor.”⁹⁵ Resolving the matter in favour of Dr. Bernstein, O’Leary J held that:

The grave charge ...could not be established ...by fragile or suspect testimony. The evidence ...had to be of such quality and quantity... In this case where Dr. Bernstein, a man of good reputation swore that no impropriety occurred...it would take very strong evidence to destroy his defense of his reputation.⁹⁶

94 (1966), 2 O.R. 81 at 105-6.

95 The insistence of the *Bernstein* court that the evidence of misconduct be clearly proven is explained both by the court’s concern about the hostile behaviour of the Discipline Committee, which revealed the Committee’s clear anti-Semitism, and in part by the Discipline Committee’s cavalier attitude toward the evidence placed before it.

96 *Supra* note 93 at 470-71.

The *Bernstein* language continues regularly to be quoted both by courts and by Discipline Committees. Most recently, it was reaffirmed by the Supreme Court of Canada in *Dr. Q v. College of Physicians and Surgeons of British Columbia*.⁹⁷

Re Bernstein is a poor set of facts on which to design a rule governing the standard of proof required in disciplinary matters. In *Re Bernstein*, several concerns were raised by the Court both about the behaviour of members of the Discipline Committee and about the hearing before the Committee. At a preliminary appearance of counsel one member of the Committee made hostile remarks. Garrett J subsequently characterized them as open to the interpretation that the Committee member had prejudged Dr. Bernstein's guilt. Furthermore, the remarks were made in the presence of other members of the Discipline Committee, and although the member making the remarks did not participate in the hearing, it was these members who subsequently dealt with the merits of the charges against Bernstein. At the hearing on the merits, another member of the Discipline Committee made remarks subsequently described by Garrett J as raising:

[O]vertones which I do not like at all...So far as I am concerned there could be no possible reasons for the cross-examination (dealing with the religious affiliation and practices of members of the Bernstein family)...other than to create, if not prejudice an atmosphere of prejudice....

The combination of these comments, their apparent anti-semitism, the refusal of the Discipline Committee to address the involvement of a disgruntled business associate in the complaint, the almost immediate withdrawal by the complainant of the allegations, and the failure by the Committee to consider the complainant's psychiatric history, all combined to predispose the Divisional Court rightly to be critical of the conclusions of the Discipline Committee. The Court overturned the 12-month suspension that the Discipline Committee had imposed for alleged sexual misconduct.

While the outcome on the facts in *Re Bernstein* is no doubt appropriate, the case unfortunately continues to be relied on as establishing the basis for a heightened standard of proof in disciplinary matters. In my view, this formulation sets the burden unreasonably high, for inappropriate reasons. The language of Laskin JA verges on a reverse onus whereby the physician

is assumed not to have engaged in misconduct unless there is “strong” evidence that “shatters” the defense of reputation he has offered – a defense to which he has “pledged his credit.” The implication in a proceeding that turns on credibility is that the complaint is not to be believed whenever a “not guilty” plea is entered or the doctor denies her testimony. The seriousness of the charge and the gravity of the consequences – a professional death sentence – are to be considered. This language inappropriately moves the usual “balance of probabilities” civil standard toward the criminal “beyond a reasonable doubt standard,” disregarding the statutory language requiring that the civil rules of evidence apply.⁹⁸ This continuing reliance, by both discipline committees and by courts, on the *Re Bernstein* language is even more problematic in light of the significant review and revision of the regulatory regime introduced by the 1991 and 1993 statutory changes. As well, this continued reliance ignores the fiduciary nature of the relationship between doctor and patient, the disproportionate impact on women who are most often the victims of abuse and the consequences of abuse for the patient.

It is noteworthy that the reasons for judgment in *Re Bernstein* also evidence the reluctance to enter a guilty finding in the absence of corroboration. Garrett J commented that:

I am not prepared to hold that even though this is a sexual case that corroboration was required although I do think that the complete absence of any evidence at all confirming the complainant’s evidence is a serious factor for the tribunal to consider ...it would only be in the rarest cases that a finding of guilt would be made in these circumstances.⁹⁹

This question of standard of proof in disciplinary matters was considered by the Task Force. While the *Preliminary Report* of the Task Force recom-

98 See also *College of Physicians and Surgeons of Ontario v. Boodoosingh* (1990), 73 O.R. (2d) 478 at 479. “This discipline proceeding is quasi-criminal in nature. The maximum penalty of revocation is more serious than many penalties imposed for criminal offences. A reprimand alone is devastating to the recipient. A person charged with a serious offence under the Health Discipline Act, R.S.O. 1980, c. 196, is entitled to have the case against him proved by cogent evidence and he or she is entitled to make full answer and defence without fear of the threat of increased penalty.” Aff’d (1993) 12 O.R. (3d) 707.

99 *Ibid.* at 486.

mended a specific statutory provision confirming that the applicable standard should be the balance of probabilities,¹⁰⁰ the *Final Report* revealed a lack of confidence that even a specific legislative directive would be sufficient.¹⁰¹ Instead, the *Final Report* abandoned its recommendation that the burden of proof be specifically identified as civil. It specifically suggested instead that it is the absence of corroboration and the presence of good character evidence that has the most dramatic effect on whether a guilt finding is likely. Addressing these issues specifically, the Task Force recommended that good character evidence expressly be countered by Counsel for the CPSO in each case as of no bearing on propensity to abuse.¹⁰² It also recommended that the legislation specifically provide that corroboration not be required in sexual abuse cases.¹⁰³ Neither of these recommendations was adopted in the 1993 revisions. Nor was clarification of the standard of proof made explicit.

IV. The Use of Psychiatric Evidence: Pathologizing the Complainant, Exculpating the Physician

Discipline Committee decisions reveal reliance by the accused physician on psychiatric expert evidence and the complainant's personal records to pathologize and discredit the complainant.¹⁰⁴ At the same time, psychiatric expertise is used to exculpate and to rehabilitate the accused physician.¹⁰⁵ The persistence of these arguments reiterates the continual focus on the professional's reputation and economic prospects rather than on public protection, recognition and prohibition of abuse, and fair and equitable consideration of the complainant's allegations.

100 *Ibid.* at 35.

101 *2000 Report*, *supra* note 16 at 186.

102 Recommendation 44, *ibid.* at 51.

103 Recommendation 52, *ibid.* at 52.

104 See e.g. Lise Gotell, "The Ideal Victim, the Hysterical Complainant and the Disclosure of Confidential Records: A Case Study of the Implications of the Charter for Sexual Assault Law" (2002) 40 *Osgoode Hall L.J.* 251; Susan M. Vella, "Recovered Traumatic Memory in Historical Childhood Sexual Abuse Cases: Credibility on Trial" (1998) 32 *U.B.C.L. Rev.* 91.

105 McIntyre, *supra* note 3.

Pathologizing the complainant

Often it is the impact of prior abuse that brings the complainant into contact with the doctor in the first place. The patient's vulnerability, arising out of a history of abuse, addiction or alcoholism, youth, depression, disability or family difficulties positions her as a target of additional abuse at the hands of the physician to whom she turns for healing.¹⁰⁶ A review of the disciplinary decisions revealed an over representation of psychiatrists among those found to have abused their patients and an over representation of women who are survivors of abuse as complainants.¹⁰⁷

The accused doctor's records concerning the complainant are available to him in mounting his defense and are part of the disciplinary file. It is not possible to know how many discipline hearings specifically considered not only the complainant's records generated by the accused physician but also third party health or counselling records. Discipline committee decisions which explicitly refer to an attempt to access the complainant's third party records,¹⁰⁸ or to question the stability and credibility of the complain-

106 It should be noted that those most likely to be abused may be the least likely to report abuse. "Immigrants, non-English speaking persons, the physically and mentally challenged, persons with life threatening illnesses, and persons in counseling 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 16 at 2). See also *2000 Report, supra* note 16. The RHPA requires a formal complaint (s. 25(4)). A few of the Colleges assist complainants by traveling 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 CPSO 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 16).

107 See e.g. *Abelsohn* (2004); *Ahmed* (2002); *Bergstrom* (2000); *Brawley* (1995); *Campbell* (2007); *Carriere* (2001); *Dobrowolski* (2004); *Dore* (1999); *Flynn* (2002); *Frith* (2002); *Ives* (2002); *Johnson* (1995); *Kambite* (2001); *Leibl* (2001); *Rafaj* (2000); *Seidman* (2003); *Totsoni-Flynn* (2002); *Umar Khitab* (2001); *Wyatt* (2001) – all involving psychotherapy.

108 See *UUO*, [1996] OCPD No. 13 (14 pages of psychiatric records released); *MYS*, [1996] OCPD No. 20 (upon motion for disclosure of the names of complainants seen at a counseling office or sexual assault center, Committee concluded

ant without a formal request for records, reveal the accused's use of emotional and mental health issues and a prior history of abuse to undermine the complainant's credibility. In doing so, the complainant is re-abused.¹⁰⁹ In *Jagoo*, the complainant was described as anxious and emotional, an ex-alcoholic, who suffered sexual abuse as a child and was vulnerable to the influence of another complainant. In *QLN*, the complainant was described as suffering from an erotic and "eroticized transference" and "erotomania" in part resulting from her early unhappy family, obesity, low self esteem and failing marriage. In *Williams*, two defense experts testified on so-called "recovered memories" or "pseudo memories" claiming that "[w]here memory is concerned is an area fraught with pitfalls and requiring corroboration."¹¹⁰ Experts for the CPSO countered with evidence relevant to sexual abuse and by rebutting the spurious claims of those relying on "false memory syndrome" as a factor in their defense. In *Deitel*, the Committee refused the accused's motion to produce the complainant's third party psychiatric records. The Discipline Committee commented that there was no evidence of collusion or false accusation. In *Heath*, the Committee pointed out that the complainant had "no motive to fabricate...no history of psychiatric problems or substance abuse." In *Gabrielle*, the Discipline Committee again went to great lengths to counter evidence of "false memory syndrome" introduced

probative value outweighed privacy interests); *Cameron* (1994) (psychiatric records); *Deitel* (1996); *Alfred* (1994) (Committee reviewed complainants psychiatric records); *Williams* (names and addresses of complainants); *Heath* (1995); *Bocking* (1995); *Gabrielle* (1995) and *Deluco* (2005).

109 "When we listened to what patients told us, we felt that time had stood still during the nine years since we submitted our first report. Very little has improved and the kinds of difficulties that patients experience in trying to access self-regulation processes remain much the same" (2000 Report, *supra* note 16 at xi); "The information indicates that, despite the efforts of Colleges in striving to meet the requirements of the Act the complaints and discipline procedures of the RHPA implemented by Colleges fail to protect the public from sexual abuse by regulated health professionals and do not adequately deal with the special dynamics of sexual abuse cases that require people to be treated with sensitivity and respect" (*HPRAC Report supra* note 16 at 1); "Individuals who were interviewed and who had been abused by a member of a Regulated College found the complaint process an amplification of an already traumatic experience" (*PWC Report*, vol. 6, *supra* note 14 at 3).

110 *Williams* (1996) at para. 149.

on behalf of the physician, with findings that the *seven* complainants had no motive to fabricate the complaint.

As the above examples demonstrate, a history of psychiatric illness, whether related to previous life difficulties or resulting from the impact of prior abuse, often is exploited first in targeting the patient for abuse and then to discredit her claim that she has been abused. In a number of disciplinary decisions, the complainant's psychiatric or other therapeutic records have been used to impugn her credibility.¹¹¹ Evidence of psychiatric illness often is provided through the files of the accused physician.¹¹²

Furthermore, the test that the CPSO applies to determine whether third party records will be relevant and the records disclosed is still described as being derived from *R. v. O'Connor*.¹¹³ The *O'Connor* guidelines were superseded in 1996 by amendments to the *Criminal Code*, now section 278(3)(3), specifically because *O'Connor* did not adequately respect the constitutional

111 *Re: Cameron, supra* note 108, set out the criteria to be considered, relying on *R. v. Coon* ([1991] 16 W.C.B. (2d) 632), a criminal precedent: "Some of the factors which may be considered as to whether a substantial foundation has been established to justify setting aside a patient's right to confidentiality with respect to medical records are: (1) the nature and seriousness of the offence; (2) the importance of the witness in establishing the guilt of the accused; (3) the proximity of the mental disorder to the date of the offence; (4) the existence of evidence to suggest a motive to fabricate; (5) criminal antecedents of the witness; (6) the mode of life or other discreditable conduct which may tend to discredit testimony; (7) evidence of bizarre or incompetent behaviour." The Committee ordered production of the records to be edited by the Committee. Counsel for Cameron asked the complainant to identify the perpetrator of the incest that sought her to seek out the medical assistance of the accused.

112 See *Johnson* (1995) where the assaults by the treating psychiatrist took place while the complainant was in a twilight sleep. The complainant informed her husband who refused to believe her. Johnson threatened to commit her to a psychiatric hospital. Subsequently, the second wife of the complainant's husband came forward with an identical complaint.

113 See e.g. *College of Physicians and Surgeons of Ontario v. Au* [2005] O.J. No. 2345 at para. 22. Dr. Au sought production of 10 of the 19 complainants, including records generated in counseling sessions. The Niagara Region Sexual Assault Centre was a party to the discipline procedure. The College Committee also referred to the provisions of s. 278.3(4) of the *Criminal Code*. At the first stage, the Committee ordered 80% of the records requested. At stage two, the Committee ordered disclosure of five records.

equality rights and fair trial rights of women. These legislative amendments were upheld by the Supreme Court of Canada in *R. v. Mills*.¹¹⁴ Thus, amendments to the *Criminal Code* that actually increase protection to women complainants are not fully imported into the disciplinary process.¹¹⁵ In addition to serving as another infiltration of criminal law principles, the use of records to impugn credibility also serves as a site for the introduction of rape myths into the disciplinary process.

The abusive and re-abusing impact of these tactics has been commented on by the Discipline Committee in several cases. One of the more egregious examples is found in *Deitel*, who earlier had been found guilty of professional misconduct involving sexual misconduct with a female patient. The second case involved complaints by two women patients as well as a third patient who served as a witness in the hearing. The decision of the Discipline Committee revoking Deitel's license was appealed on the issue of the admission of similar fact evidence. Upholding the decision of the Discipline Committee, Mr. Justice Corbett commented on the conduct of counsel for the physician at the discipline hearing and the impact of the hearing on the complainants and witness. He noted that "[t]he length and vigour of cross-examination was directly proportionate to the degree of psychological vulnerability of the patient" and that "...the attack on the credibility of the complainants was unrelenting and, often was unnecessarily brutal..."¹¹⁶

Exculpating and rehabilitating the abusing physician

In stark contrast to the use of psychiatry to impugn, undermine and belittle complainants, expert psychiatric evidence is relied on in numerous disciplinary proceedings to explain, to exonerate and to rehabilitate the abusing phy-

114 *R. v. Mills*, [1999] 3 S.C.R. 668.

115 It is ironic that the protections of the *Criminal Code* provisions are not fully available to women complainants within the disciplinary civil process. It should be noted that in *Blencoe v. British Columbia*, [2000] S.C.J. No. 43, the Supreme Court of Canada rejected the plaintiff's claim that civil proceedings for sexual harassment were equivalent in stigma and risk to security of the person to criminal proceedings and rejected his claim of a free standing constitutional right to reputation which could be infringed by unduly prolonged civil proceedings.

116 *Deitel v. College of Physicians and Surgeons of Ontario*, [1997] O.J. No. 1866 at para. 224. He notes that the transcript of the examination in chief of one of the complainants was 17 pages; the transcript of the cross examination extended to 250 pages.

sician.¹¹⁷ Thirty years of scholarship has debunked the myth that sex abuse is committed only by deviant or disordered men. Yet the decisions of the Discipline Committee often reflect counsel's attempt to distinguish the accused from a mythic abuser in order to discredit the allegations against him. This takes two forms: those in which the accused is described as "normal" and thus not an abuser and those in which he is described as "ill" and therefore not deserving of sanction. In some cases both strategies are utilized.

In the first group of cases, expert evidence is offered attesting to the fact that there is "no evidence that he is a predator,"¹¹⁸ "no evidence of psychopathic traits or anti-social personality disorder,"¹¹⁹ that he does not "meet the diagnostic criteria for a sexual disorder...for any paraphylia," that the "risk of professional misconduct is low if his practice is subject to conditions" and that he is "not currently professionally impaired."¹²⁰ In *Dobrowolski*, which involved 4 disciplinary hearings and 17 complainants, the expert testified that Dobrowolski "is neither predatory nor anti-social," but rather had marital and financial difficulties and "inadequate training in the understanding of transference and counter-transference."¹²¹ In *Nagahara*, where the physician pled guilty to professional misconduct and had a criminal conviction arising from the same abuse, testimony was offered that there was "no evidence of anti-social behaviour, psychopathy, impulsivity, sexual disorder or deviation, no personal or professional problems, no history of substance abuse, no features predictive of recidivism and that the re-offence potential was minimal." The penalty involved an order that Nagahara undergo treatment with the testifying expert as a condition of continuing to practice.

Evidence also often is offered of biochemical, phallometric, psychological and physiological testing to support the claim that no "major mental

117 In some of the disciplinary decisions, the expert witness is identified only by his initials. This means that there is no way to track the reoccurrence of the use of the same expert witness on multiple occasions on behalf of different accused physicians.

118 *Wesley* (2002): guilty plea, evidence of corroboration; see also *Comeau* (2001): "Does not suffer from a psychiatric disorder, personality disorder or physical illness that would cause him to be at risk of harming patients, not a predator."

119 *Nguyen* (2003): guilty plea, criminal conviction; *Crainford* (1998): "does not have a psychopathic mind set, not a predator, not seeking vulnerable clients, no major character flaws."

120 *Yong-Set* (2001): guilty plea.

121 *Dobrowolski* (2001): guilty plea to some charges, evidence of corroboration.

illness or personality disorder” is present.¹²² In one case, expert evidence was offered that because the accused physician had a “partner” (wife) who was a psychiatrist, it was unlikely he would have committed the abuse.¹²³ In another, the fact that the physician had been in a stable relationship for the last 10 years was offered as exonerating evidence.¹²⁴

There is no consistent evidence with regard to the length of treatment or evaluation that underlies these expert assessments provided at the request and expense of the accused. In at least one case, the forensic psychiatrist interviewed the physician for only 4 hours, before concluding that he was “unable to detect any evidence of improper ethical behaviour, impulsive behaviour or indication of mental illness associated with aberrant behaviour.”¹²⁵ In *Im*, the expert was “unable to detect evidence of conscious sexual intent in [the doctor’s] actions” and concluded that the “factors usually seen in recidivism are not present,” that there are no “antisocial feelings, impulsive behaviour or psychopathic tendencies...no evidence of sexual deviancy or psychosis” – despite *Im*’s criminal conviction for 5 sexual assaults.

Exculpatory psychiatric expertise also is offered to explain and excuse the physician’s sexual abuse of his patient. In *Re: Markman*,¹²⁶ Markman relied on both his treating psychiatrist and an “independent” expert psychiatrist to claim that “the stresses of his job environment led to a chemical

122 *ETM* (1995); *Oosterholt* (1995); *Alfred* (1994): “No evidence of paraphilia, anti-social, narcissistic or impulsive disorder, major mental illness, alcohol or drug abuse or hostility to women. I would have expected some abnormality in testing [phalometric] if a sex offender.”

123 *McRae* (1994).

124 *Irvine* (1996). But see *contra* G.R. Schoener *et al.*, *Psychotherapists’ Sexual Involvement with Clients: Intervention and Prevention* (Minneapolis: Walk-In Counseling Centre, 1989) [Schoener] at 71: “...[D]isintegration in the relationship may occur at any time, even years later. Thus, one must be careful in making judgments of post-therapy relationships that appear harmonious.”

125 *Fernandez* (1997).

126 [1999] OCPD No. 6. See also *Beresford* (1994), where the 68 year old doctor was allowed to continue practising when he identified a bipolar affective disorder as the cause of his sexual relationship with a psychiatric patient. His practice was restricted to male patients. *Bingham* (2003): Committee took into consideration a psychiatric report on his physical and emotional health; *Seidman* (2003): medical issues – mood changes in high school, breakdown during fellowship and diagnosis with ADD.

abnormality of the brain, resulting in “toucherism.”¹²⁷ Markman was the subject of 6 complaints of sexual abuse heard together. All of the complainants worked at the hospital at which he practised. Markman had been found guilty of criminal sexual assault with regard to 4 of the incidents. In the last of the 6 assaults, against an intern in the teaching program at the hospital, Markman threatened he would kill her if she told anyone. He warned her that, as a mere intern, she would not be believed if she complained about his attack.¹²⁸ The Discipline Committee found him guilty of sexual abuse.

This reliance on psychiatric expertise to exonerate the physician is misplaced. In “Psychological Evaluation in Sexual Offence Cases,”¹²⁹ W. L. Marshall critically reviewed the literature on the reliability of the various psychiatric tests used to identify male sexual deviance and concluded that “[t]here is no justification for using interview or test data as a basis for determining the likelihood that an accused male did or did not commit a sexual offence.”¹³⁰ He argued that the various tests used in such evaluations, including phallometric testing, although identified as objective and therefore scientific or respectable, are not so. He outlined their limited ability reliably to distinguish between those accused individuals who are dissimulating and those who are truthful about their involvement in deviant sexual behaviour.¹³¹ He concluded that neither personal interviews nor file reviews are more accurate. In his view the “evidence clearly indicates little can be said which is helpful” about propensity to abuse¹³² and experts are more likely to “mislead than to help the court.”¹³³

Many discipline committee penalties impose a requirement of psychiatric therapy on the abusing physician as a condition of returning to practice.¹³⁴ The theory is that therapy will ensure that he does not return to abus-

127 *Ibid.* at para. 50.

128 See *R. v. Charalambous* (1997), 92 B.C.A.C. 1. Charalambous arranged to have his former patient, Sian Simmonds, killed.

129 W. L. Marshall, “Psychological Evaluation in Sexual Offence Cases” (1995-1996) 21 *Queen’s L.J.*499 and see sources cited by Marshall.

130 *Ibid.* at 500.

131 *Ibid.* at 501, 505, 506.

132 *Ibid.* at 509.

133 *Ibid.* at 514

134 See e.g. *Beresford* (1994); *Bingham* (2003); *Irvine* (1996); *Nagahara* (1996); *Wesley* (2002); *Yong-Set* (1998); *Deitl* (1996); *Heath* (1995); *Johnson* (1995); *Oosterholt* (1995); *Turton* (1994); *Lazare* (1999); *Levy* (2003) and *Wyatt* (2001).

ing his patients.¹³⁵ Such conditions overlook that the expert who proposed the rehabilitative plan is employed by the abusing physician himself and is not an independent assessor.¹³⁶ One particularly puzzling aspect of this reliance on expert exculpatory psychiatric evidence is the practice of referring to such experts by their initials only. It is unclear why the identity of such experts needs protection. The result of this form of identity masking is that it makes it impossible to know if certain individual psychiatrists are particularly prevalent in this role.

In fact, many abusers may be untreatable and therapy unable to ensure that the physician returns safely to practice.¹³⁷ The literature reveals that such reliance on therapy as being able to ensure rehabilitation is misplaced. Schoener et al, in their leading text *Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention*,¹³⁸ found the scholarly literature on therapist abuse both limited and lacking in methodology. They raised concerns both about the procedures for assessment of the physician and the lack of clear understanding of rehabilitation. They noted that in the US a number of perpetrators are known to have re-offended.¹³⁹ They specified that in some

135 See e.g. Beresford (1994); Bingham (2003); Deitl (1996); Genereux (1994); Irvine (1996) Johnson (1995); Lazare (1999); Levy (2003); Nagahara (1996); Oosterholt (1995); Turon (1994); Wesley (2002); Wyatt (2001) and Yong-Set (1998).

136 In some cases these penalties are the joint submissions of the accused and the CPSO. Nonetheless, they are based on assessments arranged for by the accused.

137 Schoener, *supra* note 124 at 399: "...[M]any perpetrators may not be treatable, thus challenging the prevalent notion that a referral to long-term therapy will cure the problem and render the perpetrator a safe practitioner."

138 *Ibid.* See also A.M. Brodsky, "The Distressed Psychologist: Sexual Intimacies and Exploitation" in R.R. Kilburg, P.E. Nathan & R.W. Thoreson, eds., *Professionals in Distress: Syndromes and Solutions in Psychology* (Washington: American Psychological Association, 1986) at 153; L. Nielson *et al.*, "Supervision Approaches in Cases of Boundary Violations and Sexual Victimization by Therapists" in B. Snaderson, ed., *It's Never O.K.: A Handbook for Professionals on Sexual Exploitation by Counselors and Therapists* (St. Paul, MN: Minnesota Department of Corrections, 1989) at 55; S.M. Plaut & B.H. Foster, "Roles of the Health Professional in Cases Involving Sexual Exploitation of Patients" in A.W. Burgess & C. Hartman, eds., *Sexual Exploitation of Patients by Health Professionals* (New York: Praeger, 1986) at 15.

139 This is also the case in Canada, although it is impossible to be clear about the numbers who do so. In Ontario see e.g. Genereux (1994) and Deitl (1996).

such cases “far too much reliance was placed on psychotherapy as a ‘cure all’ and on supervision of whatever sort as a safety net.”¹⁴⁰

They also noted many serious weaknesses where supervisory structures are imposed as a condition of returning to practice. In their view, meaningful supervision requires authority to review the physician’s records, discuss cases and have direct client contact. They noted the failure of supervisory models to prevent both continued sexual abuse and the incompetent health care that accompanies it. They pointed out that where supervisory orders are imposed, the person chosen to act as chaperone to the abusing doctor is most often a person, such as a nurse or other assistant, who is in a subordinate relationship to the physician. As well, orders prohibiting the physician from seeing women patients ignore the possibility that the physician may engage in abusive behaviour with male patients and that sexually abusing seductive practices can occur in the treatment of couples. Supervisory orders of this kind are not uncommon in discipline committee decisions, and all of these concerns are borne out by the reported cases.¹⁴¹

Even more prevalent than orders that require psychiatric treatment and/or supervision are those that require (re)education. Often all 3 conditions – therapy, monitoring and re-education – are imposed as part of the disciplinary penalty.¹⁴² Often the Discipline Committee understands the abuse as

140 *Supra* note 124 at 419. They go so far as to say that licensing boards may be liable for the failure to obtain competent assessment and to develop sound rehabilitation plans. “It may be that the elimination of bogus rehabilitation efforts and the overly hasty granting of ‘Rehabilitated’ status.... will be facilitated by malpractice suits filed against those who are less than adequate, professional, careful, thorough, and knowledgeable in assessing and rehabilitating offending therapists.” See also *McClelland v. Stewart*, [2006] B.C.J. No. 3348, 245 D.L.R. (4th) 162.

141 See e.g. *Deluco* (2004); *Deitl* (1996); *Genereux* (1994); *Im* (2003) and *Johnson* (1995).

142 See *Wesley* (2002) (psychiatric treatment and chaperone); *Davis* (1993) (psychiatric treatment, chaperone and course); *Dobrowolski* (2004) (psychiatric treatment, chaperone and course); *Carll* (2002) (boundaries course); *Comeau* (2001) (therapy); *Bergstrom* (2000) (course); *Crainford* (1998) (therapy); *Irvine* (1996) (therapy and course); *Nagahara* (1996) (therapy and chaperone); *Deitl* (1996) (therapy and monitoring imposed on earlier offences when last offence occurred); *Johnson* (1995) (therapy and chaperone); *Oosterholt* (1995) (therapy and chaperone); *Longdon* (1995) (course); *Turton* (1994) (therapy); *Genereux* (1994) (chaperone); *Bingham* (2003) (course); *Bothwell* (2003) (course, chaper-

a failure of education or training and orders re-education as a condition of continuing to practice. Generally referred to as a requirement that the physician obtain training in “appropriate boundaries,” this device is used to lift a significant part of any license suspension imposed.¹⁴³

Schoener et al. also question the usefulness of ethics courses as rehabilitative measures.¹⁴⁴ Kenneth Pope found that “neither education nor psychotherapy has shown any evidence in published research studies of inhibiting sexual abuse of patients, and according to some studies, they actually appear to be positively associated with tendencies to abuse.”¹⁴⁵ Nor is there any evidence that abuse by physicians results from insufficient training in either ethics or boundaries. In a number of cases the physician subsequently was disciplined for sexual abuse despite the imposition of some or all of therapy, monitoring or re-education. The reliance on therapy or on ethical re-education to excuse or to “heal” the sexual abuser of his misconduct is misplaced.

one); *Deluco* (2005) (chaperone); *Dore* (1999) (course); *Dube* (2001) (course); *Henderson* (2004) (course); *Hurst* (course); *Im* (2003) (course, chaperone); *Ives* (2002) (course); *Jabouin* (1995) (course); *Kavouris* (2004) (course); *Koffman* (2003) (therapy and course); *Lambert* (2002) (therapy and course); *Levy* (2003) (psychiatric treatment, chaperone and course); *Lurie* (2004) (course); *Miller* (2001,2004) (chaperone); *Noreiga* (2003) (course and chaperone); *Rosen* (2002) (course and chaperone); *Ross* (2004) (therapy and chaperone); *Sharma* (2003) (course and chaperone); *Shiozaki* (2004) (course); *Silva-Ruette* (2003) (course); *Wong* (2003) (course and chaperone) and *Wyatt* (2001) (therapy and course).

143 For an idea of what is meant by boundary training see e.g. Jill Hefley, “Strategies for Preventing Sexual Abuse” online: (1993) *Members’ Dialogue* 8 <<http://www.cpso.on.ca/Publications/Dialogue/dialtoc.htm>>; Laurel Dempsey & Janet Ecker, “Understanding the Dating Guidelines” online: (1994) *Members’ Dialogue* 9 <<http://www.cpso.on.ca/Publications/Dialogue/dialtoc.htm>>; 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>. This is an extraordinarily prevalent order in imposed penalties.

144 Scheoner, *supra* note 124 at 415 JL (1995); *M* (1995).

145 Kenneth S. Pope, “Therapist-Patient Sex as Sex Abuse: Six Scientific, Professional, and Practical Dilemmas in Addressing Victimization and Rehabilitation” (1990) 21 *Professional Psychology Research & Practice* 227 at 232; J.L. Bernard et al., “The Failure of Clinical Psychologists to Apply Understood Ethical Principles” (1987) 18 *Professional Psychology, Research & Practice* 489.

It ignores exactly that understanding of sexual abuse that the revisions to the *Act* were meant to address – that sexual abuse is abuse of power and is violence against women and children.¹⁴⁶

Conclusion

The College of Physicians and Surgeons of Ontario and the Province of Ontario both showed early and important leadership in seriously responding to sexual abuse of patients by doctors. This leadership was informed by an understanding of sexual abuse as an abuse of trust and of power, deserving of mandatory license revocation in the most serious cases. It is deeply disturbing that the momentum of this important initiative has been undermined in its implementation. Barriers to the continuing achievement of the zero tolerance objectives contained in the legislation exist at multiple locations in CPSO processes. Their combined impact effectively avoids the specific provisions of the *Act*.

These barriers occur at multiple locations. Physicians fail to meet their statutory obligation to report those health professionals whom they know to be engaging in sexual misconduct. When mandatory reports are filed, the CPSO fails systematically to respond to those reports. Few reports from members of the public make it past the informal screening mechanisms and are seen by the Complaints Committee. When the complaint is forwarded to the Complaints Committee, few are forwarded from that Committee to the Discipline Committee.

Those complaints that do make it to consideration by the Discipline Committee generally are those where independent corroboration of the complainant, although not required under the provisions of the *Act*, is present. In those few Discipline Committee hearings where corroboration is not present, a guilty determination is unlikely. Furthermore, Discipline Committee panels often demonstrate an unwillingness vigorously and appropriately to apply the provisions of the *Act* itself, avoiding the provisions of the legislation, ignoring CPSO policies and criminalizing the disciplinary process in

146 See also Schroener, *supra* note 124 at 422: “If sexual exploitation of clients by therapists is to be taken seriously by mental health professions and the public, it is important to establish that certain kinds of exploitation are regarded seriously, and they warrant a serious response, regardless of the motives or psychological status of the perpetrating therapist. This is the same attitude that is taken toward other serious transgressions against society, such as rape and incest.”

ways which protect the accused doctor. Criminalization of the process occurs particularly by raising the burden of proof on the CPSO towards a criminal standard, paying undue attention to the impact of disciplinary proceedings on the doctor's reputation and economic situation and ignoring obligations to the public, to the profession, and to the injured complainant. At the same time they allow expert witnesses, acting on behalf of the accused doctor, to pathologize the complainant and exculpate and rehabilitate the accused. Where penalties are imposed, Discipline Committee panels are too willing to assume that the imposition of ethics or boundary training, therapy and supervision will provide the public with protection from re-abuse, and to reduce already short license suspensions even further.

A renewed allegiance by the CPSO to its original commitment to zero tolerance of sexual misconduct is required. The CPSO must ensure that the letter and spirit of the legislative provisions are implemented by staff, by all committee members and by all disciplinary panels. Vigorous training for staff and committee members will assist in ensuring that the provisions of the *Act* are not continuously undermined. It is hoped that the detailed documentation provided here of the many locations in which the provisions of the *Act* are being undermined will be of assistance. The CPSO must renew its commitment to respond forcefully to those doctors who so egregiously breach their obligation first to do no harm. The zero tolerance provisions of the 1993 *Act* were visionary. The leadership of the CPSO on issues of sexual misconduct was exemplary. A renewed commitment to the values and understandings represented in the 1993 amendments now is necessary.

