

To Zero:

Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991

I am extremely proud of the dedication, expertise and calibre of the professionals who work within Ontario's health care system. But my top priority as Minister is to protect the safety and well-being of Ontarians, which is why we have asked the task force to take a look at the existing legislation to help prevent and deal with cases of sexual abuse of patients by regulated health professionals.

– The Honourable Dr. Eric Hoskins,
Minister of Health and Long-Term Care

In each of these agencies, I am vulnerable. I may be asked questions about my medical history; I may be asked to remove some or all of my clothing; I may be touched in ways that feel personal. The system breaks down if I cannot trust that each and every person working within the walls of that agency will treat me professionally.

– Patient

The re-victimization occurs when they seek redress or justice and here it's the imbalance that is really striking in terms of access to resources... Why should taxpayers support only the doctors — how is this patient-centred? How is this just?

– Michael B. Decter, chair of the board, Patients Canada;
former Deputy Minister of Health

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Letter of Transmittal

December 15, 2015

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Government of Ontario

Since your appointment of this independent task force, which commenced on January 5, 2015, we have taken a patient-centred approach to reviewing the *Regulated Health Professions Act, 1991* (RHPA) to assess whether it and related laws, policies and programs in Ontario uphold the standard of zero tolerance of sexual abuse of patients — as you requested.

Soon after we began, the Honourable Roy McMurtry, regrettably, resigned for health reasons, reducing this expert panel from three to two. We appreciated the benefit of his contributions to developing our work plan, and we have been determined to deliver on the task you entrusted to us. We also wish to express our appreciation for the resources provided by your ministry to ameliorate some of the pressure on this task force. In the first six months of 2015, we heard from over 100 patients and presenters at public and private hearings, roundtables with experts in law, health policy and advocacy, faculty and students at five universities in Toronto, Hamilton, Ottawa and Thunder Bay. As well, we engaged with:

- health regulatory colleges and professional associations representing regulated health care professionals, as well as individual professionals;
- patients who have experienced sexual abuse by regulated health professionals;
- organizations representing individuals who have experienced sexual abuse, sexual assault or other types of sexual violation;
- institutions in which regulated health professionals are employed or hold privileges to practise.

The sexual abuse of patients is a complex problem, and complex problems require complex solutions. Our recommendations to you are interlocking and multi-sectoral in nature, situated within an ecological human rights framework. Access to justice for all is a strong theme in this report.

This task force was given the mandate to “examine the existing legislative scheme under the RHPA and provide advice and recommendations with respect to modernizing and reinforcing the province’s ongoing commitment to a zero tolerance policy for the sexual abuse of patients by regulated health professionals.” As well, the task force was asked to “undertake its work bearing in mind that patient experience is its primary focus, while also respecting the fundamental guiding principle set out in the RHPA regarding the self-regulatory model for all health regulatory colleges in the province.”

In conveying our findings to you on “patient experience,” we are of the opinion that those from whom we did not hear from is also an important consideration. For example, although we consulted experts based in both urban and northern Aboriginal communities, we did not hear directly from any patients of Aboriginal origin. As well, we heard from very few patients who moved to Ontario from other countries, or patients living with disabilities. Nor did we hear from patients who self-identified as lesbian/gay/bisexual/transgender/queer.

Reform of the self-regulatory model as it pertains to the sexual abuse of patients is central to the substantive changes that this task force recommends as crucial for modernizing and reinforcing Ontario’s ongoing commitment to the zero tolerance of sexual abuse of patients by regulated health professionals.

Upholding the standard of zero tolerance requires ongoing, courageous ministerial oversight with sustained silo-crossing within government and across various sectors of Ontario society. We believe that this government, under Premier Kathleen Wynne, with you as the Minister of Health and Long-Term Care and in cooperation with key Cabinet colleagues, can achieve what no other government has for patient safety and protection.

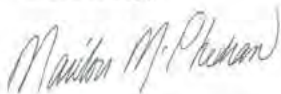
The media’s freedom to question access to justice for sexually abused patients has alerted the public’s perception of the issue repeatedly in the 25 years since it was first raised in Ontario and the first task force was formed. While this is a cherished freedom in our democracy, government must do much more than rely on the media as the primary mechanism for transparency and accountability in patient safety.

In this independent report, entitled *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991*, recommendations are predicated on transparency and accountability in responding to the pressing need for immediate substantive changes and in sustaining the multi-sectoral reform necessary to achieve zero tolerance of sexual abuse of patients in Ontario.

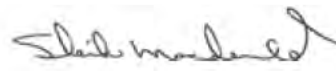
We are all patients. Patient safety is key to public safety.

We thank you for this opportunity to serve the interests of public safety and trust.

Sincerely,



Marilou McPhedran,
Task Force Chair



Sheila Macdonald,
Task Force Member



Task Force Chair Marilou McPhedran; Minister of Health and Long-Term Care Dr. Eric Hoskins; and Task Force Member Sheila Macdonald.

Acknowledgments

To the patients who came to the task force public hearings, or who wrote and called the task force, many of whom — having entrusted us with your reports of experiencing sexual abuse by a regulated health professional — chose not to be identified in this report: your voices can be heard throughout it. This minister’s task force operated entirely independently from the Ministry of Health and Long-Term Care (MOHLTC), but we had invaluable support from MOHLTC personnel. In particular, we would like to thank Denise Cole, Assistant Deputy Minister, Health Workforce Planning and Regulatory Affairs, her team and our editor, Carol J. Anderson.

During the limited time of our mandate, we asked for, and received, generous donations of time and expertise through a series of public and private hearings, roundtables and consultations. We thank each and every contributor listed in Appendix E. The task force accepted the restrictions of working in confidence and we are sincerely grateful for the trusted expertise provided to us by contributors listed in more detail on page 165, including Susan Vella (legal advisor); Dr. Gail Robinson (medical advisor); Patricia Marshall (zero tolerance standard expert); Michele Landsberg (author of Chapter 3, “A Systematic Betrayal of Trust: Survivors Speak”); Wendy Komiotis and the staff and board at METRAC; Amanda Dale, Mary Lou Fassel and the staff and board at the Barbra Schlifer Commemorative Clinic; Nicole Pietsch and the staff, board and 26 member organizations of the Ontario Coalition of Rape Crisis Centres; Dr. Lorraine Greaves; Dr. Peter Jaffe; and Dr. Earl Berger. Crafting recommendations that are transformative and achievable has been our goal, and we also wish to acknowledge with appreciation those with whom we had technical conversations in confidence, who shared their specialized knowledge on the condition that they not be named.

From Marilou: In addition to my heartfelt thanks to all those acknowledged above, I want to express appreciation to the friends who gave me guidance and “shelter” on many occasions while working on the task force: N. Jane Pepino; Darryl R. Peck; Caroline Bamford and Patrick Watson; Carolyn Bennett and Peter O’Brian; Wendy Cukier; and Thora Cartlidge and Val Monroe. To my task force colleagues, Roy McMurtry (until February 25, 2015) and Sheila Macdonald: it was an honour to work with you. And to my sons Jon McPhedran-Waitzer and David K.M. Waitzer: you were little boys

when I chaired the first task force; now you are gentle men. Your support has sustained me. May your generation see the changes that must occur to uphold and achieve zero tolerance of sexual abuse of patients.

From Sheila: I want to thank all the patients who had the courage to come forward and share their experiences. Your expressed emotions of anger and frustration at the lack of accountability (at all levels) were apparent and reinforced the need for change. I would also like to thank the health care students, educators, community members and regulated health profession colleges for their contributions. My gratitude goes out as well to the other contributors to the report, and I am also grateful for the support from the MOHLTC team. Finally, I want to thank Marilou McPhedran, task force chair, for her leadership in bringing the report to fruition under challenging circumstances. Her determination to ensure that there is accountability to patients in Ontario who have experienced sexual abuse by a regulated health professional is unparalleled, and for that, we all owe her our thanks.

Mandate

At the request of the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, the task force was asked to review the implementation of the *Regulated Health Professions Act, 1991*, to ensure that its legislative measures were appropriate and effective.

As part of this appointment, the task force was asked to provide advice and recommendations on how to strengthen the legislation in order to reinforce the province's zero tolerance policy on sexual abuse of patients by regulated health professionals.

Specifically, the task force was asked to provide advice on:

- the current definition of “sexual abuse” contained in the legislation;
- the disciplinary orders that may be imposed by health regulatory colleges against members who have been found to have sexually abused a patient;
- support tools for patient victims of sexual abuse;
- mandatory reporting requirements with respect to sexual abuse of patients by regulated health professionals;
- ways to further encourage and support patients who report incidents of sexual abuse to health regulatory colleges; and
- aspects of college discipline proceedings and other college processes.

Please see Appendix A for the full Terms of Reference.

Executive Summary

On January 5, 2015, the Minister of Health and Long-Term Care, Dr. Eric Hoskins, appointed this independent task force to review the *Regulated Health Professions Act, 1991* (RHPA) and to provide advice to him on how best to reinforce Ontario's zero tolerance standard on the sexual abuse of patients by regulated health professionals. Mindful of Premier Wynne's whole-of-government response to sexualized violence and harassment launched in December 2014 to address sexualized violence and harassment in Ontario, and of the *Patients First: Action Plan for Health Care* announced by Minister Hoskins in February 2015 (shortly after this task force commenced), our analysis and recommendations in this final report encompass what was learned from patients and heard at both public and private hearings. It also encompasses the specialized knowledge that was shared with us by task force advisors and by invited participants at consultations in several parts of the province.

These voices, taken together, inspired the crosscutting theme of genuine access to justice for patients that is fundamental to our recommendations. Every patient in Ontario — that is, every Ontarian — has the right to safety in every interaction within the health care system. Our recommendations are geared to patients being able to live that right — every time they seek care.

The need for significant changes was apparent throughout this process. Far too often, the health regulatory colleges have been unable to uphold the zero tolerance standard, and far too many Ontario patients do not have confidence in the current system.

There are particular concerns in our review, including the exclusionary definition of “patient” in disciplinary proceedings that, in our opinion, did not meet the zero tolerance standard; that colleges are using their discretionary authority to find health care professionals guilty of lesser charges, such as “professional misconduct,” instead of fully exercising their authority under the RHPA to find them guilty of the “sexual abuse of a patient”; and the overall lack of support from colleges for patients through the reporting, investigation and disciplinary proceedings in sexual abuse cases. As well, it was apparent that many health professionals (as well as health professional students and health care organizations) have limited or no understanding of their legal

duties under the RHPA to responding when patients report, or professionals suspect, sexual abuse.

Of grave concern to us is the inequity for patients in the justice process. Michael Decter, a former Ontario Deputy Minister of Health and Long-Term Care, reported in public to this task force on the millions of tax dollars that go into the defence fund for Ontario's medical doctors each year, and how this can tilt the scales of justice. He noted that "The re-victimization often occurs when they seek redress or justice and here it's the imbalance that is really striking in terms of access to resources."

Contents of this Report

This report comprises the Letter of Transmittal from the task force to Minister Hoskins, an executive summary, seven chapters and ten appendices, including a summary of the recommendations, in Appendix B.

Chapter 1 provides a comprehensive introduction to the report, explaining how the ecological human rights framework demonstrates the essential engagement of multiple stakeholders across sectors and the need for a high-level commitment to sustaining a vision of justice, health and dignity through engagement in the sectors of health, law, education and Ontario society as a whole. The first chapter also looks at how the RHPA provisions on the zero tolerance standard have been interpreted judicially since the first Ontario task force report on the sexual abuse of patients in 1991. It also includes the recommendations made by this task force, some 25 years later.

Chapter 2 is an overview and analysis of the qualitative and quantitative data provided to the task force by Ontario's 26 health regulatory colleges, and how they have responded to patient complaints, including how the colleges have collected, maintained and reported on information connected to sexual abuse complaints. Due to the gaps revealed, recommendations are made for more effective collection, analysis and use of data, to support evidence-based reform.

This report benefited from the expertise and observations provided by a number of key contributors, who are listed in appendices. We greatly appreciated their analyses and insights, which form core sections of this report — from illuminating the trauma experienced by numerous survivors of sexual abuse by health professionals (Chapter 3), to exploring the history and on-the-ground implementation of the zero tolerance standard in

Ontario and around the world (Chapter 4), to analyzing pertinent cases and outcomes (Chapter 4 and Appendix G).

Chapters 5, 6 and 7 contain our recommendations, with rationales. The recommendations are comprehensive and built on an ecological human rights framework within three interconnected, thematic clusters: modernization of the RHPA, research and education, and accountability and transparency measures for substantial and sustainable reform to uphold zero tolerance of sexual abuse of patients.

The first interconnected theme, Modernization of the *Regulated Health Professions Act, 1991*, for Health and Dignity (Chapter 5), includes the recommendation that responsibility for processing complaints and investigations of sexual abuse be taken away from the regulatory health colleges and assigned to a new, independent government-funded body, the Ontario Safety and Patient Protection Authority (OSAPPA). OSAPPA will draw upon expertise from public members and from peer reviews of regulated health professionals appointed to it. In addition, in order to ensure adequate legal support and assistance for patients reporting sexual abuse by a regulated health professional, there are recommendations for a pilot project through Legal Aid Ontario that would give victims access to legal information and options.

The second interconnected theme, Research and Education Priorities (Chapter 6), has detailed recommendations for the education of the public, health professionals, future health professionals and patients. A newly established Minister's Implementation Council would be responsible for research initiatives, including evaluation of the newly established OSAPPA, as well as for reporting/tracking mechanisms for complaints of sexual abuse, and an annual international symposium to promote and evaluate research and effective practice in preventing sexual abuse of patients.

The third interconnected theme, Sustainable Transparency and Accountability (Chapter 7), examines how patients have so often fallen off the health system reform agenda, and recommends ways to shift representation of patients to higher levels of accountability and transparency. Health care institutions have a responsibility to ensure that there is an appropriate response when reports of sexual abuse by a health professional within the organization are made. Administrations, including boards, have the responsibility to ensure staff education/policies/procedures are implemented and legal duties are fulfilled. Further, oversight bodies

such as the Ontario Hospital Association and Accreditation Canada need to incorporate accountability measures on this issue within their mandates and implement effective programs that deliver on patient safety.

The appendices comprise many of the key documents that were both drawn upon and created by this task force, including the terms of reference, the summary of recommendations, correspondence, a summary of questions sent to the regulatory colleges, the consultation summary, relevant sections of the RHPA and its *Health Professions Procedural Code*, samples of media coverage, an table of acronyms and a table of cases. In Appendix G, an actual decision of a college, selected from many similar cases where evidence of sexualized boundary crossing was clear and strong, has been “re-visioned” by invited experts to demonstrate how a college could have chosen (but did not, in their opinion) to apply the RHPA more rigorously in order to uphold and implement zero tolerance of sexual abuse of patients by regulated health professionals.

We are all patients. Patient advocacy is essential to transparency and accountability in health care. Yet the current task force, unlike the previous two (in 1991 and 2000), did not hear from even one organization or patient advocate that received any Ontario government funding to work on any aspect of the sexual abuse of patients by regulated health professionals. This imbalance generates numerous deficiencies in our democracy, including greatly reduced accountability on issues of patient safety, particularly the sexual abuse of patients.

All of our recommendations lead to an extensive overhaul of the RHPA, with emphasis on implementation for the long term. The sexual abuse of patients cannot be effectively addressed by “tinkering” with the current system, which has relied on the regulatory health colleges. In examining more than 20 years of evidence about self-regulation by health professions — in the arena of preventing and addressing the sexual abuse of patients — the task force has concluded that the current system is not working in the public interest. Immediate and bold reform is therefore crucial.

Chapter 1: Introduction and Recommendations

Introduction

In December 2014, the Honourable Dr. Eric Hoskins, Ontario’s Minister of Health and Long-Term Care, announced the Minister’s Task Force on the Prevention of Sexual Abuse of Patients as an independent expert panel to review the implementation of, and make recommendations on, the “modernization” of the *Regulated Health Professions Act, 1991* (RHPA), which includes the *Health Professions Procedural Code*.¹ The task force commenced its work on January 5, 2015, with a mandate to provide advice and recommendations on how to uphold the province’s zero tolerance policy on the sexual abuse of patients by regulated health professionals.²

The recommendations of this task force are situated within an ecological human rights framework — that is, our mandate is mindful of the diverse, interconnected responsibilities and relationships operating within the legislative framework of the RHPA and in sectors of broader Ontario society, for patient safety in the public interest. We used this framework to help us clarify:

- the harm to patients and to the public trust that is posed by the self-regulation of health professionals, because of the imbalance in the rights ecology for patients who have experienced a range of sexual exploitation/abuse by regulated health professionals and who have

“

December 2014: *Health Minister Hoskins told the Star that sexual assault and abuse is ‘unequivocally unacceptable... I have zero tolerance for any criminal sexual behaviour and will — after a thorough review by experts and victims’ advocates — make any and all necessary changes to ensure Ontarians are protected,’ he said.*³

”

*“ May 1991: Two days ago, the task force on sexual abuse of patients presented its preliminary report and recommendations to the College of Physicians and Surgeons of Ontario. The council has already carried out the first recommendation by confirming its commitment to the philosophy of zero tolerance of sexual abuse. The Ministry of Health also has a zero tolerance policy for sexual abuse, whether committed by a physician or any other caregiver.”*⁴

put their trust in the RHPA’s self-regulatory system for justice and remedies;

- why our recommendations address access to justice for patients as well as for members of regulated health professions in responding to the minister’s request for suggestions to modernize the RHPA; and
- why it is our considered conclusion that the current self-regulatory system is so disproportionately skewed against patients who complain of sexual abuse/exploitation that it must be discontinued.

The sexual abuse of patients is an issue that just won’t go away, and is a longstanding stain on the exemplary record of Ontario’s regulated health professionals. This kind of abuse is a profound breach of trust perpetrated by a relatively small number of the more than 300,000 health professionals regulated by their colleges under the RHPA.⁵ When we turn the lens around and focus on patients, however, it is much harder to discount rationally the impact of these perpetrators. As noted in the second independent task force’s report:

It is not unreasonable to estimate that well over 200,000 Ontario patients have experienced sexual abuse at the hands of health professionals [from 1994–99] ... of particular concern if we compare the 200,000 estimate with the comparatively small number of complaints received by colleges during that period.... The data compel us to say that sexual abuse by health professionals remains an important public safety problem ... magnified when we consider the specific impact and severity of sexual abuse due to breach of trust.⁶

We are all patients — and thus we all rely on one or more of the regulated health professions. The sexual abuse of patients is a persistent problem and deeply harmful to patients and their families, as well as to the perpetrators, their families and their communities.

Regulation under the RHPA

Despite major changes to legislation, principally the RHPA, over more than 20 years, sexual abuse by health professionals has proven impossible to eradicate. This disturbing fact has raised questions about both the content and the implementation of the law through Ontario's regulatory health colleges under the RHPA. These cases keep appearing, and there are convincing arguments that there are many more cases of abuse than are reported to colleges or to the police.

When we listened to patients and advocates over the task force's six months of consultations, we heard a range of concerns, including:

- no comprehensive information system available to inform patients about where to go in cases of sexual abuse by regulated health professionals;
- no assurances that patient-complainants will be represented as vigorously as are the alleged abusers through their insurance schemes;
- no assurances that patients and their families will not be deprived of health services as a result of making a complaint;
- no assurances that patients will be supported with adequate resources to participate fully throughout the complaint process, which is controlled by the alleged abuser's regulatory college; and
- how objective — no matter how well chosen they have been — the alleged abuser's professional colleagues will be in the majority of those judging the complaint.

We feel compelled to bring into our analysis this crucial question: Who are the patients who chose *not* to tell us about their experiences of sexual abuse by regulated health professionals? And why? The task force advertised in advance and travelled to northern Ontario, yet not one patient of Aboriginal origin came to either the public or private hearings.

This report does not castigate the efforts of the regulatory health colleges, which, in many cases, do their best within their legislated options under the RHPA. Rather, this task force assesses how the RHPA creates a disciplinary

process that runs parallel to the criminal legal system under the *Criminal Code of Canada*. The civil law process created by the RHPA is what colleges must use when dealing with sexual abuse complaints from patients. This process leads to specified penalties, such as the loss or suspension of the certification required to practice for a limited time, with the chance to apply for reinstatement later on. Similar assaults on the street, in a stranger’s apartment or in the marital bed would lead to jail if proven in a criminal court — but that is not the system that colleges are required to administer under the RHPA.

Mandatory Reporting of Sexual Abuse of a Patient to Police

We examine more closely the argument we heard from a number of participants in task force hearings: that *all* patients with complaints of sexual abuse by regulated health professionals should be forced to take their complaints into the criminal legal system. For the task force, the key element in support of a civil law complaints system under the RHPA is choice — retaining choice for patients who prefer a civil law option.

The recommendation that the law should be changed to require mandatory reporting to police of a complaint to a college of sexual abuse by a regulated health professional was voiced numerous times at hearings and in written submissions to the task force. For some people, reporting to the police would bring acknowledgement of the criminality of the acts committed, while for others it meant stronger accountability and penalty for offenders. Patients and patient advocates often expressed their frustration over college processes, citing a lack of accountability and transparency in sexual abuse cases. However, we also heard patient after patient express concern that

“*It’s one thing to have the college review and discipline doctors on matters that relate to their profession; however sexual assault is a criminal code violation plain and simple. The CPSO has no more right to interfere with the justice system than a police officer has to remove an appendix.*”

– *Patient to the Minister’s Task Force*

abusive professionals should be stopped from hurting more patients — and only the colleges have the authority to revoke the certificate that enables a regulated health professional to practise in Ontario.

A College of Nurses of Ontario (CNO) case involving Rick Klein, RPN, provides an example of a college upholding the zero tolerance standard under the RHPA as well as criminal legal system outcomes.⁷ Klein was charged in 2007 with one count of sexual assault contrary to subsection 271(1) of the *Criminal Code of Canada*. In his interview with the police, he admitted to touching the patient's breasts. The patient was a resident of an ambulatory dementia unit where Klein worked. In 2009, Klein pleaded guilty to the offence of sexual assault before an Ontario court and was found guilty, receiving a suspended sentence with probation for two years. As a term of his probation, Klein was not to be left alone to care for vulnerable people. Further, he was not to be employed at any long-term care facility unless under direct supervision while in contact with clients.

Subsequent to Klein's criminal conviction, the CNO acknowledged the significant breach of public trust by Klein's actions, found him guilty of professional misconduct for sexually abusing a patient and revoked his certificate of registration. The task force notes that in this case, the CNO used its discretion under the RHPA to revoke Klein's certificate, even though the sexualized acts to which he admitted are not specified in the list in section 51(5) of the *Health Professions Procedural Code (Code)*. This is a significant contrast to the decisions identified in this report in which college panels have avoided the mandatory revocation penalty by characterizing the sexualized acts of a member as being outside the ambit of the list in section 51 of the *Code* that attracts mandatory revocation. For more analysis on this point, see Appendix G, a thorough review of a case in which evidence of sexualized boundary crossing was clear and strong. The case has been "re-visioned" by invited experts, to demonstrate how a regulatory college could have chosen (but did not, in their opinion) to apply the RHPA more rigorously, in order to uphold and implement the zero tolerance standard.

In September 2015, the College of Physicians and Surgeons of Ontario (CPSO) recommended that the RHPA be amended to include mandatory reporting to police of any disciplinary decisions when potential criminal acts by doctors — including sexual abuse — are involved. The task force notes that the CPSO approach retains jurisdiction for processing sexual abuse complaints with that college and that, in effect, the CPSO is undertaking to refer all its decisions in complaints of sexualized boundary crossing to

the police. However, there are significantly fewer disciplinary decisions than complaints received. As well, this approach means that the CPSO has not undertaken to report to police, however, until *after* completing its adjudication — a process that can take years.

Patients Need Options When Making Sexual Abuse Complaints

It is the opinion of the task force that mandatory reporting of sexualized boundary-crossing to the police should not be done. Understandably, we all wish for a simple solution to a complex problem in our society. While the perspectives of patients and others who recommended to the task force that the complaints procedures under the RHPA should be abolished and replaced by mandatory reporting to police are acknowledged, the task force members know first-hand that the criminal justice system has its own challenges, many of which result in many victims of sexual violence feeling dissatisfied and traumatized by the process. Numerous patients who have taken their cases to the police have had negative experiences, much like some of the frustrations that patients reported experiencing with the college processes, including the fact that charges are often not laid by police because patients are told that there is insufficient evidence, or charges are withdrawn by Crown attorneys who are unconvinced that they have a reasonable prospect of a conviction based on the required standard of proof of “beyond a reasonable doubt.” Conviction rates in sexual assault cases are extremely low, so victims seeking recourse are frequently disappointed by the outcomes. This report was prepared in the period during which the sexual assault charges and trial of former CBC television host Jian Ghomeshi were very much in the news — in the context that sexual assault remains the most unreported and under-prosecuted of criminal offences, with conviction rates that are stagnant, at 0.3 per cent.⁸ The task force is not convinced that closing off options to patients by forcing them to take sexual abuse complaints into the criminal law sphere would increase their access to justice. The most recent findings from Statistics Canada, using data gathered from 2009–14, note that “Among all measured offences, sexual assault was the least likely to be reported to police, with just one in twenty being brought to the attention of the police.”⁹

The right to a fair trial is a right that complainants and witnesses, as well as accused persons, should be able to rely upon. But in sexual assault cases, some highly experienced lawyers are expressing concern. “There’s far too much scrutiny of the victim in sexual assault cases,” Toronto lawyer Susan Chapman says. “It’s unparalleled.”¹⁰

“It just isn’t working on the ground,” said Tamar Witelson, legal director for METRAC Action on Violence. “I don’t think that just taking the criminal justice system as it’s designed for any kind of criminal offence and then laying that into the nature of sexual assault—I just don’t think it works.” “So this idea of looking for ways of restructuring our legal response to allegations of sexual assault is really necessary; and I don’t mean just tinkering.”¹¹

The task force notes that patients who have experienced sexual abuse by a health professional have, and should continue to have, the option to report the abuse to the police and proceed through the criminal justice system process, should they so choose. However, the task force asserts that choice is essential for patients who have experienced abuse and that the patient must retain agency and control as the decision-maker in these situations. In Recommendation 4, the Ontario Safety and Patient Protection Authority (OSAPPA) is proposed as the primary mechanism to modernize the RHPA and uphold zero tolerance of sexual abuse of patients. Any patient reporting sexual abuse to one of the colleges (during the transition to the new Ontario Safety and Patient Protection Authority [OSAPPA]) should be advised of the option to also report to the police under the *Criminal Code of Canada*. Conversely, police should also offer the option to patients to report to a college under the RHPA. This would require a much higher level of cooperation than that which is currently in effect between these two systems.

Concerns About the Current System Under the RHPA

We could find no evidence that the oversight of health regulatory colleges delegated by the Ontario government via the RHPA over a number of decades has led to significant reductions in the number of instances of sexual abuse of patients by members of those colleges. However, as discussed in more detail in Chapter 2, accurate data that allow for meaningful comparisons from year to year have not been gathered consistently, and information that the task force received from colleges allowed us to reach few firm conclusions based primarily on data. This unfortunate reality is the foundation for our emphasis on implementing our recommendations through sustainable transparency and accountability built upon mandatory reporting.

When the first task force on the sexual abuse of patients in Ontario held hearings in 1991, non-governmental organizations (NGOs, also known as civil society organizations, or CSOs) addressed the work being done to address the sexual abuse of patients by regulated health professionals.

Similarly, the second task force, in 2000, heard from patient advocacy organizations and patient advocates working actively on this issue. Yet the current task force — held 24 years after the first one — did not hear from even one organization or patient advocate that received any government funding to work on any aspect of the sexual abuse of patients by regulated health professionals, and none came to our attention during our mandate. This imbalance generates numerous deficiencies in our civil society, including greatly reduced accountability on issues of patient safety, particularly the sexual abuse of patients.

Put more bluntly, patient advocacy — a crucial accountability mechanism for patient safety in Ontario — has been starved “nigh unto death,” in significant contrast to the robust legal defence schemes available to regulated health professionals and institutions.

This entrenched imbalance can now be characterized as systemic discrimination, and generates many unfortunate and unfair consequences that affect the health and dignity of Ontario patients. The previous task force reports in 1991 and 2000 also noted that this damaging imbalance needed recalibration through public investment in patient safety and accountability to patients. Yet the situation has deteriorated significantly in the past 15 years. Feedback we received during consultations suggests that many patients are not aware of the existence of the colleges or of their disciplinary roles, or they are afraid to venture into a process that they fear could render them even more vulnerable. The Ontario landscape for patient advocacy and public accountability is parched, and patients are often lost in the desert of the current regulatory health system.

In light of this situation, our multisectoral recommendations are intended to:

- provide protection and assistance to patients who experience sexual abuse and exploitation by regulated health professionals;
- ensure that the disciplinary process protects the rights of the accused regulated health professional as well as the patient(s);
- increase access to justice for patients; and
- shed light on the objectives and processes, including public tax support of defence insurance for regulated health professionals.

Access to justice is essential for preventing the sexual abuse of patients and improving health outcomes, particularly for patients who are found in vulnerable populations.

In a legislated complaints system, such as the one that exists under the RHPA and that we have been asked to assess, there are some checks and balances available through administrative tribunals such as the Health Professions Appeal and Review Board (HPARB)¹² and courts at different levels, depending on resources that determine how far parties are able to take their appeals. It is impossible to participate fully in any of the aforementioned decision-making fora, however, without significant resources of time, expertise and money. Regulated health professionals in Ontario deservedly can access these resources because they are insured through a variety of protective plans, ranging from the Canadian Medical Protective Association (CMPA) for doctors, to individual insurance plans that regulatory colleges such as the Royal College of Dental Surgeons of Ontario (RCDSO) require their members to carry.

Patients have no access to any such legal defence plans, however. Patients are seldom granted party status to be able to participate fully in most of the college processes or appeals by regulated health professionals against college findings of sexual abuse by patients. In the absence of the needed resources that would help patients to participate in a meaningful way, therefore, access to justice is greatly reduced or non-existent.

Judicial Interpretations of the RHPA Provisions

To understand our emphasis on access to justice as a crucial component of implementing the zero tolerance standard on the sexual abuse of patients, it is important to look more closely at how colleges, tribunals and courts have interpreted the RHPA provisions on sexual abuse that have been enacted since the first independent task force report, which was commissioned by the College of Physicians and Surgeons of Ontario (CPSO) and released in 1991.¹³ Later in this report, in Chapter 5 and in Appendix G, we examine more closely recent college decisions that have added to our high level of concern about the lack of parity for patients, which reduces access to justice in the self-regulatory health college system under the RHPA.

While there is some variance among lower court decisions since the RHPA sexual abuse provisions were enacted in 1994, we see considerable acceptance of the zero tolerance standard and consistency in the judicial interpretations of what is required under the RHPA to protect patients. More than 20 years after it was decided by the Supreme Court of Canada in 1992, the case of *Norberg v. Wynrib*,¹⁴ for example, stands as an authority on setting a clear standard of responsibility in protecting patients from sexual abuse.

Although lower courts did not hold Dr. Wynrib accountable for demanding sexual services from his patient, Ms. Norberg, in exchange for providing her with the drug to which she was addicted, the Supreme Court disagreed, citing and drawing upon the analysis in the *Final Report of the Task Force on Sexual Abuse of Patients*.¹⁵ In particular, Justices Beverly McLachlin and Claire L'Heureux-Dubé accepted the task force's reasoning that doctors are to be held to the highest legal standard in their care of patients — that of fiduciary trust. Justice McLachlin concluded:

where such a power imbalance exists it matters not what the patient may have done, how seductively she may have dressed, how compliant she may have appeared, or how self interested her conduct may have been — the doctor will be at fault if sexual exploitation occurs.¹⁶

This Supreme Court decision from 1992 has been questioned and interpreted in a number of subsequent cases, but the appeal court decisions in Ontario have followed the Supreme Court ruling and held firm to the responsibility of regulated health professionals as being the highest standard of fiduciary trust.

The CPSO's case, *The College of Physicians and Surgeons of Ontario v. Mussani* is a useful reference for illustrating some of the key issues that are revealed when the ecological rights framework is used as a lens through which to view the impact of the sexual abuse of patients.¹⁷

This case set a precedent: at the CPSO hearings and, again, at each level of appeal by Dr. Mussani, the Ontario Medical Association (OMA) participated fully as an intervenor in a sexual abuse case for the first time in its history, raising concerns about doctors' rights. In 2000, just as the second independent task force report (commissioned by the then-Minister of Health for Ontario) was being released, the 1999 decision of CPSO upholding the zero tolerance standard in the case of Dr. Mussani had come under appeal. In addition to the OMA's intervention, the Ontario Nurses' Association (ONA) — at the point at which the case went to the Ontario Court of Appeal — joined the OMA in the appeal to argue that certain RHPA provisions were invalid. In raising concerns about how the CPSO had relied on a number of the interconnected sections of the RHPA that were designed to implement the zero tolerance standard on the sexual abuse of patients (including the provision for mandatory revocations in certain sexual abuse cases), the OMA and ONA each made arguments against some of the RHPA sexual abuse protections (also referred to as the mandatory revocation provisions) as contravening certain rights of their members under

the *Canadian Charter of Rights and Freedoms* in the *Constitution Act, 1982* (this is discussed in more detail below).

In its 2000 report, the second task force noted that the appeal was underway. It also quoted from the CPSO decision in *Mussani*, with approval, as follows:

Section 51(5) of the Code does not regulate sexual relations per se: it regulates the way in which a doctor may practise medicine...the right to practise a profession is characterized as an economic interest rather than a legal right, and so is not the type of liberty which section 7 [of the *Canadian Charter of Rights and Freedoms* in Canada's constitution] is intended to protect...**it is the view of the Committee that the proper characterization of subsection 51(5) is not to deprive physicians of their liberty, but rather to regulate the practice and behaviour of doctors within the practice of medicine. The practice of medicine in Ontario is a privilege, which brings with it certain obligations both to their patients (to refrain from sexual relations), the public and to fellow members of the profession.**¹⁸
[emphasis added]

In responding to a 2001 article in *The Medical Post* entitled “OMA Fights Abuse Laws: Association argues mandatory revocation violates Charter of Rights,” the then-president of the OMA stated in a letter to the editor, “The OMA has always supported zero tolerance” and that the OMA intervened in the *Mussani* case to challenge the legality of sections 51(5) 2 and 73(5.1) of the *Health Professions Procedural Code*.¹⁹ Section 51(5) 2 provides that if a discipline committee of the CPSO finds that a physician sexually abused a patient, the CPSO must revoke a physician's certificate of registration. This is known as mandatory revocation. Another provision challenged by the OMA, section 73(5.1), states that the CPSO may not issue a new certificate of registration to the physician “unless prescribed conditions are met.” In his letter to *The Medical Post*, the OMA's president argued that, since no “conditions” had ever been prescribed, the penalty for sexual abuse is a “permanent lifelong suspension” of a physician's certificate of registration. These were among the unsuccessful OMA arguments presented to the courts in the *Mussani* appeals.

Although the OMA and ONA arguments in *Mussani* were made more than 10 years ago and were not successful, it is important that they be known and understood, because similar arguments continue to be made by some CMPA defence counsel for doctors and by other lawyers defending other regulated health professionals facing sexual abuse complaints. Given the mandate of

this task force to include in its analysis all the health professions regulated under the RHPA — not only physicians — it is of interest that, by the time the CPSO decision in *Mussani* was before the Ontario Court of Appeal, the ONA had joined in the appeal as a “friend of the court,” and made some arguments specific to the “rights” of nurses and some other arguments aligned with the challenges to the RHPA provisions on the sexual abuse of patients put forward by Dr. Mussani and the OMA. The OMA and ONA represent just two of the 26 regulated health professions under the RHPA, but they have a combined membership in excess of 100,000 regulated health professionals and students.²⁰

Legal challenges to certain provisions of the RHPA related to the zero tolerance standard on sexual abuse that emanate from the two largest regulated health professional unions are important elements affecting implementation of this standard in Ontario. For these reasons, we recommend that a full and careful reading be given to the suite of CPSO and judicial appeal decisions in the *Mussani* case, from 1999 to 2004, and we provide the following observations on the significance of those deliberations. The brief excerpts outlined below are taken from court filings made by the OMA and ONA in questioning certain provisions of the *Health Professions Procedural Code* that relate to the sexual abuse of patients in the *Mussani* case, before the Ontario Court of Appeal.²¹ This task force has been unable to find any indication that the OMA and ONA positions have changed in this regard.

Arguments in a factum filed by the OMA in 2002 challenging the RHPA’s mandatory revocation provisions predicated on the zero tolerance of sexual abuse of patients included the following:

The OMA submits that a physician’s decision concerning with whom to enter into consensual sexual relations is a fundamentally or inherently personal matter. By declaring that the intimate sexual relationship between a physician and another consenting adult constitutes ‘sexual abuse’ and professional misconduct, the Mandatory Revocation Provisions interfere with this choice, invading ‘the core of what it means to enjoy individual dignity and independence.’

.....

The OMA submits that the freedom of the individual to enter into consensual sexual relationships as he or she desires is protected by section 2(d) of the *Charter*. By restricting a physician’s freedom

to enter into personal relationships of this kind, the Mandatory Revocation Provisions violate section 2(d).²²

The following arguments were outlined in a factum filed by the ONA in 2004, which argued that section 7 of the *Canadian Charter of Rights and Freedoms* be interpreted by the Ontario Court of Appeal to include the need for college discipline panels and courts to balance the “liberty interest” of sexual relations with a patient with “public policy concerns”:

In order to give proper effect to the broad liberty interest protected by s. 7, ONA submits that it is critical to draw a distinction between the nature of the interest affected by the impugned sexual abuse provisions, on the one hand, and the restrictions on that interest imposed by the impugned provisions, on the other hand. Again, ONA submits that the Divisional Court erred by effectively conflating these two questions when it held that s. 7 of the *Charter* does not protect a right to have sexual relations with a patient.

.....

ONA submits that the mandatory penalty of licence revocation eliminates the balancing of this liberty interest with the public policy concerns about the seriousness of sexual abuse. ONA further submits that this balancing can only be done through the exercise of discretion on the part of the Discipline Committee to apply a wide range of penalties that reflect the appropriate balance in all of the circumstances of each particular case.

.....

ONA respectfully requests that the Court make the following orders:
a. An order granting the Appellant’s appeal.²³

If it had been successful, the “Appellant’s appeal” by Dr. Mussani (with the OMA as intervenor) that the ONA requested the Court of Appeal to grant would have resulted in the court striking down the mandatory revocation provisions of the RHPA.

An Imbalance of Resources

This task force has identified a damaging imbalance in the health regulatory system arising from a significantly disproportionate investment from various sources, including public funds entrusted to the Ontario government. This imbalance stems from the greater resources that are available to regulated health professionals and their organizations compared with the resources

— in particular, funding from the Ontario government — available to personnel and programs inside both government and to NGOs in Ontario civil society with mandates to represent the interests of patients.

One of the more complex elements of this imbalance is the way in which resources that benefit regulated health professionals tilt the entire complaints-driven system, influencing every aspect of a patient’s experience — from first point of contact with a regulatory college onward — in both subtle and not-so-subtle ways. The mandate of this task force has included hearing from patients, regulators and the 26 health professions regulated under the “umbrella” legislation of the RHPA and its *Code*. However, it is inescapable that the majority of the patients we heard from and the near-majority of the cases of sexual abuse in Ontario dealt with under the RHPA are about physicians and their organizations: the CPSO and the OMA, as well as a lesser known but hugely influential organization — the CMPA.

Although the CMPA was identified by the first task force in 1991 as having considerable influence on the negative experiences reported by many patients in CPSO cases, often due to how CMPA-funded legal counsel represented their clients (i.e., physicians) in CPSO sexual abuse cases, little information about the nature of this powerful organization could be obtained. Twenty-four years later, this task force finally heard relevant information presented for the first time at a public hearing by an expert that, while specific to the CMPA and, in turn, the CPSO, informed our analysis of the impact of the resource imbalance across the entire health regulatory system. This imbalance is addressed in our recommendations for one simple reason: patients do not have insurance that will cover the costs of their complaints, but regulated health professionals do. Taxpayers in Ontario largely fund this insurance coverage for physicians facing complaints by patients: Thus,

When a physician faces a disciplinary hearing or process or a complaint or a law suit they have the full resources of a not well known organization aptly named the Canadian Medical Protective Association (CMPA as it is known). The CMPA insures doctors — there is nothing sinister or untoward about this; it would be more surprising if a doctor’s insurer did not exist.

For a GP [General Practitioner], CMPA fees are \$4668. The Government reimbursed \$3798 or 80%. For a plastic surgeon CMPA fees are \$18,360. The government reimbursed the physician \$14,000 or 76%.

What is the price we have to pay to level the playing field and stop making double victims of patients who are abused or injured? It is the government that must decide whether they are comfortable paying to support those who abuse, but not those who are abused.

If the Ontario government chooses to continue to massively subsidize lawyers for doctors through CMPA dues it should also subsidize lawyers for abused patients.

Why should taxpayers support only the doctors — how is this patient centered? How is this just?”²⁴

Among other injustices, this significant disparity in resources — between patients bringing sexual abuse complaints and regulated health professionals defending against them — was outlined by several witnesses at task force hearings. It exemplifies the nature of the serious imbalance between victims of sexual abuse and the health care practitioners who may be accused of such abuse, within the complaint processes of the colleges. Our task force recommendations must not be seen as an attempt to “take away” privileges and benefits now flowing generously to regulated health professionals and their organizations, but rather as the means by which to redress key elements of the imbalance that undermines patient safety and dignity by *increasing* public funding to patients, to NGOs that support and advocate for patient safety and rights and to governmental bodies with patient-centric mandates and transparent, accountable programs.²⁵ Many of the key recommendations of this task force should therefore be considered “must-haves” for patients in Ontario, because we are all patients, in some way, at some time. Patient safety is public safety.

Our Recommendations

Minister Hoskins asked the task force to provide advice to him on a range of issues, including:

- the current definition of “sexual abuse” contained in the legislation;
- disciplinary orders that may be imposed by health regulatory colleges against members who have been found to have sexually abused a patient;
- support tools for patients who are victims of sexual abuse;
- mandatory reporting requirements with respect to the sexual abuse of patients by regulated health professionals;
- ways to further encourage and support patients who report incidents of sexual abuse; and

- aspects of health regulatory college discipline proceedings and other college processes.

The end of this chapter contains the compilation of task force recommendations that were delivered to the minister in December 2015. Internal consultations were held in early 2016, and this report includes corrections and clarifications made by the task force. The task force appreciates that the minister and his colleagues in the Ontario government and public service need a reasonable time to develop an implementation plan for recommendations that are accepted. The task force recommends firmly that this final independent report should be released to the public of Ontario, with no changes to content (unless by mutual agreement), within eight months of its delivery. It is the firm recommendation of the task force that, in the event that the minister (or his successor), has not released this report within eight months of receiving it, that the minister should make a public explanation as to why it has not been released and what steps are being taken to respond to the task force recommendations and to make the task force report publicly available. Public access to this information on sexualized boundary crossing by regulated health professionals is a crucial component of Ontario's relatively new government-wide policy, which states that sexual violence and harassment are never "okay" — and that sexual abuse of patients must be understood to be on that spectrum of violence.

Complex problems require complex solutions. The sexual abuse of patients is a complex problem facilitated by multiple factors, at multiple levels, that are exposed through the ecological human rights framework. Examples of the ensuing interconnections include factors at the:

- societal level (e.g., social attitudes, norms and awareness shaped by media, education, cultural and legal practices);
- sectoral level (e.g., regulatory frameworks and professional accreditation practices);
- organizational level (e.g., policies, practices and training in health care and educational organizations); and
- individual level (e.g., attitudes, beliefs and behaviours of health care professionals, patients, bystanders and others about the perpetration, reporting and the dynamics of sexual abuse).

Consequently, an integrated, multisectoral approach to addressing these problems requires that we consider interventions at four levels:

- societal: public education to increase awareness of the problem, its impacts and remedies;

- sectoral: within health, law and education, strengthening regulatory frameworks and adjudication processes, embedding the prevention of sexual abuse of patients into patient safety accreditation and quality assurance standards, and revising health care professional pre-service and in-service education;
- organizational: developing and applying risk management strategies and processes as well as quality assurance practices to ensure that patients are kept safe from sexual abuse; and
- individual: education and awareness for health care professionals, so that they understand their responsibility to avoid abusing their patients and to report the sexual abuse of patients by others; and that patients and others know their rights and what recourses are available to them.

These recommendations focus on the issues of patient safety and dignity through access to justice — with the ecological human rights model predicated on seeing and understanding intersectoral forces. Viewing patient safety through this lens, we see interlocking responsibilities shared within a sector that either enable or prevent the sexual abuse of patients. Table 1 outlines the sectors that have a key role to play in preventing sexual abuse and increasing access to safety and justice for patients, and gives examples of their responsibilities and mechanisms.

Table 1: Key Sectors in the Prevention of Sexual Abuse of Patients

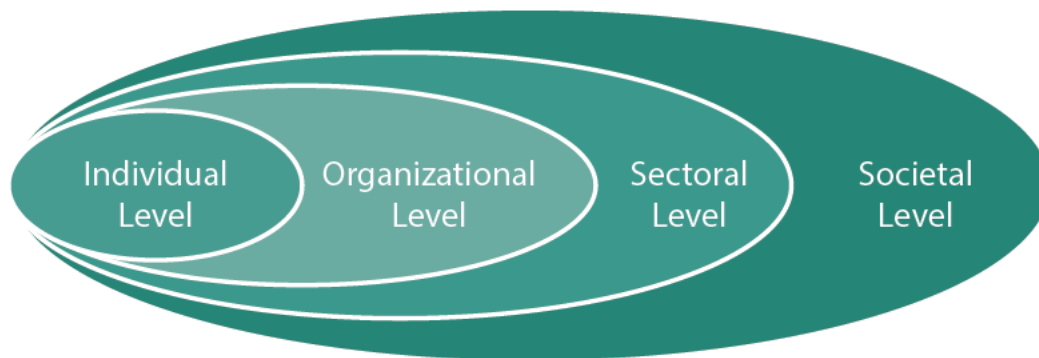
HEALTH SECTOR	LEGAL SECTOR	EDUCATION SECTOR	SOCIETAL SECTOR
Professional associations and unions for regulated health professionals	Legal defence funds for regulated health professionals, such as the CMPA	Health care professional education institutions such as medical, dental and nursing schools	Practitioners, bystanders, media, the public
Health care institutions, such as hospitals	Adjudicative bodies, such as the Health Professions Appeal and Review Board (HPARB)	Accreditation bodies, such as Accreditation Canada Continuing in-service education	Patients, families, public education, ombudspersons

By considering the problem and responsive interventions in this way, it is clear that the interdependent sectors of health care delivery, law, education, research and governance must bridge the gaps separating them and thereby stifling collaboration, by “silo-crossing” at the executive, staff and public levels.

The World Health Organization (WHO) promotes the use of the ecological model to develop comprehensive approaches to violence prevention and it has been adapted to the prevention of sexual violence (see Figure 1).²⁶ The framework adopted by this task force provides a way of appreciating the

essential engagement of multiple stakeholders across sectors — including patients, regulated health professionals, students and faculty in health professions, hospital administrators, elected officials, their political advisors, members of the Ontario Public Service and members of civil society (the Ontario public) — in preventing and responding to the sexual abuse of patients.²⁷

Figure 1: The Ecological Framework (Violence Prevention Alliance)



Adapted by Cukier et al.; used with permission.

Bold Change is Needed — Immediately

To modernize and strengthen Ontario’s commitment to preventing the sexual abuse of patients by regulated health professionals, a collaborative, multilayered, integrated approach is immediately required. This new approach will bring new resources and understanding to preventing the sexual abuse of patients as an issue of patient safety. As well, at every stage, **the zero tolerance standard should be applied** to ensure that all patients (and, by extension and, in effect, the public) are protected. The RHPA and other legislation specific to health professions transfer some government responsibility for the safety and well-being of patients in Ontario to “self-regulating” health professions through their health regulatory colleges.

We therefore recommend that the RHPA’s delegation of authority (from government to health regulatory colleges, which are mechanisms created by government) to process and adjudicate complaints about the sexual abuse of patients, should be amended to **remove from all health regulatory colleges their jurisdiction over all responses to the sexual abuse of patients by their members. This needs to happen as quickly as possible, through transition of this delegation from the colleges to a new, centralized**

regulatory body and an independent tribunal. To accomplish this essential and bold reform, we have made suggestions for careful but decisive short- and long-range transition planning and implementation, beginning with the establishment of two high-level implementation mechanisms: the **Minister’s Implementation Council** and the **Inter-Ministerial Implementation Group, with integration responsibility designated to a high-level official reporting to the minister, as part of sustainable accountability.** Via a separate letter to the minister, we have made more detailed suggestions as to the mandate and composition of these proposed mechanisms. These two crucial implementation mechanisms will jointly address the focal point of recommendations made by this task force: the establishment of a new, centralized regulatory body, the Ontario Safety and Patient Protection Authority (OSAPPA), with an independent appeal tribunal to review OSAPPA decisions.

Nurtured by roots across sectors (i.e., civil society, health, law and education) and including, but not limited to, the Ontario Public Service, OSAPPA will provide equitable, patient-centric services that encompass culturally competent outreach, education, supports and sexual abuse complaint investigations, with referral of investigated complaints to an independent adjudication tribunal. Adjudicators appointed to this tribunal — including some regulated health professionals — are to be recommended by an independent, resourced panel of public members with a minimum five-year mandate, to determine remedies and penalties in accordance with the RHPA and its *Health Professions Procedural Code* (amended as per task force recommendations) and related legislation.

Accountability requires transparency within a patient-centric, rights-based ecological framework. This is consistent with the ministerial oversight evident in the policy paper *Patients First: Action Plan for Health Care*, announced in February 2015 by Minister Hoskins.²⁸ The minister responded decisively by naming this task force as one key initiative when Premier Kathleen Wynne directed specific ministers in December 2014 to bring forward options to enhance support for victims of sexual violence relating to health care, education, the criminal justice system, policing, post-secondary campuses and Ontario workplaces. The premier’s approach is an acknowledgment that preventing violence requires a multi-layered response targeting individuals, groups, communities, health care and legal institutions, and the media, and addressing a range of social norms, attitudes and behaviours. The task force notes, with regret, that the RHPA is not listed among the “Acts Affected” in Bill 132, *Sexual Violence and Harassment Action*

*Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment), 2015.*²⁹ The task force encourages Minister Hoskins to open discussion with the Minister Responsible for Women's Issues, the Honourable Tracy MacCharles, who tabled Bill 132, while there is still time to consider amendments.

Research into violence against women, sexual harassment, sexual assault, domestic violence, child abuse and related areas is increasingly turning to examinations of gendered social norms and practices and how they support the silencing of victims, as well as the lack of engagement by bystanders and others who may observe these behaviours. Hence, directly addressing broad social attitudes and behaviours is a crucial component of preventing the sexual abuse of patients by health professionals in Ontario.

The task force proposals require sincere and sustainable commitments to engage civil society substantially over the long term in implementation and accountability mechanisms that are fairly and dependably resourced and that operate at arms length from the Ontario Public Service. Multisectoral implementation should therefore include:

- public education to ensure that patients, families and bystanders recognize abuse;
- education to ensure that the responsibilities of all regulated health professionals and institutions to prevent, report and be accountable for abuse are fully understood;
- accessible, patient-responsive reporting systems and supports; and
- balanced, separate investigation and adjudication processes that are fair to all parties, not just those with "deep pockets."

Any improved regulatory framework must be regularly audited through a transparent approach if it is to remain effective. OSAPPA and the independent adjudicative body for sexual abuse complaints must adhere to the civil standard of proof when patients decide to put their trust in the health regulatory civil system, instead of taking their complaints to the police under the *Criminal Code of Canada*. As well, the skill building of independent investigators and adjudicators will need to include substantive training in the dynamics of and damage caused by sexual abuse, including trauma-informed and cultural-competency training to understand the damages that can be exacerbated by racism, sexism, homophobia and other forms of social and economic exclusion.

In every recommendation in which the health regulatory colleges are referenced specifically or generally, the recommendation is to be understood as relevant both before and during the transition from jurisdiction of the RHPA colleges over sexual abuse complaints by patients, to the recommended new OSAPPA model.

Three interconnected themes are woven among our 34 recommendations. They are reflected throughout this report and discussed in more detail in Chapters 5, 6 and 7:

1. Modernization of the *Regulated Health Professions Act, 1991*, for Health and Justice (Chapter 5, primarily recommendations 1 to 18, 27 and 28);
2. Research and Education Priorities (Chapter 6, primarily recommendations 21, 22, 23, 25 and 26); and
3. Sustainable Transparency and Accountability (Chapter 7, primarily recommendations 19, 20, 24 and 29 to 34).

Recommendations

The recommendations are listed in their order of appearance in the rest of this report. As well, because the three themes are interconnected, some recommendations are relevant to more than one thematic cluster.

1. Definitions of Patient and Boundaries

The RHPA, *Health Professions Procedural Code*, should be amended to define “patient” as well as to specify clear boundaries and time periods for sexual contact between members and their former patients. Therefore the Minister’s Task Force recommends:

- an amendment to the interpretation clause of the RHPA, section 1.(1) by adding, after the definition for “Minister”: “patient” means an individual who at any time has received, or is receiving, health care from a member, or has been assessed by the member, or is otherwise under, or assigned to, the care of the member, including psychotherapy delivered through a therapeutic relationship or counselling for emotional, social, educational or spiritual matters delivered through a confidential treatment context; and
- an amendment on clearer boundaries so that decision-makers in colleges and/or OSAPPA processes find that a member has committed an act of professional misconduct by sexually abusing:
 - i. a patient concurrent with a health care relationship; or

- ii. an individual who was a patient within two years from the sexual abuse; or
- iii. a person to whom a member has provided treatment by means of a psychotherapy technique delivered through a therapeutic relationship, including counselling delivered through a therapeutic relationship.

2. Mandatory Revocation: Zero Tolerance Standard

The *Health Professions Procedural Code* of the RHPA should be amended to add to specific acts defined in section 51.5 that trigger mandatory revocation of the certificate of registration of a member who has been found guilty of a recurrent pattern of sexual abuse under section 1(3) (b) or (c) of the *Code* (touching of a sexual nature or behaviour or remarks of a sexual nature by the regulated health professional).

The member's college must revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:

- i. sexual intercourse;
- ii. genital to genital, genital to anal, oral to genital, or oral to anal;
- iii. digital penetration or penetration with an object of the mouth; vagina or anus without medical/health care justification;
- iv. masturbation of the member by, or in the presence of, the patient;
- v. masturbation of the patient by the member;
- vi. masturbation of the patient in the presence of the member;
- vii. touching of a patient's breasts without medical/health care justification; or
- viii. simulated sexual intercourse with the patient.

3. No Gender-Based Restrictions

As discussed in detail in Chapter 5, with case examples, the Minister's Task Force recommends immediate stoppage of any decision-making body under the RHPA placing gender restrictions on the scope of practice where a health professional has been found to have had sexualized contact with one or more patients, in contravention of any of the sections of the *Code* related to sexual abuse and/or misconduct and/or impropriety.

The *Health Professions Procedural Code* should be amended by adding a new subsection to s. 51 to clarify that, notwithstanding section 37(1) and subsection 51(2)3, where the member has committed, or has been alleged

to have committed, an act of professional misconduct by sexually abusing a patient, gender restrictions on the member's ability to practise as a term, condition or limitation on the member's certificate of registration are not to be imposed.

4. Ontario Safety and Patient Protection Authority (OSAPPA)

The Government of Ontario should establish OSAPPA, the Ontario Safety and Patient Protection Authority, with the mandate to uphold the standard of zero tolerance of sexual abuse of patients and receive dedicated long-term resources to support that mandate, including to provide for:

- public education and outreach, with particular attention and resources to cultural sensitivity and competency;
- educational liaison with all programs for students in the regulated health professions;
- supports to patients reporting sexual abuse by regulated health professionals; and
- complaints and investigations, but with adjudication of sexual abuse complaints by the independent OSAPPA Tribunal.

5. Fast Tracking Sexual Abuse Complaints

All discipline cases of sexual abuse by health care professionals should be given priority and fast tracked by the colleges during the transition to OSAPPA and any such occasion thereafter. The modernized RHPA is to place legislated onus on regulatory colleges to make immediate referrals of patients with sexual abuse complaints to OSAPPA — in person with written information provided to facilitate the patient's access to OSAPPA services, and in writing — by the most efficient possible electronic means directly to OSAPPA. Every regulatory college is to be mandated to include a record of all patient visits and other forms of inquiry vis-à-vis the sexual abuse of patients (not only referrals to a discipline panel) with documentation as to the speed and nature of referrals to OSAPPA. The modernized RHPA is to mandate OSAPPA with resources and reporting responsibility to ensure that sexual abuse complaints are processed within the required timeline.

6. Patient Privacy and Confidentiality

Oversight by the Ministry of Health and Long-Term Care should be vigilant, to ensure that the existing protection in section 85.3(4) of the *Health*

Professions Procedural Code is upheld so that a reporting member does not give the name of the patient–complainant unless the member has the express, written consent of the patient, for patients who are able to provide consent. For patients who are not able to provide consent for reasons of age (children) or mental or physical disability, consent must be provided by the legal guardian/power of attorney. However, when a complaint is received, the registrar of the college of the health professional making the report is to receive a copy of the mandatory report by that health professional, even when the patient is not named in the report.

7. Full Participation of Patients

In order to increase access to justice for patients, it is recommended that — instead of at the discretion of discipline panels to “allow” patients some greater participation in hearings, as set out in subsections 41.1(1)(b) and (2) — the *Health Professions Procedural Code* be amended to include the following provisions for complainants in sexual abuse cases:

- all complainants should have the right to participate in the proceedings of any complaints or disciplinary hearings, as a full party, with their own legal representation provided by the colleges and OSAPPA after transition;
- all complainants should have the right to a support person of her choice at the expense of the health regulatory colleges, and after transition, OSAPPA;
- the RHPA should clearly provide to all complainants in sexual misconduct/abuse proceedings the option to testify behind a screen or by closed-circuit electronic means;
- all complainants should have the opportunity, in accordance with current RHPA provisions, where the member is found guilty, to submit a victim impact statement and not be cross-examined on that statement, such statement to be taken into account in the assessment of a remedy or penalty;
- a videotape of an interview with the complainant may be admitted in evidence if the complainant, while testifying, adopts the content of the videotape; and
- under no circumstances should the alleged perpetrator of the sexual abuse be permitted to cross-examine the complainant personally.

8. OSAPPA Tribunal — Adjudication

The Government of Ontario should establish a tribunal that should provide independent adjudication for OSAPPA cases, which could be a new tribunal or developed as a specialized branch of the Ontario Human Rights Tribunal or as a thorough restructuring of the Health Professions Appeal and Review Board (HPARB).

9. Health Professions Appeal and Review Board – Restructuring Review

A. A review as to the possible restructuring of the Health Professions Appeal and Review Board (HPARB), taking into account the Professional Standards Authority for Health and Social Care in the United Kingdom, the Health Practitioner Disciplinary Tribunal in New Zealand and the Ontario Human Rights Tribunal, should be conducted for the Minister's Implementation Council to assess and then advise the minister as to whether a restructured HPARB should function as the independent tribunal to decide OSAPPA cases.

B. In any event, the *Health Professions Procedural Code* should be amended to require HPARB to:

- render a decision within 120 days of receiving the request for review of a decision of a complaints committee panel;
- allow patients as full parties to review hearings, whether in person or by other means; and
- report annually on the number of appeals heard and the number of those where the board dismissed appeals by patients, such report to be made in a timely manner to be included in the public report of the Minister of Health and Long-Term Care to the appropriate committee of the Ontario Legislature.

10. Evidentiary Rules at Discipline Hearings in Sex Abuse Complaints

The *Health Professions Procedural Code* should be amended with a new provision that the evidentiary rules governing sexual abuse complaints and related discipline hearings are governed by the *Statutory Powers Procedures Act*.

11. Admissibility of Evidence

Subsection 36(3) of the RHPA should be amended so that evidence on the findings, orders or decisions in disciplinary proceedings under the RHPA are admissible in civil proceedings.

12. Expert Witnesses in the Dynamics of Sexual Abuse of Patients

The OSAPPA should appoint at least two independent experts with specialized backgrounds in research and/or practice related to the dynamics and impact of sexual abuse by health care professionals. These experts can present evidence at complaints, discipline and reinstatement proceedings, to ensure that the OSAPPA tribunal has the benefit of this expertise to take into consideration, rather than the prosecution and defence each appointing their own experts.

13. Resources for Participation of Patients in Investigation and Adjudication

Patients deserve appropriate and timely resources for full participation in the investigation and adjudication of sexual abuse complaints including access to therapy funds (during and after transition to the OSAPPA model).

A. Provincial rules and legislation should be amended to ensure that any fines imposed on a member for the sexual abuse of a patient should be designated as a separate fund under the jurisdiction of OSAPPA, to be used for support to patients, including therapy and counselling for eligible patients.

B. Subsection 85.7(4) of the *Health Professions Procedural Code* should be amended so that interim funding for patient therapy is provided prior to the hearing stage by colleges (during transition) and by OSAPPA.

14. Therapy and Counselling

A. A regulation pursuant to section 85.7 of the *Health Professions Procedural Code* should be made to clarify that funds are to be provided to the patient-complainant throughout a sexual abuse complaint process to cover the cost of medications, childcare and reasonable travel/accommodation expenses associated with accessing therapy related to the sexual abuse.

B. A regulation pursuant to the RHPA should stipulate that a patient is also eligible for funding for therapy or counselling if:

- there is an admission made by a member in a statement to the college (during transition) or to OSAPPA or the OSAPPA tribunal that the member sexually abused the patient;
- the member has been convicted under the *Criminal Code of Canada* of sexually assaulting a person while that person was a patient of the member; or

- OSAPPA staff determine that there is sufficient evidence to support a reasonable belief that the patient was sexually abused by a member.

15. Protection from Sexual Abuse by Unregulated Health Practitioners

A. The Ministry of Health and Long-Term Care (MOHLTC) and OSAPPA should commission research to determine the most effective legislative means for creating and maintaining a public record listing unregulated health practitioners who were previously licensed in Ontario or other jurisdictions, but who have lost their certificates of registration due to findings against them of sexual abuse of patients.

B. Currently unregulated health care providers — for example, sonographers — need to be identified and assigned to an existing college for regulation in the interest of patient safety, and where unregulated health care providers are contracted to or employed by regulated health professionals or health care corporations, the regulated health professionals and/or corporations are to be held responsible for acts of sexual abuse or harassment by those employees/sub-contractors by amendments to the RHPA and the *Excellent Care for All Act* (ECFAA).

16. Enforcement of Mandatory Reports of Sexual Abuse Complaints

All health care institutions and corporations providing health services to patients in Ontario, including hospitals, universities and private clinics, should become subject to fines between \$100,000 and \$250,000 for failure to make a mandatory report of alleged sexual harassment, sexual misconduct, exploitation or abuse. Despite more than 20 years of cases since the RHPA was amended to include explicit institutional obligations to report, not one institution has been held accountable for sexual abuse of patient(s) that was proven to have occurred within its jurisdiction.³⁰

17. Prerequisites for New or Renewed Registration

The RHPA should be amended to enhance prerequisites for new or renewed registration for regulated health professionals, to ensure that:

- powers under the RHPA (for example in in subsection 43 (1)(f)) and the *Health Professions Procedural Code* (for example, in subsection 94(1)) must be used to have all college councils change by-laws to require mandatory answering of questions by applicants/members

on any complaints of sexual abuse or harassment against the applicant/member before certificates of registration are obtained initially or renewed annually;

- applications for a certificate of registration or for reinstatement of a certificate to any college under the RHPA are to require verification as to good character, including sworn statements as to previous convictions or charges of a criminal nature, any civil findings where the member has been a party in a lawsuit involving sexual abuse or harassment, and detailed reasons given for resignation or suspension if the member has resigned or was suspended from a college or any other health profession in any other jurisdiction in the world; and
- applications for reinstatement must include reference to any conditions placed by the college or OSAPPA, which the health professional was to meet, and evidence that the conditions have been met, as well as identifying the official(s) and expert(s) who deemed the evidence acceptable.

18. Access to Justice for Ontario Patients Pilot with Legal Aid Ontario

An Access to Justice for Patients pilot project with Legal Aid Ontario (LAO) is to be facilitated by the Inter-Ministerial Implementation Group, as per Recommendation 20. The Government of Ontario should provide adequate financial and other resources to LAO to launch and sustain this pilot project. The project will remove barriers that prevent patients in vulnerable populations from:

- getting comprehensive, understandable information and education about sexual abuse by regulated health professionals;
- reporting sexual abuse and impropriety for action to be taken; and
- receiving appropriate and timely resources so that they can fully participate in the investigation and adjudication of sexual abuse complaints.

Recommendation 18 is essential to an effective shift to the OSAPPA model by making the complaints and disciplinary process for patients more transparent and meaningful, through increased access to public legal information as well as skilled, culturally competent legal counsel. The project should be delivered through coordinated, sustainable programs by adequately resourced community-based organizations that are oriented to patient safety and patient rights.

A. Ontario should fund the development and delivery of a five-year pilot project, using the Barbra Schlifer Commemorative Clinic as lead community partner, to develop core legal competence for a vulnerable patient population, and to engage in direct patient legal advocacy and support throughout the complaint and discipline process. This five-year project should be evaluated at the end of year three, at which time a renewal plan will be created for the remaining two years of the pilot, with another evaluation and planning stage, with the stated goal of long-term, sustained access to justice for this vulnerable population.

B. Funding for this five-year project should include the hiring of at least two full-time legal counsel (based at the Schlifer Clinic for at least the first three years of the pilot project while OSAPPA is set up) to support the development of core legal competence of legal aid clinic lawyers and other legal aid service providers throughout the province.

C. As the lead agency, the Schlifer Clinic should collaborate with other legal advocacy partners (e.g., Community Legal Education Ontario [CLEO], ARCH Disability Law Centre, the Advocacy Centre for the Elderly [ACE], Nishnawbe-Aski Legal Services, the African Canadian Legal Clinic [ACLC], Aboriginal Legal Services of Toronto, the South Asian Legal Clinic of Ontario, Justice for Children and Youth, etc.) in consultation with the Ontario Federation of Indian Friendship Centres (OFIFC) and other community-based networks, such as METRAC and Patients Canada, as appropriate, to promote cultural competency, diversity and effective outreach to patients in marginalized and hard-to-reach communities across the province.

D. The Schlifer Clinic and LAO, in collaboration with other legal advocacy partners, as appropriate, should ensure that they develop appropriate statistical and qualitative tools to measure and understand client needs. This information can be used for ongoing needs assessment, financial planning and service delivery purposes in the transition to OSAPPA and beyond.

E. The Government of Ontario will direct Legal Aid Ontario to inform patients about and direct them to the legal aid certificate programs (see below), and to train and sensitize staff at legal aid offices and legal aid clinics in the competencies required to meet the unique needs of patients who have experienced sexual abuse by regulated health care professionals (consistent with augmenting the sensitivity training provided as part of LAO's Domestic Violence Strategy). Training should be adapted to meet the desired outcomes in this recommendation, and increased access to justice for Ontario patients should include the following actions, as needed:

- i. Expand the current summary advice legal aid certificate program to provide two hours of summary advice to potential/actual complainants, and to support this expansion with resources and action, which will include the following:
 - (a) establishing a panel of eligible lawyers throughout the province who have the core competence to provide such advice;
 - (b) proactively informing frontline service organizations of the existence of, and eligibility for, this new legal aid certificate (e.g., the Ontario Coalition of Rape Crisis Centres [OCRCC], hospitals with sexual assault services, legal aid clinics, etc.);
 - (c) proactively engaging the legal profession and inviting lawyers with the appropriate eligibility criteria to be included on the panel; and
 - (d) as part of LAO's financial eligibility test expansion, possibly relaxing the strict financial eligibility criteria (for legal aid certificates) for this vulnerable client population. The revised criteria should be consistent with LAO's June 8, 2015, announcement³¹ to expand its certificate services in criminal law, family law and refugee/immigration law and for mental health legal proceedings, as well as its November 2014 announcement³² to implement a higher financial eligibility test for family law clients who have experienced domestic violence.
- ii. Expand the current legal aid certificate program to permit patients alleging sexual abuse by a regulated health professional to obtain legal counsel throughout the discipline process (i.e., from the initial complaint to the hearing and the appeal). Legal Aid Ontario should develop eligibility criteria to establish a panel of qualified lawyers who have both legal competence in the area of patient sexual abuse and sensitivity training in dealing with survivors of sexual abuse.
- iii. Adjust LAO financial eligibility criteria so that they are not a barrier to Ontario patients in this pilot.
- iv. As a priority service, encourage Ontario's 76 legal aid clinics to develop a coordinated plan on how best to deliver legal services to eligible patients who have alleged sexual abuse by regulated health care professionals, consistent with this emerging area of legal representation.
- v. Set, as a specific priority for LAO public interest work, sexual violence in the regulated health professional context for the Group Applications and Test Case Committee of LAO, recognizing that complainants are a marginalized group.

Public Education and Legal Information Resources for the New Complaints Processes

F. Ontario should fund and develop an effective public education and legal information program, co-chaired by CLEO and METRAC, that informs the Ontario public about patients' legal rights and options for recourse when they have suffered sexual abuse by a regulated health care professional. The program will include information on:

- the scope of behaviours that constitute sexual abuse;
- the health care and forensic evidence collection services provided at sexual assault/domestic violence treatment centres across Ontario;
- the option of filing and pursuing a complaint and discipline process;
- patients' rights and status within complaint and discipline proceedings;
- the legislative provisions of the RHPA and its Code vis-à-vis patient sexual abuse;
- additional legal options under criminal and civil law; and
- legal support services and legal aid-funded services.

G. In implementing this aspect of the Access to Justice pilot project, CLEO and METRAC should offer to collaborate with other organizations that have public legal education mandates (such as Luke's Place, the Legal Education and Action Fund [LEAF], Action Ontarienne contre la violence faite aux femmes [AOcVF], the Ontario Federation of Indigenous Friendship Centres and others, as appropriate), in order to:

- i. identify effective strategies for developing relevant public legal information training and resources for service providers to assist them in responding to patients' disclosure of sexual abuse by health care professionals; and
- ii. engage diverse patient communities to develop relevant public education and legal information through the selection of topics and resource formats that ensure accessibility, and specification of relevant outreach and communications methods. The program will facilitate effective distribution of information based on intersecting needs and the provision of ongoing community feedback for improving program relevance and responsiveness, and contributing to a final evaluation to measure program results and overall effectiveness.

H. Ontario-coordinated funding to support the Access to Justice pilot should explicitly support inter-sectoral coordination and sharing of information and services across multiple sectors, including the following:

- i. ServiceOntario will distribute materials to individuals and institutions across Ontario, including government offices, patient advocates and service provider organizations.
- ii. The Government of Ontario will develop a program to educate lawyers about how to most effectively represent patients who have been sexually abused by regulated health professionals with respect to the related disciplinary processes. The government will do this in partnership with an appropriate agency, such as the Law Society of Upper Canada and/or the Ontario Bar Association.
- iii. Consolidation and distribution of examples of “lessons learned” and culturally competent proven practices, including highlighting different educational models, such as community-based approaches that include models for evaluation that can measure outcomes among multiple services and sectors, and incorporate access and equity principles.

19. Minister’s Implementation Council

A. The Minister of Health and Long-Term Care (MOHLTC) should immediately establish the Minister’s Implementation Council for an initial renewable five-year term, to make an annual public report to the minister, who in turn should report to a standing committee of the Ontario Legislative Assembly. Reports should include a detailed summary of cases, patient evaluations of processes and responses, an audit of decisions, evaluation of OSAPPA and suggestions for more effective procedures and educational initiatives for preventing the sexual abuse of patients in the public interest. Membership in the Minister’s Implementation Council should include one Ministry of Health and Long-Term Care employee/appointee at the assistant deputy minister level (or equivalent) and one at the director level in the ministry, one member of the Premier’s Permanent Roundtable on Violence and one member of the Aboriginal Roundtable on Violence, two experienced executives from health regulatory colleges, one health care administrator with extensive community-based care experience, at least two survivors and two advocates working in the field of abuse prevention and/or victim support, one executive officer of OSAPPA — taking into consideration those recommended by separate letter from the task force for the minister’s consideration. To succeed, each member of the Minister’s Implementation Council needs to be able to interact critically with every other member in a way that protects the integrity of each; thus, all members should receive the same level of remuneration for this public service — at the level of chair —

as a clear indication of the respect and need for the equivalency of the range of expertise needed for effective collaboration and implementation of this major reform.³² The Implementation Council should encourage, receive and respond to reports on educational and research initiatives undertaken, as per relevant recommendations made herein.

B. That the Minister of Health and Long-Term Care include in the mandate of the Minister's Implementation Council responsibility to develop an evaluation framework for the OSAPPA with appropriate metrics, at minimum, annual reporting to the Minister on the number and type of complaints by patients, the disposition of those complaints, the fines levied for lack of mandatory reporting, general understanding of sexual abuse of patients and the response system, and other indicators of effectiveness of the reporting system and public education initiatives.

20. Inter-Ministerial Oversight for Implementation

The Cabinet of Ontario should immediately establish an inter-ministerial implementation initiative (group) that includes leadership from the Ministry of Health and Long Term Care in cooperation with the Ministry of Training, Colleges and Universities, the Ministry of the Attorney-General, the Minister Responsible for the Status of Women and others to be named, as decided by the ministers, to coordinate an ongoing cross-government response to preventing the sexual abuse of patients by health care professionals in Ontario — consistent with the whole-of-government response to sexualized violence and harassment in Ontario. Through the Minister of Health and Long-Term Care, leadership by this Inter-Ministerial Implementation Group would generate reforms consistent with the mandate of the Minister's Implementation Council to supervise and facilitate the development and implementation of initiatives to deal with sexual abuse by health professionals, including monitoring recommendations that flow from this report.

21. MOHLTC Leadership in Research

The Minister of Health and Long-Term Care (MOHLTC) should immediately ensure funding to designate an ongoing annual research fund within the MOHLTC³⁴ health research program to support research pertaining to sexual abuse by health care professionals including but not limited to:

- rates of and remedies for same;
- comparison of rates and dispositions of sexual abuse complaints to other offences;

- relevant organizational innovations and responses;
- links to broader societal norms, attitudes and behaviours;
- improved performance of the health care system; and
- pre-service and in-service education and training intended to prevent and rectify such behaviours.

Such research should be conducted in accordance with recognized institutional ethics review policies and procedures and with appropriate consent processes and policies. Patients must be informed of such research and assured of anonymity.

22. Research and Monitoring

The Minister of Health and Long-Term Care should commission a research study to track and analyze the rates, responses and disposition of sexual abuse cases of patients by health care professionals in Ontario retrospectively and going forward 20 years, in five-year segments, recognizing the complexities of reporting, versus incidence data.

23. Minister's Annual Symposium

The Minister of Health and Long-Term Care should announce and support an annual international symposium to address systemic changes in the province of Ontario to prevent and provide remedies for the sexual abuse of patients by health care professionals. This would include ongoing research, professional and public education, community action and partnerships, and assessment of the RHPA. It is suggested that the minister be a keynote speaker at the symposium on sexual abuse of patients being planned by Women's College Hospital in 2016, and contribute substantial resources of experts, information and financial support to this symposium as an initial step in MOHLTC taking responsibility for its annual symposium, beginning in 2017.

24. Aboriginal Health Strategy Renewal

A. The task force recommends that the Minister of Health and Long-Term Care initiate the renewal of a comprehensive, cross-cutting inter-sectoral policy on aboriginal health to incorporate and act upon the 94 Calls to Action made by the Truth and Reconciliation Commission,³⁴ as relevant to the overall health and well being of Indigenous peoples in Ontario generally, and to the sexual abuse of patients of Aboriginal origin, in particular. Specific

attention should be given to research, policy proposals and commentary principally authored by experts of Aboriginal origin, including the *Final Report of the Truth and Reconciliation Commission of Canada* (released December 15, 2015), reports from the Ontario Joint Working Group on Violence against Aboriginal Women, the Strategic Framework to End Violence against Aboriginal Women (Ontario Native Women’s Association and Ontario Federation of Indigenous Friendship Centres), and the Aboriginal Sexual Violence Action Plan (Ontario Federation of Indigenous Friendship Centres).

B. The task force recommends that the minister designate an Assistant Deputy Minister to lead a five-year plan from MOHLTC officials on comprehensive, cross-cutting intersectoral policy on cultural competency in research, education and other programs addressing the sexual abuse of patients in marginalized (social and/or geographic) and/or vulnerable populations in Ontario, to be submitted to the Minister’s Implementation Council.

25. Patient Safety Reporting in Health Care Educational Curricula and Systems

A. The Inter-Ministerial Implementation Group should review accreditation standards for educational institutions providing certificate, diploma, undergraduate and post-graduate programs for professions under the RHPA, with the goal of incorporating patient safety assessments — including protections against sexual abuse — in all accreditation programs. The review of curricula should include an assessment periodically of ethical standards for professional practice and strategies in place to build awareness of the impact of sexual abuse on patients, along with the responsibilities, approaches to prevention, and requirements to report and to implement tracking mechanisms regarding knowledge of, and educational institutions’ responses to, reports of sexual abuse of patients.

B. Institutions responsible for training health care professionals should have, as a minimum, explicit senior management commitments to preventing sexual abuse of patients, clear statements and explanations of sexual abuse of patients, professional responsibilities to report as part of core training, examinations concerning professional practice and codes of ethical conduct — all embedded in performance reviews conducted periodically for funders.

26. Education for Patients and Professionals

The Minister of Health and Long-Term Care should introduce and — in cooperation with the Ministry of Training, Colleges and Universities and other affected ministries — support, with adequate resources, newly designed and evaluated pre-service, in-service and public education on sexual abuse of patients by health professionals, to be reviewed and reported on periodically, including:

- refreshed curriculum for pre-service education in universities and colleges;
- refreshed continuing education and training for in-service health professionals;
- cultural competency as a mandatory component in any education or training public education campaign addressing patients, families, bystanders and communities about rights and redress;³⁶
- education for hospital and other health care administrators on their legal, patient safety and reporting responsibilities; and
- mandatory training, with periodic reviews, for members of governing councils and staff of health regulatory colleges to begin immediately and to continue through transition to include OSAPPA officials and personnel.

27. Patients' Safety Bill

A Patients' Safety Bill should immediately be developed by the Ontario Ministry of Health and Long-Term Care in consultation with patients' advocacy groups and the regulatory colleges as an amendment to the RHPA. The *Ontario Hospitals Act* should be amended to require all regulated health professionals and all administrators of health care facilities, including privately owned health care facilities, to post, with clear requirement to maintain: a) visibility of the Bill and b) availability upon request of print copies of the Bill. The Patients' Safety Bill and current contact information should be placed in high-visibility locations wherever health professionals are providing services. This amendment may be complementary to, but is substantially different from, the Patient Ombudsman office announced in 2015.

28. Patient Evaluations re Access to Justice for Better Health Care

Following every determination and resolution of a complaint about sexual abuse during the transition to the OSAPPA system, every college is to ensure that an evaluation form, with introductory information supplied by

MOHLTC, is provided to every patient involved in the process, and include a pre-paid return envelope addressed to the Minister's Implementation Council. The OSAPPA mandate should include an ongoing responsibility to continue and improve upon gathering feedback from patients, to enable meaningful comparisons in evaluation and annual reporting.

29. Reports for the Public Record — *Excellent Care for All Act*

A. The Minister of Health and Long-Term Care should introduce the reporting and disposition of sexual abuse cases as a priority Quality Improvement Indicator under the *Excellent Care For All Act* (ECFAA) pertaining to hospitals in Ontario, community and home-based care, and primary care practitioners. Results should be included in the minister's annual report to the legislative committee and — if not included — there should be an explanation required in the report.

B. The RHPA should be amended to include the requirement that every college shall make a public annual report to the Minister of Health and Long-Term Care and to OSAPPA of any complaints received concerning the sexual abuse of patients by members or former members of the college, including a summary of the timeline and description of actions taken by the college in referring on to OSAPPA. The Minister's Implementation Council should be responsible for the template for this annual report, in consultation with patients' advocacy groups, hospitals, educational institutions, OSAPPA and the colleges.

C. The Minister should recommend to the Ontario Hospital Association (OHA) to incorporate the sexual abuse of patients by health professionals into the current Quality and Patient Safety Plan (QPSP), given that one of their stated goals is "to champion the adoption of a culture of quality and patient safety."³⁷ The OHA can support health care institutions in developing their annual Quality Improvement Plans (QIPs) as mandated under the ECFAA. The OHA could be instrumental in providing materials, supports and tools to health care institutions that include: a broader definition of patient safety, the psychological harm and other harms associated with sexual abuse of patients and definitions of patient, health care provider, and sexual abuse based on the RHPA. Responsibilities and accountabilities of the hospitals/other health care facilities and health providers for the prevention, identification, reporting, tracking and responding to reports of

sexual abuse of patients by health care providers should also be delineated. The OHA should be encouraged to contribute leadership in preventing the sexual abuse of patients by making a long-term commitment to developing, providing and sustaining education, quality assurance and reporting mechanisms to OHA members.

30. Information Accessible on the Public Record — Registers

The *Health Professions Procedural Code* should be amended to require that every college register includes disciplinary decisions in which the member was found to have committed an act of sexual abuse/misconduct/impropriety as defined in the RHPA and Code, including section 1(3)(c) (behaviour or remarks) as well as 1(3) (a) (physical sexual relations) and 1(3)(b) (touching of a sexual nature) of the Code and that staff of colleges are clearly obliged to inform anyone who inquires as to the nature of the complaint. The amendments should be designed to apply high-transparency standards to the public record of colleges during and after the transition and also to public records of the OSAPPA model.

31. Transparency and Notifications of Findings by Colleges and OSAPPA

The *Health Professions Procedural Code* should be amended to ensure that college and OSAPPA registers contain for the public record:

- any stipulations or programs imposed on a member related to any complaint of sexual abuse of a patient, with a notation on whether the requirements were disciplinary panel decisions, or determinations through any other means, including suspension or resignation of the member, related to sexual abuse complaints processed by a college (during transition) or OSAPPA (after transition); and
- determinations of any kind, including resignation, that colleges (which retain the authority to issue or revoke certificates to practise) should be legally obliged to inform all other licensing authorities in Canada and to keep written records verifying such notification, to be included in annual public reports to the Standing Committee on Government Agencies of the Legislative Assembly of Ontario or another appropriate standing committee that includes MOHLTC in its mandate.

32. Provincial, National and International Database Access

The Ministry of Health and Long-Term Care should initiate joint and reciprocal ventures to establish, link and maintain both a national and international database, with public access and capable of identifying sexual abuse offenders who are, or were, regulated health care professionals.

33. Patient Safety Standards Addressing the Sexual Abuse of Patients in Hospitals, Health Care Organizations, and Long-Term Care Facilities

The OHA and other such health organizations, as relevant, should provide increased, focused and sustained leadership in the development of policy and education for all institutional members. Included should be a broader definition of patient safety that recognizes the extensive and serious range of harm associated with sexual abuse of patients. Specific and detailed standards for hospital and other health institution leaders should be established.³⁸ These would leave no doubt about the definitions of patient, health care provider and sexual abuse, or the responsibilities of hospitals and other health care facilities for the prevention, identification, reporting and tracking of sexual abuse of patients by health care providers. Accountability mechanisms geared to hospitals and health care providers should be clear, resourced and implemented for the long term. Health care institutions, including hospitals, should have rigorous training, quality assurance and reporting mechanisms in place that reinforce their duties to prevent, report and track sexual abuse incidents within risk management systems that permeate every level of service within the health care institutions — with clear, enforced consequences for all executives who do not deliver on the patient safety and protection standards.

The minister should recommend to the OHA to incorporate sexual abuse of patients by health professionals into the current Quality and Patient Safety Plan (QPSP), given that one of their stated goals is “to champion the adoption of a culture of quality and patient safety.” The OHA can support health care institutions in developing their annual Quality Improvement Plans (QIPs) as mandated under the ECFAA. The OHA could be instrumental in providing materials, supports and tools to health care institutions that include: a broader definition of patient safety, the psychological harm and other harms associated with sexual abuse of patients and definitions of patient, health care provider, and sexual abuse based on the RHPA. Responsibilities and accountabilities of the hospitals/other health care facilities and health providers for the prevention, identification, reporting, tracking and responding to reports of sexual abuse of patients by health care providers should also be delineated. In keeping with Recommendation 29,

the OHA should be encouraged to contribute leadership in developing and providing education, quality assurance and reporting mechanisms to OHA members.

34. Accreditation standards

The Minister of Health and Long-Term Care should recommend to Accreditation Canada the development of Required Organizational Practices (ROPs) in the Safety Culture category that are specific to the sexual abuse of patients by regulated health professionals. Sexual abuse of patients is a low-probability/high-impact risk that needs to be addressed at a strategic level as an issue of patient safety. These ROPs would clearly describe the organizational/board responsibilities in addressing sexual abuse, i.e., educational requirements for employees, mandatory reporting expectations, and tracking and reporting within and by institutions.

The ROP approach would also require the sexual abuse of patients to become a “standing agenda item” at all regular meetings of the governing body. ROPs would include: a) definitions, consistent with the RHPA, of “patient” and of “sexual abuse or exploitation”; and b) clear commitments as to what patients should be able to expect from their health care provider within a patient safety context. ROPs would clearly describe for patients what to do if they experience sexual abuse and to whom reports must be made. Similar to the approach taken by many hospitals, for example, in protecting patient privacy, hospital boards should mainstream protection of patients from sexual abuse at all levels of governance and management and ensure implementation of relevant sections of the *Health Professions Procedural Code*, including mandatory reporting of sexual abuse complaints per section 85.1 (reporting by members) and section 85.2 (reporting by facilities).

Endnotes

1. The “self-regulated health professions” under the RHPA are:
 1. Audiology and Speech-Language Pathology
 2. Chiropractic
 3. Chiropractic
 4. Dental Hygiene
 5. Dental Technology
 6. Dentistry
 7. Denturism
 8. Dietetics

9. Homeopathy
10. Kinesiology
11. Massage Therapy
12. Medical Laboratory Technology
13. Medical Radiation Technology
14. Medicine
15. Midwifery
16. Naturopathy
17. Nursing
18. Occupational Therapy
19. Opticianry
20. Optometry
21. Pharmacy
22. Physiotherapy
23. Psychology
24. Psychotherapy
25. Respiratory Therapy
26. Traditional Chinese Medicine

The practice of each of these health professions and its members is governed by a college, pursuant to the provisions of the *Health Professions Procedural Code*, Schedule 2 of the RHPA (<https://www.ontario.ca/laws/statute/91r18#BK52>). The *Code* is deemed by section 4 of the RHPA to be part of each health profession's constituting act.

2. For the full mandate, see page 7. Appendix A comprises the complete Terms of Reference.
3. Sadiya Ansari, "College of Physicians and Surgeons launches review of sexual abuse policy," *Toronto Star*, December 5, 2014, retrieved from http://www.thestar.com/life/health_wellness/2014/12/05/physician_watchdog_launches_review_of_sexual_abuse_policy.html.
4. Honourable Frances Lankin, Minister of Health, *Official Report of Debates (Hansard)*, Legislative Assembly of Ontario, First Session, 35th Parliament, Monday 29 May 1991, (*Hansard* 29/05/91), retrieved from <http://hansardindex.ontla.on.ca/hansardespeaker/35-1/1038-83.html>.
5. The Federation of Health Regulatory Colleges of Ontario, <http://www.regulatedhealthprofessions.on.ca>.
6. Marilou McPhedran et al., *What about accountability to the patient? The Independent Final Report of the Special Task force on Sexual Abuse of Patients*, 2000, p. 28. Retrieved from <http://booksnow2.scholarsportal.info/ebooks/ebooks2/ogdc/2014-02-24/3/10288765/10288765.pdf>.
7. See *College of Nurses of Ontario v. Klein*, 2009 CanLII 92091 (ON CNO).
8. *Sexual Assault in Canada: Law, Legal Practice and Women's Activism*, Elizabeth A. Sheehy, editor, University of Ottawa Press, 2012, retrieved from http://www.ruor.uottawa.ca/bitstream/10393/19876/12/Sexual_Assault_in_Canada.pdf.
9. Samuel Perreault, *Criminal victimization in Canada, 2014*. Juristat, Statistics Canada (2015), p. 27, retrieved from <http://www.statcan.gc.ca/pub/85-002-x/2015001/article/14241-eng.htm#a11>. In Canada, two main national surveys collect crime-related data: the Uniform

- Crime Reporting (UCR) Survey and the General Social Survey (GSS) on Victimization. The UCR Survey collects police-reported data, while the GSS on Victimization collects information from a sample of Canadians aged 15 years and older. The GSS on Victimization is conducted every five years. Unlike the UCR Survey, the GSS on Victimization also captures information on crimes that have not been reported to police and so it is a source for demonstrating the high level of un-reporting of sexual assault.
10. Anne Kingston, "What's really on trial in the Ghomeshi case", *Maclean's Magazine*, January 28, 2016, p. 40, retrieved from <http://www.macleans.ca/society/whats-really-on-trial-in-the-ghomeshi-case>.
 11. Paola Loriggio, *The Canadian Press*, "Jian Ghomeshi's Trial Highlights Need For Deep Legal Reform: David Butt," February 11, 2016, retrieved from http://www.huffingtonpost.ca/2016/02/11/jian-ghomeshi-s-trial-highlights-need-for-deep-legal-reform-lawyer_n_9207092.html.
 12. The Health Professions Appeal and Review Board (HPARB) is an independent adjudicative agency. On request, it:
 - reviews decisions made by the Inquiries, Complaints and Reports Committees of the self-regulating health professions Colleges in Ontario;
 - conducts reviews and hearings of orders of the Registration Committees of the Colleges; and
 - holds hearings concerning physicians' hospital privileges under the *Public Hospitals Act*.
 See <http://www.hparb.on.ca/scripts/english/about.asp>.
 13. Marilou McPhedran et al., *Final Report of the Task Force on Sexual Abuse of Patients, 1991*, retrieved from https://www.cpso.on.ca/uploadedFiles/policies/publications/Sexual-Abuse-Patients_Task-Force-FinalReport_1991.pdf.
 14. *Norberg v. Wynrib* (1992), 2 SCR 226.
 15. Marilou McPhedran et al., *Final Report of the Task Force on Sexual Abuse of Patients, 1991*.
 16. As summarized in Sanda Rodgers, "Sexual Abuse by Health Care Professionals: The Failure of Reform in Ontario" *Health Law Journal* 2004;12, p. 98, fn 145, retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16539077>: "Mussani began treating A.K. in 1985. She was 23. She confided difficulties in her marriage. He began providing counselling and psychotherapy, billing OHIP. Between 1990 and 1991 he treated her 90 times. At one point she worked in his office. The families became friends and travelled together. She, a physiotherapist, treated him. They began an affair in 1992. In 1994 she became pregnant and was unsure whether her husband or Mussani was the father. Mussani arranged an abortion. At no time did Mussani attempt to terminate the doctor-patient relationship. She broke off the affair in 1994. College of Physicians and Surgeons of Ontario, 'Discipline Committee Decisions 2001' Case Summaries, College of Physicians and Surgeons v. Dr Anil Mendi Mussani (July/August)."
 17. Marilou McPhedran et al., *Final Report of the Task Force on Sexual Abuse of Patients, 1991*.
 18. *College of Physicians & Surgeons (Ontario) v Mussani*, 1999 ONCPSD 3 (CanLII); *College of Physicians & Surgeons (Ontario) v Mussani*, 2000 ONCPSD 22 (CanLII).
 19. *Medical Post*, 30 January 2001, Letter to the editor from then-OMA president Dr. Schumacher in reply to an article by Jenny Manzer, "OMA fights abuse laws: Association argues mandatory revocation violates Charter of Rights," *Medical Post*, 9 January 2001.
 20. In July 2015, the ONA website listed membership numbers that included 60,000 nurses and allied health professionals as well as 14,000 nursing students (see <http://>

- www.ona.org/faqs.html#f15); the OMA website listed over 34,000 doctors and medical students as members (see <https://www.oma.org/Mediaroom/PressReleases/Pages/cuttingfundingforphyservices.aspx>).
21. *Mussani v. College of Physicians & Surgeons (Ontario)* [2004] 74 OR (3d); 248 DLR (4th) 632 (Ontario Court of Appeal); *Mussani v College of Physicians & Surgeons (Ontario)* [2004] 74 OR (3d); 248 DLR (4th) 632 (Ontario Court of Appeal).
 22. Factum filed by the OMA, June 24, 2003, paragraphs 54 and 75.
 23. Factum filed by the ONA, June 24, 2004, paragraphs 43, 36 and 63.
 24. Michael B. Decker, former Ontario Deputy Minister of Health and board chair of Patients Canada, Public Testimony to the Minister's Task Force on the Prevention of Sexual Abuse of Patients, Toronto, April 13, 2015; speaking notes provided by Mr. Decker and video recording made by MOHLTC.
 25. From 2012–22, almost \$2 billion will be dedicated to the CMPA for Ontario physicians and surgeons. See http://www.health.gov.on.ca/en/pro/programs/phys_services/docs/phys_services_agreemnt_en.pdf.
 26. World Health Organization, *The ecological framework*, 2015, retrieved from <http://www.who.int/violenceprevention/approach/ecology/en>.
 27. Cukier et al, "What do business schools really teach?" *Dialogues in Critical Management Studies* 2013;2. Adaptation of the model with permission of the lead author, July 2015.
 28. *Patients First: Action Plan for Health Care*, February 2015, http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_patientsfirst.pdf.
 29. *Bill 132, Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment)*, 2015, retrieved from http://ontla.on.ca/web/bills/bills_detail.do?locale=en&Intranet=&BillID=3535.
 30. Case information submitted from the regulatory colleges (see Appendix D for a summary of the questions asked of the colleges), did not indicate that staff suffered any repercussions when they failed to file mandatory reports of sexual abuse. See also *Toronto Star*, "College of Physicians slow to censure silent bystanders: Porter," April 13, 2015, retrieved from <http://www.thestar.com/news/world/2015/04/13/college-of-physicians-slow-to-censure-silent-bystanders-porter.html>.
 31. Legal Aid Ontario, "Unprecedented multi-year expansion of legal eligibility for criminal, family, refugee and other matters," June 8, 2015, retrieved from http://www.legalaid.on.ca/en/news/newsarchive/1506-08_eligibilityexpansion.asp.
 32. Legal Aid Ontario, *Consultation Paper: Development of a Domestic Violence Strategy*, July 2015, retrieved from <http://www.legalaid.on.ca/en/publications/downloads/domesticviolencestrategy/2015-07-DVS-Consultation-Paper.pdf?t=1438214400037>.
 33. A separate letter from the Minister's Task Force to Minister Hoskins provided more detail on the recommended Minister's Implementation Council and included a diverse list of prominent Ontario experts willing to serve if appointed.
 34. Ministry of Health and Long-Term Care, *Health Care Professionals: Health System Research Fund (HSRF) Guidelines*, 2015, retrieved from http://www.health.gov.on.ca/en/pro/ministry/research/hsrf_guidelines.aspx#priority.
 35. *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada*, December 2015, http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf.

36. In consultation with the Ontario Federation of Indigenous Friendship Centres (OFIFC), the task force concluded that cultural-competency training should be a crucial, sustainable investment by MOHLTC that must include in-person Indigenous training for government, OSAPPA, tribunals and faculty who teach in all the regulated health professions' programs (undergraduate and post-graduate) under the RHPA, and should commence immediately.
37. Ontario Hospital Association, *Quality & Patient Safety Plan (QPSP) 2012-2013*, p. 38, <https://www.oha.com/CurrentIssues/keyinitiatives/PatientSafety/Documents/4304%20OHA%20PatientSafetyBrochure%20FA%20rev3.pdf>.
38. Accreditation Canada International defines an ROP as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk. See <https://accreditation.ca/sites/default/files/report-on-rops-en.pdf>.

Chapter 2:

Context for this Report

What We Learned from Information Provided by Health Regulatory Colleges

Major amendments to the *Regulated Health Professions Act, 1991* (RHPA) were guided by the philosophy of “zero tolerance of sexual abuse of patients,” which was adopted for the first time anywhere in the world by the College of Physicians and Surgeons of Ontario (CPSO) in May 1991, on the recommendation of Ontario’s first independent task force on sexual abuse of patients.¹ The 1991 task force was commissioned by the CPSO, but the zero tolerance standard was adopted widely, including by the Ontario Medical Association (OMA), the Ontario Hospital Association (OHA), numerous other colleges and the then-Minister of Health, Frances Lankin, who named zero tolerance as the guiding principle for the sweeping amendments to the RHPA that took effect in 1994.²

Twenty-four years later, assembling a comprehensive picture of how regulatory colleges deal with complaints of sexual abuse is still a challenge. To the best of our knowledge, the data derived from information provided by Ontario’s health regulatory colleges to this task force are the most comprehensive assembled to date. The task force requested information on college cases and processes covering the last decade, and was provided with skilled assistance from the Ministry of Health and Long-Term Care.³ We express our sincere appreciation to the staff and councils of the colleges for their responsiveness.

In this chapter, we discuss some of the concerns that underpin our recommendations for transferring certain responsibilities of colleges in sexual abuse complaints, and our “what and how” view into the responses of health regulatory colleges to complaints about sexual abuse by members of their respective colleges — all subject to the omnibus definitions and requirements of the *Regulated Health Professions Act, 1991* (RHPA) and its *Code*. We note with concern that the oversight by the Health Professions Regulatory Advisory Council (HPRAC) as an accountability mechanism that contributed to quite robust reporting by colleges on sexual abuse cases noticeably declined in the last few years, with a reduction in 2009 of the scope of authority for HPRAC, which now has “duties” solely to “advise the Minister and no other person on

any issue...but only if the Minister decides to refer the issue to HPRAC...and in no other circumstances.”⁴

Almost 1,000 Complaints of Sexual Abuse Over the Past Decade

Between January 2015 and July 2015, the task force asked 26 colleges to supply various kinds of data (see Appendix D) reporting, where possible, on the years 2004 to 2014 (the reference years). There were a number of follow-up requests on behalf of the task force, as well as in-person meetings with many of the colleges, to clarify and gain as much detail as possible. The questions asked by the task force elicited a wide range of information and data from the colleges, illustrating differences in record-keeping, the level of detail available and in membership-based resources available to some colleges, but not others.

Because some of the questions were open-ended, we were able to gather both quantitative and qualitative data. These mixed methods allowed us to garner insight into various aspects of process and experience, as well as to collect numbers and statistics about complaints. Taken together, these kinds of data paint a picture of the overall situation facing the public in Ontario vis-à-vis sexual abuse complaints, across several colleges and professions. While these data are helpful in illustrating profession- or college-specific issues, they do not offer a basis for comparing the colleges or the professions, as there are differences among the colleges in collecting and reporting data, resources, length of tenure and professional role.

Of the 26 colleges, 21 have been empowered under the RHPA since 1993; an additional 5 have been empowered since 2007 (two in 2013 and three in 2015). A wide variation in experience and processes around the responses to the sexual assault of patients remains, however, with some of the newer colleges still in the process of writing their bylaws.

We found no standardized approach to the collecting, maintaining and reporting of information connected to sexual abuse complaints amongst the colleges. Notwithstanding the recent establishment of some colleges, this lack of standardization means that the colleges and professions are not easily compared to each other, based on the data provided.

This lack of standardization between the colleges is not restricted to record-keeping. In addition, there is no standard approach to the recording of complaints, the kind of information provided post-complaint to patients or

clients, or to ensuring that the public is informed of the availability of the complaints process in the first place. Currently, responses from the colleges suggest that they address these matters inconsistently and in limited ways. In short, not only is there no standardized data collection and reporting of sexual abuse complaints, but there appears to be no standard outreach or public communication amongst and between the colleges.

Having said this, we did receive information about how the colleges communicate with complainants. There were wide variations in this practice amongst the colleges, with discretion used to either release or share information with a complainant about a registrant's response or the disposition. Some colleges recently announced that they are reviewing these procedures in order to bring principles forward more clearly and consistently.

There is also a difference in the resources available for dealing with sexual abuse complaints. For smaller colleges, the costs involved can be substantial in comparison to their overall resources and staffing. As such, the burden of maintaining complaints systems can be significant. This information was taken into account when we developed our recommendation that sexual abuse complaints should no longer be within the jurisdiction of the colleges.

According to the responses from the colleges, approximately 980 patients made allegations to the various colleges about sexual abuse during the reference years.⁵ Almost one-half of these were reported by the CPSO. A third of these came through mandatory reports or registrars' investigations. Approximately 55% came from patients, and the remainder through other sources such as staff, police or other means.

“

I believe that it may be in the interest of the public that 23 different regulated health professional colleges do not need to have 23 different discipline committee panels. I believe, quite frankly, that the public and those professions may be best served by a unified tribunal that handles disciplinary matters.”

– Member of the public

The vast majority (80%) of the complainants were female, reflecting the gendered nature of sexual abuse of patients, and 5–10% of the complainants were children or teenagers. Both of these statistics reflect the vulnerability of patients. Approximately 10% of the professionals subjected to allegations had complaints involving more than one patient, reflecting a pattern of abuse.

These numbers can be interpreted as indicative of patterns, but not reflective of the true extent of the problem. First, they are products of inconsistent approaches to reporting and collecting data, so colleges and professions cannot be compared. Second, they represent only reported incidents, which, in sexual assault cases, can be reasonably assumed to be only a small fraction of the real rates. We have few reference points or baselines to which we can compare these data, and none that could be considered current — underscoring our emphasis on the need for inter-ministerial leadership on research and education on this aspect of sexualized violence in Ontario.

An Aware Public is an Investment in Accountability

Although we cannot compare the colleges on their public outreach or assistance, colleges did offer descriptions of some of their efforts in these arena. These data suggest that the primary mode of communication with the public is via the colleges' websites. This mode does not, however, necessarily inform the public about prohibitions, standards of practice or other details. Some of the colleges provide information in two languages, but there are differences in practices. In summary, there are no firm standards on outreach, information, responses, complainant support or processes. Reliance on websites may exclude some individuals, and may inadequately inform others.

In general, with few exceptions, the colleges appear to share the registrant's response with the complainant, but less can be said about sharing

“When I put the health professionals name in {to the Register}, I could get absolutely no information, I couldn't even find out if the person was a member.”

– Patient

information later in the process. Some colleges are conducting reviews about the amount and process of information sharing, examining a range of issues such as the role of discretion, safety concerns, or third-party sharing. At the moment, it is clear that a complainant would not receive consistent treatment at all colleges.

Further, in general, the colleges do not solicit feedback from the complainants on their level of satisfaction with the processes or engage in surveys to elicit such feedback with either processes or dispositions. While some colleges receive few complaints of this nature to begin with, and others more, from the patient and public's perspective, consistent standards of processing and responding to any complaints would be beneficial.

Training of college personnel and Inquiries, Complaints and Reports Committee (ICRC) panel members also varies across the colleges, according to the colleges' responses. There are variations in training on diversity, cultural competency, conflict, sensitivity, sexual abuse dynamics and related matters, but it is not possible to say how these differences relate to dispositions. Various pre-service and in-service training issues were described by the colleges, and when the task force convened the first roundtable with public members appointed by the government to the colleges, over 50 people came. Their feedback confirmed that there is a high level of interest in more and better training.

As well, there is no consistent framework for addressing curricula development at universities on the subject of sexual abuse and related issues and responsibilities, and universities and professional schools have autonomy over the content of their curricula. Further, many practitioners are not trained in Ontario or even in Canada, and may not have had these components in their professional education. Some practitioners are mobile within Canada, and therefore may have had different exposure to training as students in other provinces.

Once students become full members of colleges as regulated health professionals, there are opportunities for the colleges to influence training, and in our conversations with college representatives, there seemed to be some coordination of effort to provide integrated training. Recommendations discussed in Chapters 5, 6, and 7 address these points further.

Endnotes

1. Marilou McPhedran et al., *Final Report of the Task Force on Sexual Abuse of Patients*, http://www.cpso.on.ca/uploadedFiles/policies/publications/Sexual-Abuse-Patients_Task-Force-FinalReport_1991.pdf.
2. Honourable Frances Lankin, Minister of Health, "Sexual Abuse of Patients," *Official Report of Debates (Hansard)*, Legislative Assembly of Ontario, Hansard 1064. October 8, 1992, retrieved from http://www.ontla.on.ca/web/house-proceedings/house_detail.do?Date=1992-10-08&Parl=35&Sess=2&locale=en.
3. By contrast, the Special Task Force on Sexual Abuse of Patients, appointed in 2000 by then-Minister of Health, Elizabeth Witmer, as a referral to HPRAC under s. 12 of the RHPA, received instruction by letter from the Program Policy Branch of the Ministry of Health and Long-Term Care "not to contact the regulatory colleges further." This letter is reproduced in *What about accountability to the patient? The Independent Final Report of the Special Task force on Sexual Abuse of Patients*, 2000, p. 89.
4. *Regulated Health Professions Act, 1991*, ss. 11(1) and 12(2), retrieved from <http://www.ontario.ca/laws/statute/91r18/v21>.
5. The data on sexual abuse of patients in Ontario are old. In 1991, the *Canada Health Monitor*, as part of its Survey #6, in cooperation with the CPSO, asked 549 Ontario women 15 years of age and older whether they had experienced any specified activities of a sexual nature in a physician's office. The activities correspond to the RHPA's current categories: 1) "sexual activities leading to mandatory revocation"; 2) "touching of a sexual nature"; and 3) "behaviour or remarks of a sexual nature." Approximately 8% of women replied "Yes" to activities corresponding to categories 2 and 3, and 2% replied "Yes" to activities corresponding to category 1. There are some variations in the responses; replied "Yes" responses are lower for older women and those with less education, and significantly higher for those respondents interviewed by a woman, and those with a university education. Retrieved from <http://data.library.utoronto.ca/microdata/canada-health-monitor-no-6-summer-1991>.

Chapter 3:

A Systemic Betrayal of Trust: Survivors Speak

One of the most common human responses to the sexual abuse of a patient — which is a profound violation of trust and sexual exploitation — is denial, at both individual and societal levels. An element of societal denial is exposed when sexual abuse of patients becomes a “numbers game” — for example, when the relatively small number of perpetrators in the regulated health professions is held up as justification for inaction. An element of individual denial can keep a patient from reporting the abuse by a trusted professional and keep that patient away from the care needed.

This task force was asked by Minister Hoskins to “undertake its work bearing in mind that patient experience is its primary focus...” To fulfill this aspect of our mandate, we invited some patients to speak with renowned journalist and author Michele Landsberg, on a confidential basis, so that her writing of this chapter would become a way to enhance understanding and empathy for the truth about the varied and extensive damage done when regulated health professionals sexually abuse their patients. Any recommendations that may have been influenced by the patients you will meet in this chapter, or elsewhere in this report, have been authored by the task force.

By Michele Landsberg

All patients’ names and professions have been disguised

Canadians are at a turning point in their awareness of the crimes committed behind the discreetly closed doors of medical offices. These places represent the last bastions of our ignorance, the line beyond which many of us refuse to go in understanding the roles of perpetrators and their victims. We have come so far in the past few years: many Canadians now understand the devastating harm inflicted by incestuous relatives, stranger rapists, date rapists, cultural misogynists and other abusers. Until recently, though, we have often not fully acknowledged the invisible wounds suffered by those who are exploited by health practitioners.

Often, the sometimes-compliant victim is characterized as a willing participant in the abuse. Sexual relations between a health professional and a patient are often described as an “affair” by the media. And those who

are preyed upon are usually unwilling to report the abuse, because they know that they may be seen as complicit. Too often, this lack of public concern makes it possible for society's watchdog institutions to shrug off the predatory abuse that is inflicted on vulnerable victims.

Changing Understanding, Better Reporting

Encouragingly, over the course of 2014 and 2015 there has been a seismic shift in the public's awareness of — and its response to — sexual violence. The recent drum roll of news stories about campus and workplace violence against women — verbal, physical, sexual — has been the culmination of a very long and difficult effort to make society accountable for a crime that mostly affects women and girls, and shapes the life experience of all females, whether through restricting their freedoms, crushing their self-worth or even imperilling their lives.

From the beginning of the Second Wave of the feminist movement, in the mid-1960s, the question of rape has been at the forefront of feminist struggles: how to force the public's attention onto this crime and the devastating impact it has on its victims; how to prevent rape; and how to reform the justice system, from policing to courtrooms, so that it better reflects women's experience of this crime.

In the first 40 years of the Second Wave, legal progress was torturously slow and very limited. No sooner had feminist advocates won a slight improvement in the law (the inadmissibility of a woman's previous sexual experience, for example), than the criminal bar and its many spokesmen put pressure on the judicial system to roll back the advance. Time and again, the women's movement had to spend scarce resources to establish even a minimum of justice for the victims of rape — victims who were not entitled to any representation in court. Even Paul Bernardo's many young rape victims had no say in his trial; it was determined that he would be tried only for the murder of two women. On the day of his sentencing, eight of the young women who had been ambushed, raped, sexually tortured and terrorized by Bernardo sat in the courtroom as mere spectators, traumatized and heartbroken that they would not have their own day in court to see their attacker held accountable.

The media have been an important part of the story, too. For the first half of the 20th century, articles about rapes were almost entirely absent from the newspapers. Robberies, murders, even petty thefts were reported in detail.

Yet rapes — unless they were dramatic stranger rapes with dire consequences — were almost never mentioned. The women’s movement pushed the reality of rape closer to the news pages, but reporters, editors and the general public mostly reacted with denial and backlash: What was she wearing? Why did she accept a ride from him? Was she “leading him on”? Judges routinely acquitted accused attackers if the victim showed no visible marks of violence or ripped clothing to indicate resistance. The onus was always on the woman to prove her case against a stone wall of skepticism and misogynist stereotypes. Because of that rush to judgment against the complainant, the overwhelming majority of rape victims (only 5% of sexual assaults were brought to the attention of the police in 2014, compared to 8% recorded a decade earlier, according to Statistics Canada in 1993)¹ did not report this crime to the police.

The “Jian Effect”

Gradually, painfully slowly, the balance shifted. More women were taken seriously by better-educated judges. Still, it was not until 2014 that the uphill struggles of the women’s movement began to gain greater traction. Ironically, the seismic shift began in October 2014, with an initial, low-key accusation of sexual harassment against a popular and apparently female-friendly CBC radio host, Jian Ghomeshi. Almost immediately, the usual protests, denials and exculpations came pouring forth — protests that were hugely enhanced through social media. Many of these came from his female friends, as well as from more typical sources. But this time, male reporters and male investigators were making the case against Ghomeshi, piling up more witnesses and more evidence day by day. The Ghomeshi defenders quickly fell silent.

By the time he was charged with four counts of sexual assault in late November that year, Ghomeshi’s reported actions had unleashed a tsunami of Internet fury. For the first time ever, women felt emboldened to tell their own truths about sexual assault, and the outpouring was so vociferous — tens of millions of tweets, circling the globe, using the hashtag #BeenRapedNeverReported — that the usual cacophony of derision and disbelief failed to materialize.

For six months, the front pages blazoned stories of campus rape, both here and in the United States. Names were named and men were openly shamed for outrageous sexual harassment online and in person. For the first time ever, the public consensus seemed to be against the accused harassers and rapists.

During that same time, the *Toronto Star* zeroed in on doctors who were caught in shocking acts of sexual violence against patients. Revealingly, the case that caused a wave of sympathetic public reaction was one in which women were preyed upon while anaesthetized and completely physically and mentally helpless. There could be no doubt in anyone's mind about the possible "complicity" of the victims in the notorious Doodnaught case.

By the end of 2014, Ontario's Minister of Health and Long-Term Care, Dr. Eric Hoskins, announced the creation of his Minister's Task Force on The Prevention of Sexual Abuse of Patients and the *Regulated Health Professions Act, 1991*.² A few months later, the Premier of Ontario, Kathleen Wynne, announced an unprecedented \$41-million, three-year initiative to curb sexual violence and harassment.³ Never before had a government taken such forceful action against such a pervasive and sensationally under-prosecuted crime.

Through Patients' Eyes

It would seem to be the perfect moment to shine a light, once more, on the crime of sexual abuse of patients by health practitioners. The public has never been more sympathetic or more willing to hear victims' versions and to insist on accountability for the perpetrators. Yet for the public, one more hurdle still has to be overcome. We have to get past our own deep squeamishness about a victim who is illicitly seduced, not physically forced, into sexual acts. It may be that the long history of negligence in pursuing and punishing the perpetrators of patient abuse lies in this difficulty: unlike many other forms of rape, this kind of sexual abuse almost never seems to result from force.

This chapter will attempt to address exactly these questions. It will also try to illuminate the answers through the actual experience of a number of abuse survivors who have come forward, either at the public hearings of the task force or in private sessions with the task force's investigators. For the government to succeed in curbing sexual abuse, it must have the support of the public. Only a widespread surge in the public's understanding of, and revulsion against, these secretive crimes can shore up our government's resolve. The regulation of health professionals is like a constantly moving body of water, with hidden shoals and tricky currents.

Precisely because the public must be helped to understand the nature of sexual abuse, survivors were willing to come forward and, with renewed pain and shame, tell their stories to the task force. The public must not

underestimate the trauma these people were willing to undergo in order to advance this work. It was a sacrifice for them, willingly undertaken for the greater good. We can thank them by stretching our imaginations and expanding our powers of empathy to hear what they are telling us.

Patient abuse is a deceptive and sometimes elusive crime. It is founded on a complete power imbalance between a patient and a practitioner: a patient is, according to the word's Latin roots, someone who is "undergoing, suffering or bearing" illness or trauma. In this vulnerable state, the patient seeks help, placing their trust in someone whom they believe will help relieve the pain. The psychological power of the father figure, the rescuer, the saviour, is enormous; even the most sophisticated and level-headed adult, in a vulnerable state, may yield to a health practitioner's greater wisdom and authority. Too often, the need for the practitioner's healing power is so great, and the trust so deeply ingrained, that the patient numbs him- or herself into returning to the healer, even after abuse has taken place.

To the public, the abusive situation can look very much like an "affair" — an indiscretion committed by two consenting adults. Picture this scenario, for example: a wise, older psychiatrist leaves his wife and is seen squiring a beautiful, much younger woman around town. She is vivacious, articulate and adoring. One's snap judgment might be that she is a "home wrecker," an unscrupulous young woman who has not let morality stand in the way of what she wants.

Now let the image of the beautiful blonde dissolve into its true, underlying picture: a terrified, abandoned six-year-old with haunted eyes, clutching desperately to the only hand that reached out to save her. Would that confused and frightened child be a home wrecker — or a victim?

"No one had any idea what to say to me"

Charlotte G. is that six-year-old frozen in time — and, later, "disguised" as an attractive woman. She was privileged, not only in her beauty and intelligence, but also in her upper-crust upbringing. Her large family is prominent in that city, but "I'm the one who lives in the shadows," she says wryly.

In grade one, this lively child caught the eye of her public school principal. Before long, he was summoning her to his office for private "special enrichment" classes. The sexual abuse continued all year, until the last

time he thrust his penis in her mouth — and she bit him. He lashed out so violently that the blow left her ears ringing and her sight blurred; she fled to the bathroom and curled up on the cold, tiled floor of the toilet stall until long after the last bell rang and the school was empty. No one at home asked her why she was so late.

The abuse finally stopped when Charlotte — in the cryptic way that children often convey difficult information — told her mother, “Mr. X is a bad man.” Her parents moved her to a different school. But nothing was done to hold Mr. X to account, or to help Charlotte heal. Within a family that had its own troubled secrets (her mother, too, Charlotte learned, had survived childhood sexual abuse), Charlotte learned to suppress her pain. She drifted through primary and secondary schools, suffering from severe anxiety and, for a while, anorexia. She had friends, but no boyfriends, and her arts training seemed to lead nowhere. At the end of her 20s, when a friend suggested that she might need therapy, Charlotte scrolled through phone numbers, seeking a psychologist or psychiatrist who wouldn’t just ask her if she were The first one who sounded kind, and who could see her almost at once, was Dr. W.

“His practice was in a friendly old house; the smell of furniture polish reminded me of my grandmother’s house.” For someone whose inner child trembled perpetually on the verge of extreme separation anxiety, Dr. W. was a saviour. He recommended daily psychoanalysis, and every morning at 7:05, Charlotte was there. And Dr. W. was always there too, waiting for her — even when she was late, even when she lay on the couch silently for days on end. His patience was her safe harbour.

“All my information was passed to Dr. W. . . . he had all the rights of the accused. He was surrounded by friends, family, colleagues, lawyers. For me, there was no one to shepherd me, no one to meet me at the door and say ‘hi,’ no one to tell me what to expect. . . . Then I heard absolutely nothing for a whole year and a half. Then I got a business-like letter saying he was guilty.”

Gradually, as the months turned to years, the relationship grew deeper, more intimate in tone. Strict psychoanalytic boundaries began to stretch and wobble. Dr. W. phoned her at home, “just to check in.” Once, they met at a coffee shop, and she was as thrilled as a schoolgirl. “I became the golden girl — he gave me free rein to come in and see him any time I needed to. And he was my god, my everything. I was beginning at long last to feel I was making progress, understanding what had happened to me.”

It was 10 years before Dr. W. came to her apartment. The first visit led to a kiss. “Did you like it?” he asked her in therapy the next day. “Do you want more?” “Yes,” she quavered in a tentative, girlish voice.

For the next eight years, she lived “under great fear of loss. I was very afraid of not being the good little girl or the lover he wanted.” His office felt like her home; he was as important to her as the air she breathed. He had a habit of popping into her apartment during his morning jog. Eventually, his marriage broke up and his “relationship” with Charlotte came more into the open. They went to the theatre and dinner parties together, all the while continuing the psychoanalysis. When he finally decided he had had enough, Charlotte almost went mad from need and grief and the gradual realization that she had let herself be exploited. She lost her job; “It was the abandonment of all abandonments,” she said.

The harm done by an abusive practitioner is difficult to calculate. In Charlotte’s case, an extremely fragile and vulnerable person was caught up in an almost infantile dependency on someone who knew very well the meaning of transference and who used his intimate knowledge of her psyche to manipulate her for his own gratification. He consumed the prime of her life, and robbed her of everything. “I have nothing...no job, no children, no career,” Charlotte said.

When a female doctor who was treating Charlotte after the breakup discovered what had happened, she followed the rules and reported the abuse to the College of Physicians and Surgeons of Ontario. Luckily for Charlotte, justice was swift. The investigation took place promptly and a horrified discipline committee took away Dr. W.’s licence to practise.

Yet, if you had seen this “couple” on the street or at a social event, you might never have suspected that a crime was in progress. It would have looked utterly consensual. Emotional victimhood is invisible. Like many other victims of crime, Charlotte is safe now, but still paying the price for what Dr. W. did to her.

“That chapter is engraved in my life”

More often, predatory sexual behaviour by a health practitioner does not wear the guise of “love.” Extraordinarily, victims who could not have prevented the abuse in any way are just as plagued by shame and guilt as those who might appear to have more agency.

Dee was one of the women preyed upon by the notorious anaesthetist Dr. George Doodnaught.⁴ He was sentenced in 2014 and is now serving 10 years in jail for his crimes. The record of his crimes clearly shows the sadistic pleasure he took in humiliating and debasing his prey. He deliberately maintained his patients’ anaesthesia at a level at which they were slipping in and out of consciousness, yet physically paralyzed. In other words, they could be aware of his repulsive actions, but helpless to stop them. At the same time, even though these women were as helpless as animals caught in a trap, Doodnaught tried to make them feel that they were the sexual aggressors.

Dee, a middle-aged woman undergoing surgery, was blurrily aware of the clock on the wall and the distant laughter of people around her in the operating room. “I thought I was dead because the laughter was far away and no one was with me,” she recalls. Suddenly, she felt Doodnaught’s hand manipulating her nipples under the surgical coverings. “I bet you like sex,” he hissed at her. When she tried to flinch away, he increased the anaesthetic. Next she became aware of his breathing in her ear. Something was in her outstretched hand — unbelievably, she realized, it was his penis. Dee felt him bend over her and mutter, “Just to be fair, *you* took it out.”

Eventually, Doodnaught was convicted on 21 counts of sexual assault. But during her recovery, Dee was alone with disgusting memories and confused sensations. “I was trying to deal with the pain of recovery in hospital, and

“*I’m stuck. I used to be an upbeat person, busy with knitting, needlework, reading. . . but now I can’t concentrate. I can’t complete anything. I get flashbacks, when I can’t breathe, my heart is racing. I’m not a trusting soul any more. I need more help.*”

I kept thinking, 'But why would I take it out?' And I was bothered by a recurring sensation of something awful in my mouth." She said nothing to her family and fought off a series of nightmares. "I was in shock, not quite living in reality...there was a big hum between me and the world, like being outside the window looking in."

It was not until the day Doodnaught was charged, and she and her husband were watching it on the news, that the dam broke. Her husband looked at her strangely and said, "What did he do to you?" And then, at last, she says, "The tears flowed."

The harm done to Dee was compounded by medical staff and other workers at the North York hospital where the assault had occurred. Ironically, her own job kept her in close touch with colleagues who knew the perpetrator. She frequently heard joking and dismissive remarks about Doodnaught's victims; when she told her own doctor, who had referred her to the surgeon who worked with Doodnaught, he laughed it off. "Oh, you were hallucinating because of the anaesthetic," was his jolly response.

Nothing is as wounding and destabilizing to a victim as not being believed. Dee left her long-time position and is now more happily employed elsewhere, but the demeaning dismissal of her suffering still rankles. It is some comfort that so many other victims came forward. "We got no support from the college, but four or five of us patients have been in touch on the phone quite a bit, helping each other through it."

It was much later that Dee was diagnosed with post-traumatic stress disorder. Even now, five years later, it's hard for her to concentrate on tasks she used to enjoy, and she avoids crowds ("Everyone started looking like Doodnaught, and I couldn't breathe") and can't take the subway. Doodnaught, although in jail, still has his licence to practise although it has been suspended by the CPSO.⁵

The ugly truth about health practitioners who commit sexual abuse is that they choose their victims with finely tuned instincts for the most vulnerable prey — exactly the patients they are sworn to protect. In Dee's case, she was physically immobilized; in most cases, the chosen victims have vulnerabilities that are less tangible but that render them equally helpless.

"I will never be the same"

Ann G. was sensitive and anxious; as a child, she had been diagnosed with attention deficit disorder. She struggled to please her distracted parents, both

“ I hate being a victim! I hate that my entire life story is now common knowledge. I hate that I am often turned inside-out just to bring this man to justice. ”

busy professionals. As an adult, Ann found herself with two very young children, a distant and angry husband and an overwhelming challenge: her father was dying of AIDS (contracted in his medical practice), while her mother was succumbing to cancer.

An only child, Ann worked frantically for almost a year to nurse her father in his home. It was a gruelling task, both physically and emotionally, in the days when AIDS patients were shunned and there were no antiretroviral drugs available. Ann frantically tried not to neglect her two small children, or infect them with HIV. By the time her father died, she was also coping with the death of two grandparents who had provided love and stability in her childhood.

Overwhelmed, Ann sought grief counselling from a “stress management psychologist” and hypnotist recommended by a friend. Soon, she was captivated by the emotional “support” offered by Dr. L. There were reassuring hugs, small gifts, touching that went just over the line of propriety...and several odd practices. Dr. L. always locked his office door after Ann entered. He always offered her a paper cup of juice and pressed her to drink it; she wonders now if it was drugged. She describes “an altered state of consciousness” in which she numbly acquiesced to his sexual demands.

The year-and-a-half with Dr. L. pushed Ann into a netherworld of shame, self-disgust, guilt and despair. Even now, years later, her current therapist concludes that she has not recovered. Before she began seeing Dr. L., she could be described as functional, although one of the “walking wounded”; after Dr. L., after her hearing at the college, during which she felt exposed and violated, and after the retraumatizing horror of having to testify again two years later, when Dr. L. appealed his conviction, Ann has descended into a state of “chronic post-traumatic stress disorder.” Her business failed, her husband left and she could barely count all that she has lost. Dr. L., however, is back in practice.

It is quite possible that — even now — Dr. L. is seducing another fragile patient into sexual intimacies that will eventually erode her sense of self and fray the fabric of her life. Health practitioners have undeniable authority and emotional power over their patients, and because the public so often fails to understand the plight of the victim, there is little public outrage or demand for change.

Many of us, for example, find it difficult to picture the stark isolation that can trap someone as surely as Dee was trapped on that operating table. If you looked at Scarlet, a poised and attractive woman with a melodious voice and a very self-controlled, contained manner, you would never dream that she could have lived through a terror scenario as extreme as that of a victim in a horror movie.

“There was no victim support”

Scarlet and her former husband were both successful . After Scarlet suffered serious injuries in an accident at work and had to take prolonged medical leave, the couple moved with their small children to what they thought of as an idyllic retreat in the countryside north of Toronto, where they became extremely close to members of their evangelical congregation.

Instead of recovering, however, Scarlet found herself struggling with excruciating chronic pain, while her husband began to show frightening signs of psychological imbalance. “This kind, nice man I’d known for years suddenly turned psychotic,” she recalls with pain. He began to bring home weapons of every kind. He menaced Scarlet and even the children with the weapons. Gradually, his rages escalated to violent attacks. Scarlet deeply believed in her faith’s injunction to stay true to her partner and to work to

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At the lowest point of your life, it’s so hard to find your words and your composure. The self-stigma is terrible; the voice of the abuser carries on in your head.

”

build a loving relationship. But when she sought help from her pastor, he seemed to blame her for the troubles. When she began to fear for her life, she quickly learned that her husband's close friends would insist that she was lying about the violence.

Scarlet needed a doctor to treat her chronic pain, and she found a highly respected practitioner in her congregation. By now, the strength and competence she had shown in her working life had been chipped away by fear and panic about her children's safety, by isolation and by the chronic pain she was suffering. She was easy pickings for a medical doctor who was by turns gentle and then aggressively domineering. He cited the Bible when he wanted to bend Scarlet to his will, and, when she resisted, he threatened to write to her _____ and tell him that her injuries were fabricated. Scarlet desperately needed her sick leave pay in order to make a planned escape from her husband, so she gave in to the doctor's demands.

Scarlet's religious beliefs only deepened her internalized guilt and shame. She became as cornered and isolated as it's possible for a person to be, and her own self-blame became part of her invisible prison.

It was not until she learned that her doctor/abuser had — shockingly — deliberately kept quiet about some test results that showed her health to be endangered that Scarlet was outraged enough to phone the college and report his medical delinquency and his sexual aggression.

The college's hearing process was as emotionally brutal as a criminal trial is for a rape victim. "I had no emotional support — he had his lawyers, he had the support of the congregation, he was there claiming it was consensual, and at the lowest point of my life I had to be organized and credible as a witness. The whole time, the voice of the abuser was in my head — it was so hard to forgive myself for being so stupid."

The doctor lost his licence at that hearing, but he appealed — and Scarlet had to go through the demeaning and lonely battle once more. "I was outgunned, not in control. My voice, my whole experience, was never heard."

The burden of being a witness at the discipline hearing is so great — and the imbalance of power so unfairly reinforced by the victim's lowly and humiliated status as a mere witness, all of whose evidence is placed in the hands of the accused — that it's no mystery why so few patients come

forward. Once again, the public seems in the dark; our indifference plays into the hands of the predators.

“I felt like a pawn”

Let’s look at the case of Tom, now 28 years old. Tom is a pleasant-looking young man who looks 10 years younger than he is, with nervous social mannerisms and an anxious expression around his eyes. It’s not possible to understand why or how Tom succumbed to abuse without first grasping the emotional desert of his childhood and adolescence. In an oppressively conventional suburban home in a southern Ontario city, his parents were distracted by their own problems (the father has never admitted his secret gay liaisons, though his children had long known, and his mother was chronically depressed), and so Tom grew up in loveless neglect.

“Nothing ever felt right to me,” he says, thinking about his childhood. He was shuffled off to special education classes and labelled as having attention deficit hyperactivity disorder. “It was driven into me that something was fundamentally wrong with me...no one ever bothered to ask *me* what was wrong.”

Tom was tormented by social isolation throughout high school, inept at his studies although clearly very intelligent, and plagued by _____ and moods of hopelessness. When he was 19, Tom took himself to a psychologist who was recommended by his family doctor. Dr. B. began “relaxation exercises” during the counselling sessions — massaging Tom’s shoulders and chest, and gradually becoming more and more slyly sexual.

Tom was alarmed and confused by this gradual encroachment. He prides himself now on “keeping tuned in, keeping lucid” and not blanking out as Dr. B.’s hands went further and further. In the next breath, though, Tom admits that there are gaps in his memory of these events and that he sometimes felt disassociated — it’s hard for him to remember, for example,

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I left those sessions feeling weird and detached. I told myself I was remembering wrong. After, my self-blame was that I kept going back.

”

how long he attended counselling with Dr. B. He left the sessions rattled enough that he felt detached from reality: “What the f—, did that really happen?” he would think. With his girlfriend, who expressed shock at his description of events, he slipped readily into denial. “No, no — he’s professional; he would never do that on purpose,” he remembers saying.

To a teenager with a shaky identity and fragile self-worth, the aftermath was devastating. Tom cut off the therapy with Dr. B. but found himself increasingly defiant of authority and deeply distrustful of therapy. In his second year of university, after leaving Dr. B., Tom spiralled downward into chaos and self-harm. During his first year at school, he had forced himself to break out of his isolation, trying to make friends and becoming a joiner. After his experience with Dr. B., Tom retreated into a whirlwind of alcohol, violent tantrums, cocaine and even overdosing . Tom was in imminent danger. He still bears many knife scars from slashing himself.

“People don’t get it. You don’t cut yourself because of the pain; you do it when you’re so numb, you have all these terrible swirling feelings that are pressed down and not going anywhere...you don’t know what you feel, so you cut to feel anything. And it’s very effective.”

Somewhat miraculously, Tom’s life is now back on track. A therapist who helped him reported Dr. B. to the college, and when Dr. B. lost his licence, Tom seemed to regain some focus and composure. “I thought, maybe I have it in me to be more than a coked-up drunk f— up.” He began seeing a former girlfriend, started doing better in his studies, auditioned successfully for local amateur theatre and is now planning on going to graduate school. It may be that when the world (in the shape of the college) reflected back to him that he was a victim of an abusive therapist, he felt vindicated for the first time in his life.

“I’ve been diagnosed with PTSD”

No one should ever underestimate the terrifying vulnerability of people who might look perfectly fine on the surface — and the havoc an unscrupulous therapist might inflict on that person’s life. Janie was performing superbly at her professional administrative job , but behind the scenes, she was struggling in a number of unproductive ways to deal with the aftermath of|

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There are invisible scars. The biggest misconception about all this is the idea that “Well, you weren’t hurt.” But a shrink does lasting damage if he messes with your head.”

”

Janie was an activist in her community, a lively organizer of family events, the centre of a large circle of friends and well-loved by her husband. At the same time, she was falling in love with a woman and secretly clawing her way through confusion about her sexual identity. In the midst of all this, her son was diagnosed with attention deficit disorder and referred to a psychiatrist.

Janie began to wonder whether the psychiatrist could help her, too. A year and a half into the therapy, the doctor declared his love for her. “I knew nothing then about transference and counter-transference,” Janie says ruefully. “I questioned the appropriateness of it but I couldn’t resist his advances. We both came from religious families and he tried to persuade me that ‘priests do this, and are forgiven.’”

He showered her with expensive gifts, flooded her work phone with imploring messages whenever she stayed away, deluged her with e-mails and handwritten letters — and kept increasing her prescriptions for sleeping pills and tranquilizers.

Janie’s over-stressed life began to implode like a collapsing tower of cards. Her husband discovered the letters and ordered her out of the house; her father died; she lost her job; soon after coming out and beginning an open relationship with her girlfriend, she was diagnosed with a potentially lethal cancer. “The doctor actually told me to begin planning my funeral.”

It turned out to be easier to beat the cancer than it was to cope with the aftermath of the psychiatrist’s sexual predation. “Therapy for post-traumatic stress disorder is very, very hard,” she says now. “You have to revisit and visualize all the trauma.” She still throws up whenever she sees someone who resembles her former psychiatrist. She still suffers from the shame. “It’s a question of ‘power over’...the violence happened in my head and the scars are invisible.” People’s biggest misconception is that “you didn’t fight back, so it was consensual.”

Janie's life is happier now, and the turbulence has subsided, but the impact has been staggering and permanent. "I lost my home, the cottage, my income — and I lost a circle of friends and family who think I was 'having an affair.'" One of the worst outcomes has been a new element of distrust in her life. She still has occasional symptoms but is unwilling to see a doctor.

"I felt so violated by it"

Let the last word go to Neil. Neil is a medical practitioner himself who was brave enough to state a truth that few want to admit. Much of the shame and self-blame, much of the lasting harm done in a victim's mind, stems from the fact that the body may respond, willy-nilly, to an unwanted sexual overture. This is part of what tangles the patient's emotions into a knot of guilt and inner torment.

Neil was an 18-year-old student, a happy-go-lucky kind of kid who had just proudly shot up in height and had begun dating Rose, the young woman he would eventually marry. A sore in his mouth took him to see a doctor in the outpatient service at a downtown hospital.

"He told me to take off my shirt and lie down on the examining table. I thought that was weird, but I co-operated...and then he started undoing my pants." When Neil protested, the doctor insisted a general exam was necessary. He not only fondled Neil's genitals but also started to do a prostate exam.

Neil was horrified and embarrassed — and had an erection. "I jumped off the table and ran to the bathroom. I felt so violated, I was totally thrown by it." He left the hospital in such haste that he didn't remember the doctor's name. But that one incident, and his body's betrayal, had a profound impact. He tried to bury the memory; he worried that something was wrong with him; he was plagued by nightmares and gradually became anorexic. It wasn't until he had therapy for sexual abuse that he overcame these fears

"Until then, I liked my body. I had just grown up, I had just started dating. But afterward, I hated my body. I became anorexic. I wouldn't let anyone touch me."

and symptoms, but he was left with a lifelong aversion to being touched. “It just happened to me at the wrong time,” Neil reflects. “I was so vulnerable at that age.”

Moving Forward: The Aftermath of Abuse

Sexual abuse by an authority figure — a person who has power over you — plays havoc with a patient’s thoughts and emotions. Every testimony heard by the task force resonates with the pain of being made complicit in one’s own debasement, even though what happened was a crime. That experience can reverberate throughout a lifetime, at terrible cost to the victim and to society. And yet, for the most part, there is no punishment for the aggressor, no being held to account — and no societal redemption for the victim.

Every person who told her or his story to this task force did so with renewed embarrassment and pain, often with anguished tears — and did it solely for one reason: to urge the public to hold health practitioners accountable when they ruin the lives of the people who come to them for help.

We hold the power — the power of public outrage and public pressure — to strengthen the safety of patients and protect the victims of abuse. We can, as a society, decide that this pattern of irresponsible interference with patients’ integrity and impunity for molesters is no longer acceptable at any level, and that those who have allowed it to continue unchecked for so long must now be held to account. This is the thrust and the determination of this report, of the task force members and of the courageous patients who dared to speak their truths. We owe them no less.

Endnotes

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Chapter 4: The Why and How of Ontario's Zero Tolerance Standard

The Why of Zero Tolerance

Introduction

Patient safety means public safety for all Ontarians. The sexual abuse of patients by regulated health professionals affects our entire society, because we are all patients within the health care system. Ensuring patient safety within our system is primarily the responsibility of the government of Ontario, through the Ministry of Health and Long-Term Care (MOHLTC). For more than 100 years, however, the Ontario government has chosen to delegate its regulatory authority for patient safety to self-regulating health profession colleges. Vigilant and thorough oversight of these colleges through legislation is therefore crucial to the safety of all Ontarians.

Ontario was the first jurisdiction in the world to set an explicit zero tolerance standard for the sexual abuse of patients. To this end, and to ensure that the authority and trust invested in Ontario's self-regulating health professions are focused on public interest, the legislation regulating health professions requires a clear articulation of core standards and values.

In Ontario, systematic reviews over more than 20 years have resulted in legislation such as the *Regulated Health Professions Act, 1991* (RHPA) and its *Health Professions Procedural Code*, and implementation strategies to strengthen policies and practices designed to eliminate sexual abuse by dismantling inadequate practices (see Appendix F). A crucial question forms part of the mandate of this task force: Is everything possible being done to reach the zero tolerance standard in Ontario, including adequate support for those patients whose reports of abuse are essential to creating and maintaining effective complaint-driven regulation?

The standard of zero tolerance originates from a proposal made by Patricia Freeman Marshall, who was a member of the Independent Task Force on

Sexual Abuse of Patients commissioned in 1991 by the College of Physicians and Surgeons of Ontario (CPSO). In order to provide a perspective on the evolution and importance of zero tolerance, Ms. Marshall was asked to provide her personal reflections and analysis in the following section of our independent report to the Government of Ontario. Any recommendations influenced by Ms. Marshall have been authored by the task force.

By Patricia Marshall

The Independent Task Force on Sexual Abuse of Patients, 1991: History, Process and Outcomes

Almost 30 years ago, in a 1986 brief to the Ontario Health Professions Legislation Review (HPLR) from the Metropolitan Action Committee on Violence Against Women and Children (METRAC), I described the harm done to women by health professionals who were sexually abusing them, and the difficulty these women experienced when they complained to the regulatory colleges. In light of this reality, METRAC recommended changes to the complaints process, including the creation of a single complaints committee through which all the regulated health professions could deal with sexual abuse complaints; the creation of an advocacy office; and full participation through party standing for complainants at the discipline hearings. I believed then — and I still believe today — that only by naming the tolerance of sexual abuse could we ever effectively eliminate it. I also believed that a new, zero tolerance standard for sexual abuse was the only way in which patient safety could be adequately ensured within the health care system.

Five years later, in 1991, CPSO created the Independent Task Force on Sexual Abuse of Patients, of which I was a member.¹ During its hearings, task force members listened carefully to patients who spoke powerfully about the pain of the abuse they had suffered and the ongoing damage they were experiencing. Their lives had been drastically altered by the criminal conduct of their trusted doctor — abuse that often occurred when these patients were physically or emotionally at their most vulnerable.

The 1991 task force reported on practices throughout CPSO that indicated a high level of tolerance of sexual abuse. In the opinion of the task force, these practices included inadequate policy development; little specialized training of staff and college members vis-à-vis sexual abuse; insensitive, inadequate responses to complainants that included long delays, no responses or complaints seemingly evaporating into thin air; high attrition rates for

complaints after ineffective or inadequate investigations; and no mechanism for third-party reporting in a complaint-driven system. As well, CPSO had no formal mechanism addressing the prevention of repeated sexual abuse by physicians. The 1991 task force met subsequent victims of doctors who had been found guilty, lightly sanctioned for their “impropriety” or “misconduct” but allowed by CPSO to continue practising medicine.

Outcomes of the 1991 Task Force

In its report, the task force submitted 60 detailed recommendations that outlined how the government and CPSO could support the zero tolerance standard to which CPSO had committed. The offences of sexual impropriety and sexual violation were defined. A finding of guilt for sexual violation included a mandatory licence revocation for five years and a fine of \$20,000. At the end of that five-year period, the task force recommended stringent requirements to be met by the offending doctor if re-entry to the profession was sought.

In addition, it was recommended to CPSO that there be no sexual contact between a patient and her or his practitioner for a two-year period following the termination of the professional relationship between them. For a

Zero Tolerance: Guiding Principles

The 1991 task force report set out the guiding principles of zero tolerance, which include the following:*

- that there is no tolerance of sexual abuse by physicians or of the ways sexual abuse by physicians is implicitly supported;
- that doctors and the public are sufficiently educated so that abuse cannot occur out of ignorance by either party and that the harms of the abuse are fully understood;
- that there is full support of touch as a crucial, healing part of the practice of medicine when that touch is caring and nurturing, and not sexual or exploitive; and
- that there is full support of due process for the physician.

**The Final Report of the Task force on Sexual Abuse of Patients, November 25, 1991, pp. 15-6.*

psychotherapeutic relationship, however, a complete prohibition on any future sexual contact between physician and patient was recommended. It would also be mandatory for a member to notify CPSO if he or she had a reasonable belief that another member had engaged in sexual impropriety or violation; the college was to maintain records of such reports. Although the 1991 task force reported only to CPSO, its findings were taken seriously by the Ontario government as part of an ongoing review of government responsibilities in regulating health care more generally.

Legislation enacted after the final report of the 1991 task force, principally the *Regulated Health Professions Act, 1991* (RHPA) and its Schedule 2, the *Health Professions Procedural Code*, mandated reporting by facilities if there are reasonable grounds to suspect that a member is incompetent, incapacitated or has sexually abused a patient.² New safeguards included practices, policies and procedures that were put in place to prevent the sexual abuse of patients. Information on the disposition of complaints of sexual abuse by hospital staff or patients was also to be included, and fines would be imposed for any non-compliance, as part of the powerful, transparent process of accountability with full stakeholder participation recommended by the task force.

In 1994, the zero tolerance standard for the sexual abuse of patients was codified in amendments to the RHPA. This new standard applied to all Ontario health professions regulated under the RHPA.³

Resistance to the 1991 Task Force Recommendations

Although the zero tolerance standard was the first of the task force recommendations adopted by CPSO, significant resistance appeared: no doubt some doctors felt threatened, perceiving risk to the continuation of self-regulation. In context, this resistance reflected the larger society's tendency to distrust the abuse victims' accounts, as well as the general lack of awareness about sexual abuse of patients. For example, there was limited understanding of the fact that under-reporting of sexual abuse is common, that the harms and risk of harm of patient sexual abuse are great, that false accusations are statistically quite rare and that the mandatory revocation of abusers' licences serves the profession well by building the public's confidence in CPSO's ability to govern the conduct of its members in the public interest.

The emergence of a zero tolerance approach can be seen as central to inquiries in a larger context — principally the work of the Canadian Panel on Violence Against Women, established in 1991 by the Government of Canada, which undertook the largest and most comprehensive national review of violence ever conducted in the world. As co-chair of the panel, I participated in extensive hearings and research, including new findings on the pervasiveness of sexual violence, that revealed a starkly different picture of Canada — an often invisible landscape of violence in communities, held in place by a web of tolerance.⁴

Like the 1991 task force in Ontario, the panel heard heart-searing testimony from survivors of sexual abuse by health professionals in other parts of Canada — testimony that included tragic inaction by health institutions in several provinces. The panel also heard how the extensive use of the biomedical model, with its artificial separation of physical from psychological health, worked against effective treatment for some abuse survivors. Both the 1991 Ontario task force and the national panel heard how prior sexual abuse was not identified, leading to years of costly *missed* diagnosis and *misdiagnosis* — not identified as a competency issue that was worthy of an oversight response from the health practitioner’s college.

If the panel’s implementation plan had been adopted nationally, it is possible that institutions — including the Canadian Armed Forces, the Canadian Broadcasting Corporation (CBC), hospitals, self-regulating professions, universities and colleges — could have had more effective prevention and response protocols and policies in place that would have mitigated against the individual and institutional harms being documented by the media today.

The Special Task Force on Sexual Abuse of Patients, 2000: History and Process

Almost a decade after the 1991 task force recommendations, the Health Professions Regulatory Advisory Council (HPRAC) commenced a mandatory five-year review of the RHPA (1994–99). As the review progressed, it became apparent that information from patients in Ontario (about the RHPA amendments to address sexual abuse) was not being sought.⁵ Early in 2000, the Minister of Health and Long-Term Care asked Marilou McPhedran to assemble another task force “to conduct an independent inquiry into the experience of patients and members of the public on the subject of sexual abuse by regulated health professionals in Ontario.”⁶ Unlike the 1991 task force’s focus on CPSO, however, this time patients were invited to recount

their experiences with any of the 21 health regulatory colleges that were then regulated by the RHPA.

Again, the task force listened to powerful and painful testimony from patients who had been sexually abused by health care practitioners, and from patients' families and advocates, who also gave compelling testimony at the task force hearings. Several witnesses reported that, in their experience, the CPSO had reneged on its previously strong commitment to zero tolerance and had "diluted" some of the early changes it had made in response to the 1991 task force recommendations. At task force roundtables, some of the colleges expressed concerns about the burden that the implementation of new programs to prevent sexual abuse would impose on them. There were also concerns expressed about the duplication of services across the colleges, particularly in relation to complaints of sexual abuse.⁷

In its final report,⁸ the 2000 task force made 34 recommendations. These included a new legislated patients' bill of rights, which was to be posted within every health professional's premises and that would include the definition of sexual abuse in the RHPA, as well as contact numbers and clear information about how to make a complaint. Zero tolerance was to be reaffirmed as the essential standard that would, going forward, guide the development, implementation and evaluation of all policies and practices designed to stop sexual abuse by health practitioners. Clear reporting and transparency mechanisms included use of the zero tolerance standard for any future reviews of the RHPA. The task force also recommended a variety of initiatives to ensure the implementation of the zero tolerance standard through a comprehensive approach to preventing the sexual abuse of patients.

International Uptake of Ontario's Zero Tolerance Standard

Since the zero tolerance standard for sexual abuse was first introduced in the 1991 task force report, it has been widely adopted and adapted. For example, the Zero Tolerance Charitable Trust, launched in 1994 and based in Edinburgh, works to prevent the abuse of women and children in Scotland; Google instituted a zero tolerance policy on child sexual abuse content; and the international organization PLAN notes that the zero tolerance standard lies at the heart of its "Because I am a Girl" campaign. As well, in the United Kingdom (UK), the Halton Domestic Abuse Forum uses a zero tolerance approach; and in Halton, Ontario, the Regional Council's recent zero tolerance strategy includes police, survivors and advocacy organizations

in the campaign to eliminate violence against women. As well campaigns to reduce violence against nurses have adopted a zero tolerance standard in Ontario, Australia and the UK.⁹

Several bodies in the United Nations (UN) have made commitments to a zero tolerance standard for violence against women and girls, demonstrating a significant policy impact worldwide.¹⁰ Many UN member countries have undertaken anti-violence projects since then, with reference to a zero tolerance policy standard. In 2012, the UN also established the International Day of Zero Tolerance for Female Genital Mutilation,¹¹ and in 2013 the UN peacekeeping office adopted a zero tolerance policy governing the sexual exploitation of civilians in conflict zones by personnel.¹²

It should be noted, however, that the zero tolerance standard has sometimes been used merely as an attention-getting slogan, with results that are rarely positive. The term can also be used as a “measuring stick” of the difference between bloated language and effective leadership. Madam Justice Deschamps (now retired) recently recommended (in 2015) the creation of an independent agency to deal with abuse complaints in the Canadian Armed Forces, thus exposing the hollow nature of the Forces’ formal commitment to zero tolerance. The Vatican’s espousal of zero tolerance in a February 2015 letter was released amidst compelling examples of Church-tolerated abuse by clergy in many countries. As well, the Ontario Human Rights Commission has raised concerns about the enforcement of zero tolerance policies in schools that resulted in targeting disadvantaged students.¹³

Zero Tolerance and Education within the Regulatory Colleges

The 1991 task force recommended the creation of a Patient Relations Committee (PRC) within CPSO, to be a catalyst for organizational change through the development of bold, proactive educational programs complemented by clear zero tolerance practice guidelines. The 1994 amendments to the RHPA introduced the PRC function to all of the regulatory colleges as internal accountability mechanisms, with internal education as well as supportive patient-outreach programs seen as integral to the viability of self-regulation. It is difficult, however, to discern fully functioning PRCs in CPSO or other regulatory colleges, perhaps due to removal from the HPRAC mandate to monitor colleges regarding sexual abuse cases and public education — meaning that, for the most part, there has been no meaningful oversight of PRCs for more than five years now.

Zero Tolerance and College Disciplinary Proceedings and Decisions

Bringing perpetrators to justice within the regulatory college disciplinary system is a complaint-driven process, and one in which complainants can experience a significant degree of trauma and uncertain outcomes, in addition to the original harm.

Effect of Proceedings on Complainants

In some cases, medical and psychiatric evidence has been allowed by colleges in ways that do not uphold the zero tolerance standard. For example, the use of patients' medical records in attempts to attack their credibility and advance the health professional's case is still allowed by some colleges.

There are serious implications for public safety every time a complainant witness is insensitively treated or — unable to bear the stress of the disciplinary hearing — withdraws her or his complaint. Patients have described themselves as feeling “disposable” and frustrated, with no direct say in a process in which they are deeply invested. Although most patients launch a complaint feeling that there is hope for a just outcome, their traumatic experiences in the disciplinary hearing far too often shatter those expectations. These kinds of experiences would likely be ameliorated by according party standing to patient-complainants and developing protocols to protect from unduly harsh and abusive cross-examinations — of all parties. Although colleges have the discretion to grant party status to patients, this has seldom happened.

“The CPSO allowed my psychiatric records to be used against me and against my vehement protests yet nothing from the doctor's psychiatric history was brought forward. And the psychiatric records were proven factually inaccurate and distorted but nevertheless it was all dragged out and I had no legal standing or protection.”

– Patient

Effect of Decisions on Complainants

Decisions and penalties imposed by colleges that do not uphold the zero tolerance standard minimize the severity of the behaviour and its significant adverse impact on the patient. The CPSO decision in *Maharajh* is a clear example of this kind of decision. The committee wrote that it considered it to be one of several mitigating factors that “he had no previous Discipline Committee findings,” even though it had already received the information that he voluntarily brought forward information on similar conduct with 10 or more other women patients. This decision overlooked the future risk of harm arising from allowing an abuser to continue to practise.¹⁴

The assumption that a boundary violator will confine himself to a single boundary violation, and the dependence by the college on abusers informing their patients that the abuser’s practice has been restricted, fail to uphold the zero tolerance standard in the RHPA. For example, Dr. Sharif Tadros, one of approximately 20 doctors reported in late 2014 to be in practice in Ontario with gender-based restrictions, recently admitted that he continued to treat female patients in his office and at a clinic in spite of the CPSO’s prohibition.¹⁵

Allowing the voluntary resignation of health practitioners in the midst of a patient’s sexual abuse complaint when there is evidence of abuse is also an inadequate disciplinary response, because it lacks recognition of the very real potential risk of harm from the alleged abuser, who may opt to move and practise in another jurisdiction. The College of Psychologists of Ontario (CPO), for example, allowed a member to resign from the college and undertake that he would “never reapply for or resume practice as a registered psychologist anywhere in the world at any time.”¹⁶

A lack of transparency in decisions raises concerns about accountability to patients in the public interest. For example, in the *Redhead* decision (see Appendix G), the CPSO used a pseudonym for a physician in a subsequent disciplinary hearing of his colleague, Dr. Redhead, some 23 months after the CPSO decision to revoke that physician’s registration.¹⁷ Protecting the identity of a doctor after publicly announcing revocation, does not uphold the zero tolerance standard, nor is it consistent with the current transparency promises emanating from some colleges, including the CPSO, nor can it be logically defended as protection of the patient’s identity when so much personal detail was included in the subsequent hearing of Dr. Redhead.

Mandatory Reporting Provisions and Institutional Failings

Robust enforcement of mandatory reporting provisions is a key component of the complaint-driven process. Only when abusers are identified and stopped can their potential to devastate more lives be halted. Lack of enforcement by colleges and by the Ministry of Health and Long-Term Care under the mandatory reporting requirements of the RHPA undermines patient safety and does not uphold the zero tolerance standard.

HPRAC and Zero Tolerance

The Health Professions Regulatory Advisory Council was created in the 1994 amendments to the RHPA as the designated review mechanism. A review of materials supplied by HPRAC revealed an early application of the zero tolerance standard. Sexual abuse prevention plans were developed and delivered by the colleges to HPRAC in a timely manner — a welcome start to achieving zero tolerance goals. After a decade, the records indicate a shift, however, and by 2006, HPRAC recommended that PRCs be abolished — something the Minister of Health and Long-Term Care refused to do.¹⁸

In 2008, HPRAC recommended a broader approach to patient relations that further diluted the essential function of the PRCs to improve the colleges' responses to the sexual abuse of patients.¹⁹ In 2012, HPRAC recommended the creation of an exemption in the RHPA that would remove from the sexual abuse provisions the prohibition around health practitioners treating their spouses.²⁰ This recommendation was implemented as an option for the colleges with the passage of Bill 70 in 2013.²¹ The CPSO and CPO thereafter decided that there could be no spousal exemption that is consistent with the zero tolerance standard, given the imbalance of power in the relationship between health professional and patient. By mid-2015, only the Royal College of Dental Surgeons of Ontario (RCDSO) had created such a regulation, which allows its members to treat spouses.

Can Self-Regulation Achieve Zero Tolerance of Sexual Abuse?

Each college is a concentrated repository for the specialized knowledge of its health profession. It is this base of expertise around health-related issues common to its profession that should have made the colleges well-suited to regulate the practices of their members while upholding patient safety in the public interest. As discussed in the recommendations made by this task force, sexual abuse of patients is an exception. The highly trained

expertise of the health practitioner who serves as a college member does not necessarily extend to an adequate knowledge base and expertise in the complex realm of sexual abuse. This has been demonstrated in some of the more recent decisions by colleges — for example, those allowing doctors to return to practise with only “gender restrictions.”

Why Has Achieving Zero Tolerance Been So Difficult?

Society’s ingrained tolerance of sexual abuse is generally invisible until an abusive incident becomes the focus of media attention, often revealing inadequate institutional responses to sexual abuse. While media coverage is a crucial aspect of accountability, the flurry of activity following a media story can decline soon after the media spotlight disappears. For more than a decade, there has been little or no investment of public funds to sustain patient advocacy and patients’ voices as essential to long-term viable accountability in the public interest.²²

Institutional Responses

The zero tolerance standard cannot thrive in a culture of tolerance of sexual abuse. We need more institutional leaders to make reducing tolerance for sexual abuse a priority on par with all other aspects of their patient safety protocols. Tolerance of abuse and resistance to the zero tolerance standard have had tenacious holds on institutions. There can be an unequal match between an alleged abuser, who is well-known in the institution and holds a position of trust, and an often vulnerable complainant–victim whose credibility may be easily shredded and whose resources seldom match those of the institution and the professional.

“The reality is that many of the disciplinary actions are not made public and many of the complaints are not made public even after they are investigated and dealt with, which leaves the public and patients in the dark about anything that’s gone on.”

– Patient advocate

Every institution that does not make sexual abuse prevention a stated priority with allocated resources is leaving those within it vulnerable to sexual predators. This institutional breach of trust is, unfortunately, aided by ineffective policies and practices that are inconsistent with the zero tolerance standard.²³

Conclusion: Achieving Zero Tolerance and Ensuring Patient Safety

The iceberg that is the sexual abuse of patients has remained frozen for far too long — it must be dissolved. The establishment of new, fair and effective processes to increase the reporting of complaints, reduce abuse significantly and provide public accountability is overdue.

From three decades of supporting sexually abused patients, I know all too well that “one is too many.” Those with the ability to effect change need to reflect on the heartbreaking and tragic harm that sexual abusers have perpetrated over the years under the protective cover of tolerance by those around them. Insufficient implementation after the 1991 task force and almost no implementation after the 2000 task force — for example, inadequate monitoring by the regulatory colleges and the Ministry of Health and Long-Term Care — have shattered lives. The public of Ontario is composed of patients, and they — we — deserve more.

Notes

1. The 1991 independent task force, appointed by CPSO, was chaired by Marilou McPhedran, with myself, Patricia Freeman Marshall; Dr. Harvey Armstrong; Dr. Rachel Edney; and Roz Roach as members. See http://www.cpso.on.ca/uploadedFiles/policies/publications/Sexual-Abuse-Patients_Task-Force-FinalReport_1991.pdf.
2. *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991* (RHPA), S.O. 1991, c. 18, s. 85.2, retrieved from <http://www.ontario.ca/laws/statute/91r18>.
3. *Health Professions Procedural Code*, ss. 1(3), 51(5).
4. The Canadian Panel on Violence Against Women, *Changing the Landscape: Ending Violence, Achieving Equality*, 1993, pp. 114-210, prepared for the Minister of Supply and Services Canada; see also Haskell, L., and Randall, M., *Sexual violence in women's lives*. Findings from the Women's Safety Project, a community-based survey, 1995. Violence against women, 1, 6–31. Retrieved from <http://www.lfcc.on.ca/chanland.htm>.
5. See Health Professions Regulatory Advisory Council, *Adjusting the Balance: A review of the Regulated Health Professions Act*, 2001, p. 119, retrieved from http://www.hprac.org/en/reports/resources/RHPA_2001.pdf.
6. Marilou McPhedran et al., *What about accountability to the patient? The Independent Final Report of the Special Task Force on Sexual Abuse of Patients*, 2000, p. v. The 2000 task force was chaired by Marilou McPhedran, with myself, Dr. Harvey Armstrong, Dr. Briar Long and Dr. Roz Roach as members. Retrieved from <http://booksnow2.scholarsportal.info/ebooks/ebooks2/ogdc/2014-02-24/3/10288765/10288765.pdf>.

7. Ibid.
8. Ibid.
9. For example, the Registered Nurses' Association of Ontario has a policy on zero tolerance of violence against nurses. See <http://rnao.ca/policy/position-statements/violence-against-nurses>, retrieved July 21, 2015.
10. See "Joint Statement by Heads of UN Agencies on Ending Violence Against Women and Girls," (2013), retrieved from <http://www.unwomen.org/en/news/stories/2013/3/joint-statement-by-heads-of-un-agencies-on-ending-violence>.
11. See <http://www.un.org/en/events/femalegenitalmutilationday>.
12. See <http://www.un.org/en/peacekeeping/issues/cdu.shtml>.
13. San Martín, I. (2015, February), *Francis tells bishops to back 'zero tolerance' on sexual abuse*, retrieved from Crux: Covering all things Catholic website, <http://www.cruxnow.com/church/2015/02/05/pope-writes-bishops-to-back-zero-tolerance-on-sex-abuse>; Ontario Human Rights Commission (2004, April), *Submission of The Ontario Human Rights Commission to the Toronto District School Board Safe And Compassionate Schools Task Force*, retrieved from <http://www.ohrc.on.ca/en/submission-ontario-human-rights-commission-toronto-district-school-board-safe-and-compassionate>.
14. *College of Physicians and Surgeons of Ontario v. Maharajh* 2013 ONCPSD 37 (ON CPSD).
15. Oved Chown, M. (2015, May 4), "Burlington doctor admits to sexual abuse," *The Toronto Star*, retrieved from <http://www.thestar.com/news/gta/2015/05/04/burlington-doctor-admits-to-sexual-abuse.html>.
16. Armstrong, L. (2014, October 9), "Arrested Mississauga psychologist once disciplined by college," *The Toronto Star*, retrieved from http://www.thestar.com/news/crime/2014/10/09/arrested-mississauga-psychologist_once_disciplined_by_college.html.
17. *College of Physicians and Surgeons of Ontario v Redhead*, 2013 CanLII 96591 (ON CPSD).
18. Health Professions Regulatory Advisory Council (HPRAC) (2006, April), *Regulation of Health Professions in Ontario: New Directions*, p. 26, retrieved from http://hprac.org/en/reports/resources/New_Directions_April_2006_EN.pdf.
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21. *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991* s. 1(5), (6), retrieved from <http://www.ontario.ca/laws/statute/91r18>.
22. The last time that METRAC, the NGO that first addressed sexual abuse of patients in 1986, had funding to work on this issue was in 2008. See Ontario Women's Justice Network, "Doctor-Patient Sexual Assault and Abuse" (2008, August), retrieved from http://owjn.org/owjn_2009/legal-information/aboriginal-law/99.
23. Symons, M., and Marshall, P. (1992), *Breach of Trust in Sexual Assault: Review of Social Institutions*, pp. 1-50. Prepared by METRAC for the Ontario Women's Directorate.
24. Marshall, P. (1990), *Understanding of sexual abuse involving a breach of trust: A barrier to equality in the administration of justice*, unpublished paper presented at The Society for the Reform of Criminal Law Conference, Edinburgh, filed with the Minister's Task Force, 2015

The How of Zero Tolerance

Introduction

As part of the mandate for this task force, we were asked by Minister Hoskins to advise on a range of potential changes, including:

- disciplinary orders that may be imposed by health regulatory colleges against members who have been found to have sexually abused a patient;
- support tools for patient victims of sexual abuse;
- ways to further encourage and support patients who report incidents of sexual abuse to health regulatory colleges; and
- aspects of college disciplinary proceedings and other college processes.

In the first part of this chapter, “The Why of Zero Tolerance,” Patricia Freeman Marshall provided her reflections and analysis on the evolution of the zero tolerance standard, since she first suggested the term that became the centrepiece of recommendations by the 1991 task force and the 2000 task force.

In this part of the chapter, the medical advisor for this task force, Dr. Gail Robinson, discusses the “how” of zero tolerance, by drawing upon her role as a psychiatrist. Dr. Robinson’s expertise is built on decades of wide-ranging experience that includes treating patients who have been sexually abused, advising colleges and governments, testifying as an expert in sexual abuse cases, reviewing and providing an expert assessment of case submissions, and teaching peers, medical students and residents as a professor of medicine at the University of Toronto. Any recommendations influenced by Dr. Robinson have been authored by the task force.

An Expert’s Opinion On Upholding the Zero Tolerance Standard

By Dr. Gail Robinson

As the medical advisor to this Minister’s Task Force on the Prevention of Sexual Abuse of Patients and the RHPA, as a psychiatrist and educator who has been responsible for teaching boundaries and ethics to medical students and supervising psychiatric residents for decades, and as a regulated health professional who has been an expert witness in numerous cases of patient

sexual abuse complaints before college panels and courts, I was asked to provide my observations on the overall decline in zero tolerance of sexual abuse of patients in Ontario.

In order to provide my opinion as to what key issues must be addressed if the standard of zero tolerance of sexual abuse is to be upheld, my observations must be placed in a brief historical context. Although responsibility for protection and remediation, in the event of protection failure, must be fully shared by men and women in our society, to a significant degree the sexual abuse of patients has been viewed as a “women’s issue,” because the majority of victims are women. This fact became apparent early in my psychiatric practice, and led me to engage in proactive and preventive measures beyond the confines of my medical office.

As I sought the means to bring about deep systemic change, it became clear that “not-for-profit” community-based organizations are at the core of building a safe and civil environment in which all citizens can thrive. The “public” comprises patients; we are all patients. And when patients can thrive, caregivers like me will end up treating far fewer trauma survivors, at far lower cost to our society. This realization led me to co-found the Metropolitan Toronto Action Committee on Violence Against Women and Children (METRAC) in 1984, and to be an “early responder” in alerting the College of Physicians and Surgeons of Ontario (CPSO) to the fact that a significant number of patients were being abused by physicians and were either not reporting this abuse to the college or, when they did, that their reports were being dismissed without proper investigation.

After extensive media coverage of some of these dismissals, the CPSO commissioned the independent Task Force on Sexual Abuse of Patients, which held hearings in four regions of Ontario in 1991. A shocking number of patients came forward to report having been sexually abused by a physician. As a physician, I was proud when the CPSO became a world leader by adopting the zero tolerance standard, the first recommendation of that task force.

As a recognized medical expert, I was consulted by the government of Ontario on extensive amendments to the RHPA, which applied to more than 20 regulated health professions through their self-regulating colleges. These amendments would both identify and address the sexual abuse of patients for the first time. Based on the number of requests for assistance with cases that I received when the amendments took effect, the colleges were active in

pursuing complaints and using expert witnesses to explain the complicated dynamics of sexual abuse to college discipline panels, including: why such abuse occurs; why patients are vulnerable; why some patients are slow to report; and the harms to the patient and others that result from this abuse. From my perspective as an expert witness, I could see how carefully colleges were applying the new law and observing the zero tolerance standard.

However, for unclear reasons, as the years went by, I noticed a reduction in how vigorously colleges were pursuing some of these cases. In my considered opinion, some college discipline panels used their discretion to give lighter penalties or to slide back into the pattern of dismissing patients' accounts — instead of exercising their discretion to uphold zero tolerance of sexual abuse. This pattern was similar to what I had witnessed before the implementation of the RHPA amendments addressing the sexual abuse of patients.

More than 20 years after those RHPA amendments, which were predicated on the zero tolerance standard of sexual abuse of patients, I still act as an expert witness and I still treat survivors of sexual abuse by health professionals. For the most part, though, I am disappointed by how colleges deal with patients' sexual abuse complaints. The depth of my concern is illustrated by my assessment of the following two cases: in the first case, the perpetrator was a medical physician; in the second, she was a member of another college.

Case 1: Not Zero Tolerance — A CPSO Decision

The first case is analyzed in more detail in Appendix G. I have chosen to analyze it in this chapter, however, to offer my opinions on this case, from my perspective as a medical expert.

Dr. Redhead was a physician who admitted to having a sexual relationship with Ms. X in the winter and spring of 2007. He gave her medications and money, and had previously attended in person as her physician on five occasions within a hospital setting: twice on November 12, 2006, and then on December 27, 28 and 29, 2006. He had seen her in the emergency department (ED) when she came in

, and had admitted her to the hospital on two occasions.

Dr. Redhead began having sexual relations with Ms. X in late January or early February 2007.

Although he acknowledged that they had had a sexual relationship, Dr. Redhead pleaded not guilty to the allegations. He stated that, at the time

the “affair” started, he did not remember that Ms. X had been a patient of his, because she looked better than she had in late 2006 when he saw her in the hospital. The CPSO panel concluded (correctly) that his defence lacked credibility; Ms. X was memorable in many ways,

The defence for Dr. Redhead maintained that Ms. X was not actually his “patient” during the course of their sexual relationship because he had never done intensive counselling with her. The term “patient” is not explicitly defined in the RHPA. It is not necessary to engage in counselling with a patient for a physician–patient relationship to exist. He had seen Ms. X when she was very distressed, both in the ED and as an inpatient, and had allowed her to provide him with personal details about her troubles. Clearly, she understood him to be her physician.

In his defence, Dr. Redhead stated that the therapeutic relationship had ended in December 2006, and that Ms. X was therefore not his patient in early 2007. Yet Dr. Redhead clearly knew that she was a vulnerable person. He had seen her on five occasions over a two-month period, during which she presented with _____ that she required admission to hospital twice. He knew all about her personal history but had disclosed none of his to her. Although he may well have helped her improve her mood _____, it would be highly unreasonable for him to think that, just one month after she had experienced _____, she would be well enough to begin an informed sexual relationship with him.

Consistent with the CPSO’s discipline committee findings, it is clear that there was still a significant power differential between this fragile patient and this physician, whom she idealized, as is common in many physician/patient dynamics. He took advantage of her ongoing vulnerabilities and her desire to please. The evidence also suggested that Ms. X was trying to please one of his colleagues, another of her physicians who had also had sex with her, by agreeing to answer a social call from Dr. Redhead, which led to their sexual interaction.

The CPSO committee did not accept the majority of Dr. Redhead’s arguments. The committee noted that its determination was guided by the principle of protection of the public, and therefore the penalty should serve as a general deterrent to the health professions and a specific deterrent to this member. The only mitigating factor it noted was that that Dr. Redhead had no prior disciplinary record. In my opinion, this is the point at which

the CPSO's conclusions and its penalty decision begin to diverge to a disturbing degree — away from upholding the zero tolerance standard.

The committee concluded that Dr. Redhead's conduct was disgraceful, dishonourable and unprofessional. It found that his misconduct was serious; he engaged in sexualized conduct with a person who had been his patient until about one month before the sexual acts began. It noted that Ms. X was cared for by Dr. Redhead

, and that he had seen her five times within a short period of time, during which she had been repeatedly assessed . It determined that he had engaged in significant therapeutic interventions with Ms. X, and it found that he knew of her troubled past history and was fully aware of the extent of her emotional problems, and that even though he did not provide intensive counselling or formal psychotherapy, he had treated her while she was in significant distress, providing her with verbal support and medications.

The committee determined that Dr. Redhead was, therefore, fully aware that Ms. X was a highly vulnerable patient and that there was a significant power imbalance in their relationship. He provided her with gifts of money and pharmaceutical drugs that had the effect of further exploiting her vulnerability and augmenting the power imbalance between them. It noted that, even if Ms. X was feeling better at the time the sexual contact started, she had a long history and therefore continued to be vulnerable. As well, the committee did not give weight to letters describing Dr. Redhead's good character

Yet a sad irony unfolded in the committee's decision on the penalty for this physician, which was issued on May 15, 2013. Instead of assessing Dr. Redhead's misconduct in accordance with the mandatory revocation provisions in the RHPA, the committee relied on CPSO case precedents in which the mandatory revocation of a physician's certificate was not applied. These cases involved physicians who were found to have engaged in sexual relations with former patients between 1994 and 2011, and in which the suspensions ranged from two to nine months. In a sharp turn away from the logic in the reasoning in their decision, the committee concluded that a five-month suspension appropriately recognized the seriousness of the misconduct.

In my opinion, this could well have been considered a mandatory revocation offence, but college's discipline committee chose to exercise its discretion at

a level that was far below the threshold of zero tolerance of sexual abuse of patients (see Appendix G). This underscores the need to amend the RHPA to include a clear definition of “patient.” Consider that Dr. Redhead tried to claim that Ms. X was not his patient, when the evidence clearly showed that he had seen her on five occasions in the ED and in the hospital, where he twice admitted her. He had also prescribed medications for her. The physician–patient relationship had clearly been established despite whatever notes had, or had not, been written, and no matter who had completed the billing for the visits.

As a physician at the hospital, Dr. Redhead had provided counselling to help Ms. X . He had taken a history and knew that she had a previous history and a troubled past. He, on the other hand, was likely seen by her as a “saviour” and who supplied needed support, caring and assistance to help her get through a chaotic few months.

Within a month after the last time he had seen her as a patient, Dr. Redhead initiated sexual contact with the patient. Even had she completely recovered from a transient crisis, this was a professional boundary violation: there was an extreme power differential between her, a patient recently in crisis, and him, the physician who had “saved” her . This differential was exacerbated by the short period of time between their last professional visit and the start of the sexual relationship, her long history of problems and his supplying her with money.

It is my opinion that the demonstrated facts of this case brought it within the mandatory revocation provisions of the RHPA. Ms. X was in no way capable of making an informed decision as to whether an intimate relationship with Dr. Redhead was advisable. It is also my considered opinion that Dr. Redhead exploited his patient’s dependency and vulnerability, and risked adding more stress to her life and putting her at an even greater risk of a future breakdown

Case 2: Another Regulatory College

Although the CPSO processes more sexual abuse complaints than the other health regulatory colleges, other health care professionals (HCPs) are also disciplined by their regulatory colleges for the sexual abuse of patients. I will give my opinion on a case at another college that has been brought to my attention.

A female HCP worked in a program attended by a patient who had been off work on disability for many years. She began to engage in sexualized conduct with this patient. Several months later, both the patient and the HCP separated from their spouses. Following these separations, the patient became very upset and went to an ED after almost hanging himself. When the HCP's conduct was discovered, the patient was transferred out of the program he had been attending and was sent to a different program. The HCP was fired, but it is not clear if any report was made at that time to her health regulatory college. The couple began living together and then married, less than two years after the professional relationship ended.

A considerable time after their marriage, the patient's ex-wife made a complaint to the college. The lawyer defending the HCP maintained that no harm had been done, because the patient denied that he had been harmed by this new relationship. The HCP even stated that the relationship had been helpful to the patient — that his condition had improved because of it. No mention was made by either the patient or the HCP about how he had come very close to killing himself after his separation. Neither did they refer to any harm experienced by the HCP's ex-husband or the patient's ex-wife, the patient's children, other patients in the rehabilitation program or to the profession in general.

In my professional opinion, this is a straightforward case of sexual abuse, for which the HCP should have received a mandatory five-year revocation of her licence. It is not logical or reasonable, in a zero tolerance framework, for regulatory bodies to rationalize such sexualized conduct on the premise that, if one falls in love and gets married, the offence is not as serious. In a scenario such as this, consideration also must be given to the fact that the relationship could have failed and had a very negative effect on the patient, thereby putting him at risk of more attempts at self-harm.

Flawed and Troubling College Decisions

These two cases reveal some troubling paradoxes. In the first case, the CPSO's findings, reasoning and conclusions appear, at first, to be correctly headed toward mandatory revocation of Dr. Redhead's licence for sexually abusing his patient; they did not accept his excuses or rationalizations. The CPSO recognized that, given the patient's vulnerability, there was no way that, approximately one month after termination of the physician-patient relationship, the power differential and vulnerability between them would have ended.

Yet the penalty for his sexually abusing this very vulnerable patient included only a five-month suspension. It is not clear why this case and the other precedents cited by the CPSO did not warrant a five-year revocation. What is clear is that the college paid “lip service” to the issues of power differentials, exploitation and patient vulnerability, but then chose a penalty that was inconsistent with its conclusions, its own set penalty for such an offence and its statement about protecting the public and being a deterrent for other members. The college’s reliance on previous cases illustrates that this was not the first time there was an inconsistency between its conclusions about the nature of the offence and the penalty it imposed. (A more detailed analysis of the Dr. Redhead case is found in Appendix G.)

In the second case, despite the fact that there was a clear violation of both the RHPA and the college’s own rules against sexual contact between patients and members, and against intimate sexual relationships between HCPs and patients for at least two years following the end of treatment, the college found that there was no immediate, clear harm to the patient. This finding ignored the fact that the HCP could in no way predict whether or not the patient could be harmed by her conduct; in fact, the patient had to leave the treatment program,

Both of these cases clearly demonstrate the troubling situation that now exists, whereby, even if the regulatory colleges seem to understand and accept the reasoning behind the rules governing sexual abuse of patients, they do not enforce appropriate discipline against offenders in cases such as these. While it is not clear why some colleges have found it increasingly difficult to enforce their own policies, the cases that are brought to my attention demonstrate to me that there has been increasingly lax enforcement of strong disciplinary measures in the RHPA against sexual abusers.

As the medical adviser to this task force, I support its bold recommendations for major changes to how sexual abuse complaints by patients are to be dealt with by the health regulatory system. The intersectoral approach in the recommendations, which includes prioritizing the education of patients, trainees and practising HCPs, gives me hope that the sexual abuse of patients will again come to be considered to be a serious offence with serious consequences for perpetrators — applied consistently within the regulated health professions.

In reviewing these two case studies, it became apparent that the colleges’ decision-makers did not seem to understand the complex dynamics inherent

in the sexual abuse of patients, or the extent of the damage caused by their members through sexually exploiting their patients. In the following section, I provide an overview of what I teach to medical students, residents, psychiatrists and other health care professionals, as a way of supporting the conclusions reached by this task force that education on sexual abuse of patients at every level of training is crucial and that regulatory colleges have — in too many cases — demonstrated their inability to implement the zero tolerance standard, and are, therefore, ill-equipped to respond to complaints by patients of sexual abuse by their members.

Sexual Abuse By Health Care Professionals

Boundary violations can occur between any dyad of HCP and patient, whether male–female, male–male or female–female. Because the most commonly reported abuse occurs between male HCPs and female patients, I use female terminology in this section to describe patients, and male terminology to describe HCPs (any member of the 26 regulated health professions in Ontario).

Boundaries

The term “boundary” is defined as a border, or limit. Within a patient–HCP relationship, boundaries define the relationship by establishing the framework of the intervention. Therapeutic boundaries refer to such issues as: touching; language used; the time and place of meeting; duration of the meeting; disclosure by the HCP; gifts; favours; socializing; dual relationships; and sexual behaviour between the HCP and the patient. Solid boundaries help to set positive expectations of the professional relationship. The maintenance of appropriate boundaries is fundamental to the establishment of trust between patients and HCPs.

Boundary crossings are behaviours that disrupt the treatment framework for the benefit of the patient — for example, spending extra time with a suicidal patient. A boundary violation is any behaviour that infringes on the primary goal of providing care, thus causing harm to the patient, the HCP and the treatment. Violations of any of the boundaries listed above are damaging in and of themselves, but also may potentially lead to sexual abuse by the HCP.

Why Sexual Abuse Occurs

Certain elements of the HCP–patient relationship increase the potential for sexual abuse. The patient usually comes to the HCP because she is worried or suffering, and needs help. The patient may be anxious about symptoms or emotional problems, and may feel frightened and vulnerable. She sees the HCP as a wise and knowledgeable person who holds the answer to her problems. The HCP receives the patient’s trust and respect merely by virtue of his position: because patients usually do not know how to carry out medical, therapeutic or psychological treatments, they rely on HCPs to ensure that they are receiving legitimate procedures, carried out ethically.

This inequality between the patient and the HCP is enhanced by the fact that the HCP has the opportunity to find out everything about the patient’s personal life while divulging only what he chooses about his own. The power differential may also be accentuated and enhanced when the HCP is male and the patient is female (since, in our society, greater power is generally accorded to men than to women); when there is a marked socioeconomic difference between the patient and the HCP; and/or when there is a marked age difference.

Transference and countertransference

Transference and countertransference feelings may also increase the risk of boundary violations. Transference is generally defined as the set of expectations, beliefs and emotional responses that a patient brings to the patient–HCP relationship. Transference reflects not necessarily who the HCP is, but, rather, what persistent experiences a patient has had with other important authority figures throughout her life, such as a parent. Transference involves how those experiences influence the patient’s relationship with her HCP — for example, whether the patient “loves,” idealizes or feels anger toward the HCP. These feelings generally are unconscious to the patient but can affect her feelings and behaviour.

In the same way, an HCP may bring countertransference feelings that are negative, disproportionately positive, idealizing or even eroticized. If these feelings are not understood, they can affect the HCP’s reaction to and behaviour toward the patient.

Although transference and countertransference can be enhanced in intensive psychodynamic psychotherapy or psychoanalysis, this is not the only type of treatment in which they occur. The automatic respect, trust and

acquiescence given by the patient to the HCP's instructions demonstrate that a certain degree of transference is part of any patient–HCP relationship. Although a therapist or other HCP may not choose to identify or work with transference as part of the treatment, this does not mean it does not exist. In the same way, countertransference — unrealistic feelings toward or about the patient — may also happen in any kind of HCP–patient interaction, and increase the risk of a boundary violation occurring.

Consent

Patients who go to an HCP for treatment often bring their prior behaviour with them. For example, a patient may propose or invite sexual behaviour because this was part of her previous way of dealing with relationships. Of major importance is the fact that patients do not study or understand the potential harm of sexual behaviour between an HCP and patients. Their only experience of this behaviour may be through watching movies or reading books in which these relationships are romanticized. Patients cannot, therefore, be expected to understand the risks of such involvements.

Mere mutual consent is never a justification for sexual relations with patients because the disparity in power, status, vulnerability and needs make it difficult for a patient to give meaningful consent to sexual contact or sexual relations. Because of the imbalance in the relationship, the vulnerability of the patient, the possibility of a transference reaction and, hence, the potential for exploitation in a HCP–patient relationship, **it is always the HCP's responsibility to refrain from unethical behaviour**, even when the patient appears to consent to or even initiate an intimate relationship.

Patients may have various reasons for submitting to an intimate relationship with a HCP. A patient may have low self-esteem and believe that she will acquire importance and an enhanced sense of self-worth by establishing a relationship with someone who appears to be more powerful. A patient may feel grateful to the HCP, or feel dependent and needy, and therefore fear that the HCP will stop helping her if she does not cooperate. Patients may not enjoy the sexual relationship, but trade sexual favours for drugs, support, attention, concern and “love” from the HCP. None of these motivations provide justification for the HCP to violate boundaries.

Why Patients Continue to be Involved with Abusers

There are a number of reasons why patients continue to be involved with an HCP who has committed boundary violations. Patients essentially believe that HCPs are helpful, caring and trustworthy individuals. They therefore give HCPs the benefit of the doubt, assuming that whatever an HCP does is in the patient's best interest. Even such behaviour as a kiss or hug, which might raise alarm in other circumstances, is likely to be perceived as something the HCP is doing for the benefit of the patient. This respect by patients for HCPs can be accentuated by a difference in age or socioeconomic status between the HCP and the patient.

Despite the patient's awareness that certain behaviour by the HCP makes her uncomfortable or feels inappropriate, the patient may feel that she is getting something from the HCP that she believes she needs, such as feeling special, listened to, cared about or even loved. A patient who has become sexually involved with a HCP may also feel embarrassed and ashamed. This shame and embarrassment may interfere with the patient's ability to reach out to others for help to get out of the situation. She often can feel guilty about what has transpired, even though she is blameless. The patient wishes to believe that the HCP is a good, honourable and helpful person, and so feels that, if there has been any violation, it must have been provoked by her. This assumption of guilt by the patient prevents her from recognizing that she has actually been exploited by the HCP. Health care providers often add to this guilt by convincing the patient that it is her fault that the boundary violation occurred. This betrayal of trust by someone who is supposed to

“The acts were sexually demeaning, humiliating, intimidating and aggressively manipulative. The perpetrators used their position of privilege to abuse me. And in doing so they left deep scars on my life and my psyche. They impacted the way I view the world and how I conduct myself with others. The acts took a toll on my family life and have adversely affected all interactions with all medical personnel.”

— Patient

look after the patient often leads the patient to mistrust any other authority figures, thereby making it difficult for her to turn to anyone else for help.

The patient can often have ambivalent feelings about the HCP. She may have felt that the HCP was helpful to her in many ways. Despite the abuse, these persistent feelings of gratitude or affection may result in the patient's continuing wish to protect the HCP. If the HCP discloses a great deal about his personal problems, the patient can end up feeling responsible for the HCP's well-being, rather than the reverse. The HCP may emphasize the trouble he will get into if she reports him to the regulatory college, making the patient feel like a bad person and responsible for protecting him.

Frequently, it takes a long period of time before a patient is able to come forward and report the abusive incident. During that time, the patient may be trying to recover from the consequences of the abuse and gain inner strength. Patients must also deal with their guilt and embarrassment, sort through their feelings and begin to understand that it is the HCP who has erred and that it is reasonable for the patient to be angry at the HCP.

Consequences

Sexual abuse has many possible consequences for victims. Patients' presenting problems are often ignored and, indeed, complicated as a result of the abuse. Abused patients may find it difficult to trust other authority figures in the future. Since the abusive physician may have been kind, helpful or even loving in some ways, the patient may have confused, ambivalent and protective feelings towards the HCP. Patients often erroneously blame themselves for the abuse and feel guilty and ashamed. The secrecy in which abuse takes place often leads to isolation and loneliness. Patients may experience anxiety, depression, repressed anger or suicidal ideation, any of which may require treatment in hospital. They may become suicidal, have stress-related somatic complaints or be less able to cope with the symptoms of other physical problems they might have. They may suffer from symptoms of post-traumatic stress disorder, and try to cope with their distress by abusing drugs or alcohol. The distress and feelings of worthlessness patients feel following sexual abuse may interfere with their ability to work or have healthy relationships.

The abuse also has wider-reaching consequences. Other patients might be harmed by the unexplained extra attention being shown to the abused patient. When the sexual abuse is exposed, patients may lose their HCP

and feel betrayed, shocked and violated. Their trust in therapy may be destroyed so deeply that they are unable to seek help from other HCPs. The profession as a whole also suffers, because the public loses faith and respect for all HCPs. This situation is enhanced if the abuser does not receive serious punishment for the violation, because it leads to the conclusion that HCPs protect each other at the cost of harm to the public.

Post-Termination Relationships

Because some HCPs appear to believe that merely ending the professional relationship with the patient means that there is no obstacle to developing a personal intimate relationship, it is important to clarify the reasons for restricting post-termination relationships. First, if such a relationship is seen by either the patient or the HCP as a future possibility, it colours and distorts the treatment. The patient may withhold important information that might present her in a negative light, thereby interfering with the investigation and diagnosis, which will limit the effectiveness of the treatment. The HCP might hesitate to be as direct and challenging as he should be, in order not to seem unkind or uncaring. The openness and honesty that are necessary for excellent care are lost as the patient and HCP calculate the odds of a future relationship.

The power differential that exists in the relationship between the HCP and the patient does not change the moment the professional relationship ends: the professional still knows a great deal about the patient, yet the patient knows only what the professional has chosen to reveal about himself. This is true not only in physician–patient relationships, but may also be true in every HCP–patient relationship. All patients are vulnerable, because they generally seek care when they are ill or worried about their health and, during the course of treatment, frequently disclose a great deal about their personal lives. In the case of counselling, the HCP may learn a great deal about a patient’s vulnerabilities and weaknesses, and the patient increasingly will view the HCP as a knowledgeable, trustworthy, helpful and important part of their recovery and well-being. A deeper transference may also develop, whereby the patient may believe that she is in love with the HCP. This belief makes the patient even more vulnerable.

These differences in perspective and vulnerability do not change once therapy ends. If the sessions are ended before the patient feels ready, she will continue to feel helpless, vulnerable and needy — willing to please the HCP in order to have continued support. The fragility that caused the patient to seek

treatment will not have disappeared and may, in fact, be exploited by the HCP in order to draw the patient into a relationship that will satisfy his desires, without any concern for the potential harm that may be done to the patient.

Conversely, if the treatment has been successful, the patient may view the HCP with gratitude and even greater idolization. The HCP is seen as the person who has “cured” her; someone who has been kind, thoughtful, caring, helpful and wise. The patient may also feel that she loves the HCP. All studies of former psychotherapy patients show that transference and power differentials persist and that — even after a break — they can be instantly re-established. The patient may feel flattered and special because of her belief that this wonderful person wants to have a relationship with her. All the ingredients are there for the patient to create an idealized view of the HCP and begin eagerly hoping to have an ongoing personal relationship. It is, therefore, impossible to establish an equal, unbiased relationship between an HCP and a former counselling patient.

The power differentials and idealization may continue even for patients who have not been involved in psychotherapy, making them vulnerable to an offer from the HCP for an ongoing relationship, or to seek it out on their own. Even if an HCP and a patient believe that they are mutually agreeing to an equal relationship with no persistent power differential, there is no way to predict the outcome. Patients may come to realize they have been caught up by their own idealization and transference. An HCP who believes that he is not consciously taking advantage of a vulnerable patient may realize that he has become attracted to his patient through her idealization of him and then may then no longer want that kind of dependent relationship. The relationship may then end with a disillusioned, emotionally crushed, guilty, embarrassed and depressed patient who has no one to turn to for help.

Preventing Sexual Abuse

The sexual abuse of patients can be prevented in three key ways:

1. Appropriate punishment of offenders, with severe consequences — this sends a clear message to the public that this behaviour will not be tolerated by the health professions. Punishment also acts as a deterrent to others.
2. Establishment of clear boundaries — the public needs to understand that sexual behaviour between HCPs and patients is never justified.
3. Adequate, ongoing education — students in all of the regulated health professions must receive detailed, adequate education about

“ I have searched through my lecture notes and am unable to find the precise lecture during which we talked about sexual abuse, which I think speaks to how superficial and not memorable the discussion was. ”

– Health care profession student

appropriate boundaries, and boundary violations, and should be regularly examined on this to demonstrate its importance.

The Importance of Curriculum

Although Ontario medical schools are teaching about professionalism and ethics, there is no standard, well-defined course on boundary violations and the sexual abuse of patients. Each physician must keep to the “no sexualized contact” boundary, even though the challenges may differ in some ways (e.g., in psychiatry, more personal information may be obtained from the patient; other HCPs are more frequently in physical contact with patients). It is also true that non-physician HCPs may believe that the power differential between them and their patients is minimal or non-existent, and that there is therefore no risk in establishing intimate relationships with patients. The issues described below, however, are relevant to all HCP–patient relationships.

In general, these courses should not be taught only in a didactic manner: they need to include experiential components that incorporate materials such as videos, case vignettes, standardized patients or role playing. As well, it is not sufficient to teach this course only one time during the course of HCPs’ professional training: the issue needs to be readdressed every year. Questions about these areas of ethical standards and the possibility of abuse should also be included on professional examinations, to ensure that their importance is emphasized.

The following nine components should be an essential part of students’ curriculum.

1. Zero Tolerance

The zero tolerance standard is fundamental to preventing the sexual abuse of patients. Zero tolerance implies that there will be no excuses made for sexual abuse by HCPs. Sexual abuse is defined as sexual intercourse or other forms of physical sexual relations between the member and the patient; touching of a sexual nature of the patient by the member; or behaviour or remarks of a sexual nature by the member towards the patient. Under the zero tolerance standard, no rationalization or justification can be accepted when these behaviours occur.

2. Boundary Crossings and Boundary Violations

The concept of boundaries must be clearly taught. A clear definition of boundaries sets the framework for any kind of HCP–patient interaction. The difference between a boundary crossing and a boundary violation should also be clarified. The importance of boundaries in all areas of the HCP–patient relationship should be defined. These include but are not restricted to: touching; duration of treatment sessions; time of day of the treatment sessions; place where the treatment occurs; language used by the professional towards the patient, including sexual jokes, demeaning or suggestive remarks; questions about sexual functioning that are not relevant to the specific examination or treatment; ogling or flirting with the patient; inappropriate personal disclosure by the HCP; socialization; and dual relationships.

In examination or treatment sessions in which the patient is required to undress, teaching should involve such issues as: explanations to the patient before any physical examination or procedure is carried out; appropriate draping and gloving; and allowing the patient to dress or undress in private.

3. Why Sexual Abuse Occurs

Students need to understand the fundamental power differential that occurs in all professional interactions between HCPs and their patients. No matter what the profession, the HCP has the professional knowledge and the ability to help that the patient requires. Patients have not been educated as to the harms of boundary violations, and thus are not trained to recognize inappropriate or improper examinations or treatment. Most examinations and treatments occur in privacy, where no one else is supervising the procedure. Patients believe that they can trust their HCPs. This trust begins

“A single incident can be life-shattering.”

– Patient

before they even meet any specific HCP; indeed, it is built into the concept of seeking help from a knowledgeable professional.

This educational component should include education around factors that increase the vulnerability of patients, including: fear about their health problem; a feeling of helplessness to diagnose or cure themselves; neediness, as they seek help; a desire to please and avoid alienating the HCP; a previous history of sexual abuse; strong positive transference feelings toward the HCP; and age and socioeconomic status differences between the HCP and the patient.

Some HCPs are exploitative people who take advantage of the power differential to prey on vulnerable patients. Other HCPs may experience certain factors and situations that can increase their likelihood of violating boundaries. These factors include: lack of knowledge; current life stressors; mental illness; a personal need for approval; lack of a fulfilling life outside of work; countertransference feelings toward the patient; a rationalization that if one “falls in love,” the boundaries no longer apply; and a sense of entitlement or omnipotence.

It is important for HCPs to clearly understand that the **maintenance of boundaries is always the responsibility of the HCP.**

4. Harm Resulting from Sexual Abuse

Students must be taught the about the harm caused by boundary violations. These harms include negative consequences for the patient, the HCP, the families of the patient and the HCP, other patients in the practice and to the profession in general, because of the ensuing loss of trust in the practice by the general population.

Further harms to the patient include: ignoring the presenting problem; adding additional problems to those the patient is already experiencing; guilt; self-blame; shame; isolation from friends and family; anger; loss of trust in health care providers or authorities in general, which may result in

“For all these years I have not understood that this was sexual abuse until most recently when I developed symptoms of PTSD. I never knew it was related to abuse of power, sexual assault, betrayal of trust.”

– Patient

future health care needs not being adequately met; role reversal, in which the patient becomes excessively concerned about the HCP’s well-being; ambivalence about the HCP’s actions; sexual confusion; anxiety; depression; PTSD; and suicide.

5. Consent

Students must be taught the difference between consent and submission. Factors that must be stressed include: the inability of the patient to give informed consent because of their neediness and vulnerabilities; lack of awareness of the harm of sexual abuse; strong transference feelings; power differentials; possible limited availability of alternative sources of help; and initial increased self-esteem at being “chosen” by the HCP.

In some situations, it may appear as if the patient is consenting to or even seeking a sexual relationship with the HCP. It must be emphasized to HCPs, however, that this may be part of the patient’s overall way of functioning and an aspect of how she deals with relationships in general, as well as an attempt to ensure the HCP’s assistance. Even if the patient attempts to overtly or covertly seduce the HCP, this is not true consent, and the HCP must not act on this invitation.

6. Post-Termination Involvements

The risks and harms of post-termination involvement with a patient must be clearly taught to students. The imbalance in power within the professional relationship does not immediately end with the end of treatment: it continues for an unknown period of time. The power imbalance is perpetuated by: differences in the level of disclosure between the HCP and the patient; the HCP’s awareness of all of the patient’s vulnerabilities; the continuation of transference and countertransference feelings; the continued neediness of the patient if her issues have not been addressed in treatment;

gratitude toward and idealization of the HCP if the patient has been helped; and the basic trust and respect that the public tends to extend to HCPs.

It should be emphasized that there is no HCP–patient relationship — no matter how brief — that can be said to be completely clear of any ongoing power differential or idealization of the HCP by the patient. When the treatment has included any type of counselling, the patient’s vulnerability continues for an undisclosed time after the therapy ends, because of the heightened power differentials. There should, therefore, be a lifetime ban on any type of personal, intimate relationship between HCPs and former counselling patients. For other HCP–patient relationships, there should be a minimum of a one-year ban. This year-long period must not be negotiated with the patient when the treatment ends: it must begin to apply only when the HCP and former patient meet, by chance, under different circumstances more than a year later, and strike up a relationship. Even in this circumstance, the HCP should be aware of the possibility of ongoing transference, power differentials and vulnerability on the part of the patient.

7. Mandatory Reporting Rules

Students need to understand the importance of mandatory reporting, to the appropriate college, of any HCP suspected of boundary violations with a patient. Because patients who have been sexually abused by an HCP are generally left feeling confused, guilty and ashamed, and yet frequently ambivalent about and protective toward former abusers, they may find it very difficult to complain about an abusive HCP. Every HCP has a vested interest in identifying abusers so that they can be appropriately disciplined. If this does not occur, the public can lose faith in the health care professions, and begin to assume that many HCPs are abusers and that these professionals always protect their own. This belief does a great disservice to the health care professions but also can interfere with patients’ willingness to seek out necessary health care.

Every HCP who sees a survivor of this type of abuse has an obligation to report the name of the offender to his or her regulatory college. Although it is important to protect the patient’s identity until she is willing to disclose, it is essential to try to obtain enough details and information to allow the college to begin an investigation into this serious matter. Failure to carry out a mandatory report is punishable by a \$25,000 fine.

8. Knowledge of the Rules and Standards

All students should be familiar with the rules and standards around sexual abuse of the regulatory college of which they are a member, as well as the RHPA's requirements.

9. Evaluating and Avoiding Boundary Violations

Although the prohibition on any sexual contact with patients should be very clearly understood, every student and HCP needs to learn how to evaluate potential boundary crossings so that they don't slip into violations that result in sexual abuse. Every HCP should also be taught to ask themselves the following questions before they consider crossing any boundary in the HCP-patient relationship:

1. Why am I thinking of doing/saying this?
2. Would I do this with all my patients? If not, why with this particular patient, and why at this particular time?
3. How much do I know about how this will be received by the patient?
4. Is there a safer way of achieving the same goal?
5. Why do I think I can do this without harm?
6. Would I hesitate to tell a colleague what I have done?
7. Would I worry if my patient told someone about what I have done?

Continuing Professional Education

Health care professionals should need to verify that, at least once every five years, they have attended a course or seminar that reviews the information on and prohibitions around sexual abuse so that they do not lose sight of why it happens and the harm it causes. These seminars should include an overview of the topics noted above.

Chapter 5: Modernization of the *Regulated Health Professions Act, 1991*, for Health and Dignity

Background and Rationale

To be considered fair and capable of delivering credible decisions, a complaints-driven accountability system (such as the college processes set up by the *Regulated Health Professions Act, 1991* (RHPA) to deal with sexual abuse of patients) is predicated on there being an equivalency of resources for each stakeholder and a “level playing field” without barriers that obstruct one party but not another. Under-reporting of sexual assault, including sexual abuse by regulated health professionals, is a given. As discussed in Chapter 1, the task force heard from experts working with patients of Aboriginal origin in urban and isolated areas of Ontario, and from experts working in immigrant communities, that distrust of current complaint options is a significant cause of sexual abuse under-reporting by patients.

Across Ontario, patients who have experienced sexual abuse by regulated health professionals do not currently have adequate access to either legal support or effective legal representation, largely because they are not usually considered to be full parties in the discipline process that is triggered when their sexual abuse complaint is referred to a college panel for a discipline or reinstatement decision. Only the regulatory colleges can revoke certificates of registration that entitle regulated health care professionals (HCPs) to

“*If I had known about these issues I probably would have been a much stronger advocate for myself, I would have been a stronger witness. I would have asked for more involvement. I lost my voice during this time. I lost my sense of self.*”

– Patient

practise in Ontario. This lack of resources is a particularly significant barrier to patients who are marginalized and vulnerable, and affects patients' health outcomes. The task force recommendations regarding a new system for deciding sexual abuse complaints by patients is predicated on self-regulation by health professionals and fairness to professionals and patients alike. Self-regulation of health professionals through their colleges is guaranteed through the RHPA, but patients often do not know — and report having difficulty finding out — where they can go to report sexual abuse.

Our recommendations for a modernized RHPA are responsive to this reality, which is why public education and outreach are such clear priorities in the new proposed model, the Ontario Safety and Patient Protection Authority (OSAPPA) — well beyond what any of the regulatory colleges have been doing. During and after the transition to the OSAPPA model, some patients will continue to turn to regulatory colleges. Under the modernized RHPA, there is to be a legislated onus on regulatory colleges to make immediate referrals of patients with sexual abuse complaints to OSAPPA — in person, with written information provided to facilitate the patient's access to OSAPPA services and in writing — by the most efficient possible electronic means, directly to OSAPPA. Every regulatory college is to be mandated to include a record of all patient visits and other forms of inquiry about the sexual abuse of patients with documentation as to the speed and nature of referrals to OSAPPA.

Although some legal expertise in this specialized field exists within some of Ontario's legal aid clinics, it is not widespread throughout the legal aid network or the bar generally. The core legal competence of lawyers in this underdeveloped and underserved area of the law must therefore be strengthened across the province's legal aid system.

Public legal education also needs to be enhanced in Ontario, in order to provide patients with the information they need to understand both their

“Many survivors do not know the law or even where to begin to proceed with a complaint when an incident of sexual violence occurs by a health professional.”

— Patient advocate

rights when they experience sexual abuse by a regulated health professional, and the processes they must embark upon to pursue sexual abuse complaints. Greater access to justice for patients is a key theme in this task force report because of the discrepancies in resources available to patients, compared to health professionals and their colleges.

Competent legal support and information/education for patients (that is, the public) in Ontario can be achieved by using the expertise, and strengthening the capacity of, existing resources, especially Legal Aid Ontario (LAO), which has a network of clinics and services, Community Legal Education Ontario (CLEO), the Barbra Schlifer Commemorative Clinic and the Metropolitan Action Committee on Violence Against Women and Children (METRAC). The services provided to marginalized and vulnerable patients by each of these organizations are outlined below based on task force discussions with them.

Description Of Key Players

Legal Aid Ontario

Legal Aid Ontario is an independent but publicly funded and publicly accountable non-profit corporation that administers the province's legal aid program. It has a statutory mandate to promote access to justice throughout Ontario for low-income individuals.

The values of LAO are to “ensure that healthy communities include responsive and meaningful legal aid services and improved access to justice.”¹ Because there are legal aid clinic and services across Ontario, LAO can provide legal aid services to patients regardless of their geographical location.

Community Legal Education Ontario

Community Legal Education Ontario is a community legal clinic and part of Ontario's legal aid system. Since 1974, CLEO has been a key provider of legal education to the public. The organization develops “clear, accurate, and practical legal rights education and information to help people understand and exercise their legal rights,” with a focus “on providing information to people who face barriers to accessing the justice system.”²

Barbra Schlifer Commemorative Clinic

The Schlifer Clinic is Canada's only integrated counselling, language interpretation and legal clinic specializing in assisting women from underserved communities who are experiencing violence or its aftermath. The clinic provides services in over 100 languages, has a variety of innovative counseling services and is the "go-to" resource for community mobilization, public legal education and information and representation for gender-based violence, both nationally and internationally.³ The Schlifer Clinic has experience and expertise in providing summary advice to patients who have been sexually abused by regulated health professionals.

METRAC

Founded in 1984, METRAC is a community-based, not-for-profit organization that works with individuals, communities and institutions to change ideas, actions and policies, with the goal of ending violence against women and youth. It focuses on education and prevention and uses innovative tools to build safety, justice and equity.⁴

A proposed collaboration between LAO, CLEO, the Barbra Schlifer Commemorative Clinic and METRAC, as outlined in this chapter and reflected in the relevant task force recommendations (see Chapter 1), will increase access to justice for the portion of Ontario's vulnerable patient population that has experienced sexual abuse at the hands of regulated health professionals.

Access to Justice: Amendments Essential to Modernization of the RHPA

Numerous amendments are required to the RHPA in order to make the complaints and disciplinary process for patients more transparent and meaningful by enhancing access to justice, through the availability of skilled legal counsel and important public legal information, to this process. In addition, with the creation of a new complaints and investigative regime in the form of OSAPPA, the legal aid network of lawyers and services will require specialized training in order to provide quality legal services to complainants, and the sensitivities which surround representing victims of trauma.

Amendments to the RHPA should include:

- Adding a definition of "patient";
- Expanding section 51(5) of the *Code*, adding more revocable offences; and

- Stopping gender-based restrictions on practice as a response to sexual abuse or any form of “sexual misconduct.”

Amendments made to the RHPA more than 20 years ago created “mandatory revocation offences,” which are set out in subsection 51(5), paragraph 2 of the *Code*, in order to:

- (a) signal the seriousness with which the sexual abuse of patients is to be taken;
- (b) underscore the gravity of the breach of fiduciary trust involved, and take away from the offending health care professionals (HCPs) their certificates of registration — the means by which self-regulated health professionals can command privilege and trust in our society;
- (c) emphasize the considerable impact of the practitioner’s failure to meet his or her responsibility towards maintaining the integrity of the profession; and
- (d) respond to the need to protect the public from the risk of recidivism by removing the practitioner from practice for a minimum period of time.

The proposed amendments, which follow in the recommendations, are necessary because the sexual abuse provisions are intended to protect the individual patient, the public and the integrity of the health care profession in the eyes of the public. When a health professional violates the sexual integrity of a patient, the result is a violation of the trust that the health care professions, as a whole, owe to the public as represented by patients — in short, sexual abuse of any patient is a violation of the public trust, which lies at the heart of the privilege of these professions to be self-regulated. The proposed amendments will also promote clarity for health professionals and their patients as to the absolute nature of professional boundaries where those boundaries protect the sexual integrity of patients and maintain the protected space that every patient deserves in their care from regulated health professionals. It is fair that the *Code* be as clear as possible, to ensure that there can be no uncertainty as to the types of conduct which will, unequivocally, attract mandatory revocation of one’s certificate to practice in the health system in Ontario. Finally, these amendments are essential to advance the public policy mandate of zero tolerance for sexual abuse of patients by regulated health care professionals, as enshrined in the *Regulated Health Professions Act* and its *Health Professions Procedural Code*.⁵

Thus, the mandatory revocation provision should be expanded to include forms of sexual abuse consistent with the zero tolerance policy affirmed by the Ontario government in this task force’s mandate and reflected in the *Code*.

As another example supporting the need for an amendment to the RHPA to define “patient,” and to codify boundaries and timelines, the task force notes with concern the 2010 case of Paul Johnston,⁶ a clinical psychologist who provided psychological services

. In describing her health issues to this practitioner, the patient disclosed that she had . Mindful of the guidelines of the College of Psychologists of Ontario (CPO), the member engaged his patient in social interaction and discussion about the possibility of commencing a sexual relationship with her. Shortly after the passage of two years from the last provision of psychological services, he commenced a sexual relationship with the patient.

The disciplinary panel accepted Johnston’s plea of guilty and found that he had committed professional misconduct but that he could continue to practise, with conditions on his certificate of registration that his therapist make quarterly reports to the registrar, confirming regular attendance and placing an onus on his therapist to inform the registrar if she had any concerns about the safety of Dr. Johnston’s patients, and that he had to attend an objective assessment by a therapist selected by the college, with costs of the assessment shared equally between the college and the member.

In May 2015, the CPSO Council endorsed a number of proposed changes to the sexual abuse provisions in the governing legislation, the *Regulated Health Professions Act, 1991*, including a proposal for two different definitions of sexual misconduct:

1. all physical sexual contact between a physician and patient would fall within the definition of sexual abuse, and would result in revocation – but not necessarily for the mandatory five years as currently required under s. 51 of the *RHPA Code*; and
2. sexual comments and gestures would be defined as sexual impropriety, and penalties for sexual impropriety would be at the discretion of the Discipline Committee.

This approach is the opposite of what the task force recommends, in that the CPSO proposal would eliminate the list of specific acts — currently in s. 51 of the *RHPA Code* — that triggers mandatory revocation. However, the CPSO proposal is of interest in that all physical sexual contact between a doctor and a patient would be deemed a fundamental breach of a physician’s obligation to patients that requires revocation. But key to this aspect of the proposed amendment is doing away with the current minimum five-year period prior to a reinstatement application, in all cases of mandatory

revocation. In effect, the CPSO proposal would restore to Discipline Committee panels much wider discretion that is currently allowed under the RHPA, including the power to specify a period between one and five years before a physician can apply for reinstatement following a revocation for sexual abuse or other professional misconduct of a sexual nature.

Of particular concern to the task force is the pattern of decisions by some colleges that resulted from “diversion” from the mandatory revocation standards in the *Code*. This concern is discussed elsewhere in this chapter and more detail is given in the re-vision commentary on the case chosen to demonstrate task force concerns more extensively, in Appendix G, with the CPSO having the most sexual abuse cases of any college, to “divert” discipline cases from the zero tolerance standard implicit in the mandatory revocation provisions of the RHPA. While the CPSO and other colleges are to be acknowledged for initiatives that respond to a range of concerns, the information available to the task force about such initiatives is not sufficient to alter our first recommendation that Ontario patients should not be required by the RHPA to make complaints of sexual abuse to the colleges, and that a new government agency, with the suggested title of the Ontario Safety and Patient Protection Authority (OSAPPA), be established.

First, the amendments recommended by this task force are necessary because the sexual abuse provisions are intended to protect the individual patient, the public and the integrity of the health care profession in the eyes of the public. When an HCP violates the sexual integrity of a patient, the result is a violation of the trust that the health care professions, as a whole, owe to the public, as represented by patients — in short, sexual abuse of any patient is a violation of the public trust, which lies at the heart of the privilege of these professions to self-regulate.

Second, the proposed amendments will also promote clarity for health professionals and their patients as to the absolute nature of professional boundaries where those boundaries protect the sexual integrity of patients and maintain the protected space that every patient deserves in their care from regulated health professionals. It is fair that the *Code* be as clear as possible to ensure that there can be no uncertainty as to the types of conduct which will, unequivocally, attract mandatory revocation of one’s certificate to practice in the health system in Ontario.

Finally, these amendments are essential to advancing the public policy mandate of zero tolerance for sexual abuse of patients by regulated HCPs, as enshrined in the RHPA and its *Code*.⁷

Fiduciary Trust Owed to Patients

The first task force, in 1991, proposed that the highest level of trust recognized in law was the appropriate measure of the breach of trust that occurs when a medical doctor sexually exploits one or more patients. This was confirmed by the Supreme Court of Canada in the 1992 decision of *Norberg v. Wynrib*,⁸ which cited the task force reasoning extensively. The Ontario Court of Appeal clearly confirmed, more than 10 years ago, that the importance of responding to these objectives is not contested (see *Mussani v. College of Physicians and Surgeons*, at paragraph 80).⁹

For thousands of years, as reflected in the Hippocratic Oath, HCPs have understood that they must not harm patients, that it is wrong and unprofessional to place their own sexual gratification interests ahead of the health interests of their patients. Because of the power, authority and trust health care professionals hold in our society over patients, they are held to the highest ethical standards of conduct. As such, HCPs are in a status-based, or presumptive, fiduciary relationship with their patients. This was recognized in the decision of McLachlin J. (as she then was), writing for herself and L'Heureux-Dube J., in *Norberg v. Wynrib*. In this landmark doctor/patient sexual abuse case, McLachlin J. explicitly characterized the doctor and patient relationship as presumptively fiduciary.¹⁰ All of the Justices in *Norberg* recognized that a significant power imbalance exists in a doctor/patient relationship.¹¹ Other courts, including Ontario courts, have characterized various HCPs as being in a fiduciary relationship with their patients both within the context of sexual abuse and in other contexts as well; for example, psychologist/psychotherapist and patient (*N.C. v. Blank*, [1998] O.J. No., 2544 (Gen. Div.) (Q.L.)), psychiatrist and patient (*TC v. Scott*, [1997] O.J. No., 2389 (Gen.Div.)(Q.L.)), and dentist and patient (*Axelrod (Re) (In Bankruptcy)*).¹²

It is well established that HCPs owe a duty of loyalty to their patients and must avoid a conflict of interest between their own self-interests and the best health-related interests of their patients. These obligations have been recognized as informing the scope of an HCP's fiduciary duty to their patients. When an HCP sexually abuses a patient, that professional has placed his or her own sexual gratification needs ahead of the best health-related interests of the patient. Accordingly, the sexual abuse of a patient is a breach of the fiduciary duty owed by the HCP to the patient. To be clear, although some colleges in some cases have chosen to define "sexual abuse" in narrow terms, the task force intends "sexual abuse" to be understood to

include sexual impropriety, misconduct and incompetence in our discussion of access to justice for patients who have experienced sexualized boundary-crossing by regulated health professionals.

The public policy purpose underlying the fiduciary doctrine is the desire to preserve the integrity of socially valuable or necessary relationships. The courts recognize that the fiduciary must be entrusted with the power and authority to perform his or her function, and that there is an inherent risk of an abuse of power within the fiduciary relationship. Embedded in the concept of a fiduciary relationship, as applied to a health professional and his or her patient, is the recognition that the patient must rely on, and is vulnerable to, the health professional's exercise of professional judgment, as it affects her or his health care and well-being. The patient must repose trust in the health professional in order for the health care relationship to be effective.

In its landmark doctor/patient sexual abuse decision rendered in *Mussani*,¹³ the Ontario Court of Appeal recognized the public trust vested in HCPs, and the serious harm caused not only to the patient but to the public generally, when an HCP commits sexual abuse against a patient. The Court of Appeal also upheld the zero tolerance policy recommended by the 1991 Task Force on the Prevention of Sexual Abuse of Patients and enshrined in amendments to the *Health Professions Procedural Code*:

In more general terms, the objective of the legislative scheme is to ensure that discipline for serious forms of sexual abuse signals the serious harm that such abuse causes the patient as well as the breach of trust committed by the health professional and the harm such misconduct causes to the profession itself.¹⁴

Why the RHPA Needs to be Amended to Define "Patient"

The RHPA currently does not include a precise legislative definition of "patient," perhaps because, for many, this is clearly a matter of common sense, but disciplinary decisions of colleges in sexual abuse complaints by patients have revealed a different reality. Given the absence of a specific definition, the discipline committees of the respective regulated health colleges have had to resort to a case-by-case factual determination, subject to interpretation, as to whether or not the complainant was indeed a "patient" for purposes of section 51(5) of the *Health Professions Procedural Code*, Schedule 2 to the RHPA.¹⁵

The failure in the legislative scheme to define the term “patient” has resulted in the release, by some of the regulated health colleges’ respective discipline committees, of decisions in which proven acts of sexual abuse (as defined by subsection 51(5) of the *Code*) faltered on the lack of specificity in the *Code* as to who is a “patient.” This has resulted in the temporary suspension of the HCP’s licence for a period of months, rather than the license being revoked.

For example, in *The College of Physicians and Surgeons v. Powell (Powell)*,¹⁶ Dr. Powell, a psychiatrist, admitted to engaging in sexualized acts with two of his long-term psychotherapy patients, whom he had been treating. He kissed the first complainant during the course of a psychotherapy treatment session, then terminated formal treatment of her and continued with the sexualized kissing and hugging, which progressed to sexual intercourse within approximately 10 months after the formal termination of the patient’s treatment. Dr. Powell also engaged in sexualized conduct with another long-term psychotherapy patient that consisted of repeated sexual intercourse commencing between four and six weeks after the psychiatrist formally terminated the patient’s treatment. The discipline committee stated in the course of delivering its reasons for decision that:

It is of paramount importance that a psychiatrist maintains professional boundaries in a psychotherapeutic relationship in order to treat a patient effectively and that appropriate boundaries be maintained after the doctor-patient relationship is terminated.

In fact, depending upon the circumstances, a sexual relationship may never be appropriate with a former psychotherapy patient. At all times, it is the physician’s professional responsibility to maintain appropriate boundaries with patients and former patients.¹⁷

The committee then accepted the joint submission of the college and Dr. Powell’s lawyer regarding the penalty, and suspended Dr. Powell’s certificate of registration for nine months. While there was no explicit rationale as to why Dr. Powell’s certificate of registration was not revoked pursuant to subsection 51(5) of the *Code*, it appears that it was because the committee believed that these complainants were not deemed to have been “patients” at the time of the sexual abuse, since the proven sexual acts, including sexual intercourse, would have otherwise mandated revocation of the certificate of registration.¹⁸

Other examples of doctors found to have committed sexualized acts which, in the opinion of this task force, amounted to sexual abuse of their patients, but which, in the opinion of the college decision-makers, did not meet

the threshold of sexual “abuse” of “patients” for purposes of s. 51(5) of the *Code*, are *College of Physicians and Surgeons of Ontario v. Carter*¹⁹ and *College of Physicians and Surgeons of Ontario v. Minnes*.²⁰

Carter involved a family doctor who treated the complainant for various medical conditions, including supportive psychotherapy. Dr. Carter hugged and kissed the complainant on one occasion at the end of a medical appointment. The kissing and hugging continued until Dr. Carter formally terminated treatment of the complainant. CPSO’s discipline committee found as a fact that shortly after the formal termination of treatment of the patient, the doctor engaged in repeated sexual intercourse with her.

Of particular note is the fact that the committee observed that the “romantic relationship between Dr. Carter and the complainant commenced prior to the termination of the doctor/patient relationship, and that this became a sexual relationship very shortly after the official termination.”²¹

The Committee also made the following finding regarding the vulnerability of the complainant to Dr. Carter as his patient:

the complainant was a very vulnerable individual. She had a history Dr. Carter would have been aware of her vulnerabilities, of the power imbalance inherent in the doctor/patient relationship, and of the risk of harm to the complainant which was likely to arise on account of his actions. Conduct of this nature not only exposes patients to harm, but impugns the integrity of the profession and must be strongly sanctioned.²²

Notwithstanding these strong statements condemning the doctor’s actions, the committee did not apply the mandatory revocation penalty under subsection 51(5) of the *Code*, apparently because while Dr. Carter was found to have committed serious sexual abuse against the complainant, the only form of sexual abuse that was concurrent with the active medical treatment of the complainant was the kissing and hugging, which falls short of the conduct captured by the mandatory revocation provisions of the *Code*. The repeated sexual intercourse followed the formal termination of treatment.

The committee accepted the joint penalty submission, which included an 18-month suspension of Dr. Carter’s certificate, rather than revoking his certificate. Again, while there is no explicit analysis as to why the mandatory revocation provision was not applied, it is implicit that this decision rested on the fact that the sexual intercourse did not commence until after the doctor formally terminated treatment, and that, according to this formalistic

approach, therefore, the complainant was not a “patient” at the time of the sexual intercourse.

Minnes concerned sexualized boundary-crossing by Dr. Minnes, who at the time was the camp doctor (and the only camp doctor) at the camp at which the then 17-year-old complainant worked.²³ Importantly, the CPSO’s discipline committee accepted the complainant’s testimony of sexual contact, which included Dr. Minnes taking the complainant’s hands and placing them on his genitals over his pants, fondling her breasts, rubbing himself against her buttocks as she was laying face down on his bed, and having her touch his exposed erect penis. All of this conduct occurred in Dr. Minnes’s cabin at the camp.

The committee referenced the *Mussani* decision for the proposition that the determination as to whether or not a doctor-patient relationship exists between the physician and the complainant, at the time of the sexual abuse, is “a factual enquiry that is subject to interpretation by the tribunals and the courts.”²⁴

The committee found the complainant’s version of events to be credible, whereas the doctor’s version was “simply not credible, is contrary to human nature and common sense and, in fact, verges on the preposterous.”²⁵ The committee also found that the age difference between the complainant (17 years old) and the doctor (47 years old), “and the compelling aspect of his authority over her by virtue of his position as camp physician”²⁶ meant that Dr. Minnes was “in a position of authority vis a vis [the Complainant].”²⁷

On the other hand, the committee found that Dr. Minnes’s professional involvement with the complainant (looking at her injured ankle, and “brief informal conversations” about her injured ankle) was not sufficient to constitute the complainant as a “patient” because this activity constituted “informal” treatment, thus removing this complaint from the mandatory revocation provision of subsection 51(5) of the *Code*.

However, due to the serious nature of the proven allegations of sexualized boundary crossing, which were characterized in the course of the penalty decision as “predatory” and involving an abuse by Dr. Minnes of “his position of authority and trust vis a vis the complainant, in order to take advantage of her for his sexual gratification,”²⁸ the Committee exercised its discretion under a different provision of the *Code* and revoked Dr. Minnes’ certificate of registration to practice.²⁹ Dr. Minnes appealed the committee’s decision to court and no practice restrictions attached to his certificate to

practise, according to CPSO's public register, meaning that he was free to continue to practise medicine pending the outcome of his appeal, which resulted in revocation of his certificate of registration.

The CPSO committee declined to characterize the complainant as a "patient," notwithstanding its findings that it was through Dr. Minnes' position as camp doctor that he possessed significant authority and trust over her.³⁰

By applying a narrow formalistic definition of "patient" based on the start and end of the formal/official treatment, at least some of the colleges, in some cases, have failed to recognize that the sexual abuse of patients by regulated health professionals represents, fundamentally, an abuse of the health professional's trust, power and authority in exploiting patients who are vulnerable to their professional influence. The apparent approach by some colleges that the patient's vulnerability to the health professional does not start until the first formal treatment, or, conversely, ends on the last recorded date of formal treatment, ignores the authority, respect and trust that society has vested in our health professionals as necessary to have an effective health care system.

The term "patient" captures the pervasive influence that health professionals have over individuals with whom they have professional contact, and that influence and its related ethical responsibility can either pre-date or post-date the formal treatment provided. Recognition of the power, trust and authority of health professionals over individuals is particularly compelling where the professional contact included an element of psychotherapy or counselling.

Recommendation 1. Definitions of Patient and Boundaries

The RHPA, *Health Professions Procedural Code*, should be amended to define "patient" as well as to specify clear boundaries and time periods for sexual contact between members and their former patients. Therefore the Minister's Task Force recommends:

- an amendment to the interpretation clause of the RHPA, section 1.(1) by adding, after the definition for "Minister": "patient" means an individual who at any time has received, or is receiving, health care from a member, or has been assessed by the member, or is otherwise under, or assigned to, the care of the member, including psychotherapy delivered through a therapeutic relationship or

- counselling for emotional, social, educational or spiritual matters delivered through a confidential treatment context; and
- an amendment on clearer boundaries so that decision-makers in colleges and/or OSAPPA processes find that a member has committed an act of professional misconduct by sexually abusing:
 - a patient concurrent with a health care relationship; or
 - an individual who was a patient within two years from the sexual abuse; or
 - a person to whom a member has provided treatment by means of a psychotherapy technique delivered through a therapeutic relationship, including counselling delivered through a therapeutic relationship.

Expanding the List of Types of Sexual Abuse that are Subject to Mandatory Revocation of Certificates

The task force reviewed many cases in which the regulatory colleges found a way to avoid mandatory revocation, even in cases where, in the opinion of the task force, the acts should have resulted in mandatory revocation.

Often, the colleges' rationale for less than zero tolerance was that the conduct was not specifically included under subsection 51(5) of the *Code* (the "mandatory revocation" provision). The task force considers sexual abuse to include impropriety, misconduct and/or exploitation of a sexualized nature to be sexual abuse and serious in nature, and regrets that a hierarchy of which kind of abuse is considered "serious" has arisen in cases and commentary under the RHPA. This approach is reminiscent of attitudes and judgments that used to require penile penetration in order to qualify as "real" rape — prior to amendments in the 1980s to clarify what constitutes sexual assault. In particular, it is recognized that all forms of non-medically justifiable penetration of a patient (or penetration by a patient of

“ I am stunned that a perpetrating doctor, where it is historically rare for these offenders to be found guilty in these warped tribunals, has been given the luxury to continue working with a chaperone nurse present or with a simple stipulation of only attending to male patients. ”

— Patient advocate

a health professional), such as digital penetration, are serious forms of abuse commensurate with the types of serious sexual abuse listed under subsection 51(5). In addition, simulated sexual intercourse is a serious form of sexual abuse. As well, there is never a legitimate reason for a health professional to place his or her mouth on a patient's breasts.

Yet none of these forms of sexual abuse are the subject of mandatory revocation of a health professional's certificate of registration under the current mandatory revocation provision of the *Code*. This omission has resulted in some health professionals receiving temporary suspensions rather than losing their certificate of registration to practise. It is time to remedy this gap in the legislation.

For example, in the *College of Physicians and Surgeons of Ontario v. Gorman*,³¹ Dr. Gorman was found to have "engaged in what would be reasonably regarded as disgraceful, dishonourable or unprofessional conduct and sexually abused" his patient within the context of a concurrent psychotherapeutic physician/patient relationship by engaging in sexual acts and behaviour as follows: "(i) lying next to each other, (ii) caressing, (iii) embracing, (v) kissing, including kissing on the lips, (vi) fondling her breasts, and (xi) engaging in a simulated act of sexual intercourse as well as 1.2(vii) placing her breast in his mouth; 1.2(x) asking her to let him perform oral sex on her; and 1.3 sending an essay containing sexual innuendo in an email dated late September 2002, to Patient A."³²

However, the committee found that while the sexual misconduct occurred within the context of a psychotherapeutic relationship, none of the forms of misconduct fell within the acts listed in subsection 51(5) of the *Code*, and therefore the sexual behaviour did not attract mandatory revocation of the doctor's certificate to practise.

It is important to note that, in cases such as this, where sexualized acts have been proven to have been perpetrated by a regulated health professional on one or more patients, colleges are choosing not to exercise their discretion and authority under the RHPA to revoke the certificate required for practice. The specific acts listed in subsection 51 (5), when proven in due process, require mandatory revocation. Yet nothing in the RHPA specifies that this is an exhaustive list. If and when college panels so choose, they can use their discretion to revoke a certificate when patient safety is their paramount concern. It is possible that the scenario of looming, well-funded legal challenges on behalf of some regulated health professionals may be a factor in some of these decisions.

In Dr. Gorman's case, the committee ordered that the registrar suspend his certificate of registration for 24 months, to be reduced to 12 months if he successfully completed an ethics course acceptable to the college and if he continued in psychotherapy with a therapist acceptable to the college for as long as the therapist deemed necessary (but not to be less than two years). The committee also imposed restrictions on Dr. Gorman's practice, including a restriction on his practice in psychotherapy and psychodynamics with respect to female patients, in that such activity must be supervised by a supervisor acceptable to the college. Dr. Gorman was ordered to appear to be reprimanded and required to pay a fine. Subsequently, at Dr. Gorman's request, the committee varied its own restriction by excluding Dr. Gorman's hospital practice from the mandated supervision restriction, and reducing the frequency of supervision of his office practice from monthly to quarterly.³³ On a further motion to vary the supervision term in 2013, the committee determined that ongoing clinical supervision of his private practice was no longer required in order to protect the public interest.³⁴

Recommendation 2. Mandatory Revocation: Zero Tolerance Standard

The *Health Professions Procedural Code* of the RHPA should be amended to add to specific acts defined in section 51.5 that trigger mandatory revocation of the certificate of registration of a member who has been found guilty of a recurrent pattern of sexual abuse under section 1(3) (b) or (c) of the Code (touching of a sexual nature or behaviour or remarks of a sexual nature by the regulated health professional).

The member's college must revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:

- i. sexual intercourse;
- ii. genital to genital, genital to anal, oral to genital, or oral to anal;
- iii. digital penetration or penetration with an object of the mouth; vagina or anus without medical/health care justification;
- iv. masturbation of the member by, or in the presence of, the patient;
- v. masturbation of the patient by the member;
- vi. masturbation of the patient in the presence of the member;
- vii. touching of a patient's breasts without medical/health care justification; or
- viii. simulated sexual intercourse with the patient.

In submissions made to the task force, particularly from the Ontario Coalition of Rape Crisis Centres (OCRCC), a compelling argument was

made *not* to add to the structure of the RHPA, which has already created a hierarchy of acts that are considered to be “serious” sexual abuse. The OCRCC stressed that damage to a patient cannot be accurately measured in relation to certain sexualized conduct not being “serious,” nor can deleterious impact on a patient be pre-determined by the nature of a specific breach of trust.

The task force deeply appreciated OCRCC bringing forth this analysis, and while we are in agreement on principle, nevertheless the task force has concluded that the structure of the RHPA dominates the reality of the system that patients and professionals must navigate. To better protect patients through implementation of the zero tolerance standard, the task force recommends that specific additions are needed to the section 51 (*Code*) list of sexualized acts that trigger mandatory revocation.

In May 2015, the CPSO Council endorsed a number of proposed changes to the sexual abuse provisions in the RHPA, including a proposal for two different definitions of sexual misconduct:

- all physical sexual contact between a physician and a patient would fall within the definition of sexual abuse, and would result in revocation, though not necessarily for the mandatory five years as currently required under section 51 of the *Code*; and
- sexual comments and gestures would be defined as sexual impropriety, and penalties for sexual impropriety would be at the discretion of the CPSO’s Discipline Committee.

This approach is the opposite of what the task force recommends, in that the CPSO proposal would eliminate the list of specific acts — currently in section 51 of the *Code* — that trigger mandatory revocation. However, the CPSO proposal is of interest in that all physical sexual contact between a doctor and a patient would be deemed a fundamental breach of a physician’s obligation to patients that requires revocation. Fundamental to this aspect of the proposed amendment, however, is doing away with the current minimum five-year period prior to a reinstatement application, in all cases of mandatory revocation. In effect, the CPSO proposal would restore to discipline committee panels much wider discretion than is currently allowed under the RHPA, including the power to specify a period between one and five years before a physician can apply for reinstatement following a revocation for sexual abuse or other professional misconduct of a sexual nature.

Of particular concern to the task force is the pattern of decisions by colleges, discussed elsewhere in this chapter and in the case chosen to demonstrate task force concerns more extensively in Appendix G, with the CPSO having the most sexual abuse cases of any college, to “divert” discipline cases from the zero tolerance standard implicit in the mandatory revocation provisions of the RHPA. While the CPSO and other colleges are to be acknowledged for initiatives that respond to a range of concerns, the information available to the task force about such initiatives is not sufficient to alter our first recommendation that Ontario patients should not be required by the RHPA to make complaints of sexual abuse to the colleges, and that a new government agency, with the suggested title of the Ontario Safety and Patient Protection Authority (OSAPPA), be established.

Stopping Gender-Based Restrictions that Enable Sexually Offending Health Professionals to Continue to Have Access to Patients

When it is recognized (as affirmed by our courts) that sexual abuse of a patient is about the abuse of power, authority and trust within the context of a health care relationship, and not about sexual preferences of the health professional, it becomes readily apparent that the imposition of gender restrictions, such as prohibiting a health professional from treating females because they have sexually abused one or more female patients, but permitting the health care professional, notwithstanding the finding of sexual abuse, to continue treating male patients, is missing the point and continues to place the public (or a segment of it) at risk for future sexual abuse. It also falls short of the zero tolerance standard, since the implicit message of imposing a gender restriction as a condition of ongoing practice is that the public trust has only been violated with part of the population. Once a health professional is found to have sexually abused a patient, the health professional has, by extension, betrayed the public’s trust in preserving the safety and well-being of all patients.

On a practical note, policing compliance by health professionals with respect to these types of gender-based restrictions has proven to be a challenge. A recent example demonstrating this difficulty is the case of *College of Physicians and Surgeons of Ontario v. Tadros*.³⁵

In *Tadros*, three separate patients alleged that Dr. Tadros had committed acts of professional misconduct in that he engaged in sexual abuse of them. The nature of the sexual abuse included repeated sexual intercourse over a period of time with each of the patients (and oral sex with two of the patients)

that occurred concurrent with the treatment provided by Dr. Tadros to each of these patients. Prior to this matter going to discipline committee, the Inquiries, the CPSO's Complaints and Reports Committee (ICRC) made an order, on July 15, 2014, under section 37 of the *Code*, directing the registrar to impose terms, conditions and limitations on Dr. Tadros's certificate of registration that included the term that Dr. Tadros not engage in any professional encounter or interaction with any female person, except in the presence of a monitor.

It subsequently came to the attention of the ICRC that Dr. Tadros failed to comply with the terms of the section 37 order by, among other things, repeatedly having professional encounters and interactions with female patients without a monitor, failing to comply with the requirements of the order regarding posting a sign advising of this gender restriction to his practice, failing to maintain a log and failing to submit to and not interfere with unannounced inspections of his office and practice by the CPSO for the purposes of monitoring and enforcing his compliance with the terms of the section 37 order.

Hence, on September 16, 2014, the ICRC varied the terms of the section 37 order to impose the stricter condition that Dr. Tadros not engage in any professional encounter or interaction with any female person under any circumstances. It then came to the ICRC's subsequent attention that Dr. Tadros breached the terms of this revised order by continuing to have professional encounters and interactions with multiple female patients. This included his interaction with female patients at a medical spa. It was revealed that Dr. Tadros never advised the owners of that medical spa of the terms of the section 37 order and did not post the requisite sign advising of the section 37 order, as revised from time to time, at the medical spa. Therefore, on November 7, 2014, the ICRC varied the terms of the original section 37 order for a second time, directing the registrar to suspend the doctor's certificate of registration effective November 8, 2014.

On May 6, 2015, the CPSO's Discipline Committee ordered and directed, among other things, that Dr. Tadros's certificate of registration be revoked, effective immediately.

This case is illustrative of the point that imposing a gender restriction as a term of practice, in the face of sexual abuse allegations, is not an adequate measure for protecting the public or for addressing a concern that the conduct of the member exposes, or is likely to expose, his or her patients to harm or injury, as per subsection 37(1) of the *Code*.

In the case of *College of Physicians and Surgeons of Ontario v. Maharajh*,³⁶ the CPSO's Discipline Committee issued a decision on July 29, 2013, in which it found that Dr. Maharajh committed an act of professional misconduct in that he engaged in the sexual abuse of a patient, and in that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonorable or unprofessional. In particular, Dr. Maharajh, a family physician, touched his patient's breasts and nipple, including cupping her nipple with his mouth, without medical justification.

Dr. Maharajh admitted that, in addition to this transgression, he had engaged in conduct that was similar to the inappropriate conduct engaged in with the complainant with approximately 10 to 12 other female patients between approximately 2005 and 2011. The committee ordered and directed that the registrar suspend Dr. Maharajh's certificate of registration for eight months, apparently in relation to all of the patients whom he admitted to having either placing his mouth on the patient's breast or allowing his cheek to rest "lightly" on the patient's breast. The committee also ordered and directed that the registrar impose certain terms, conditions and limitations on Dr. Maharajh's certificate of registration for an indefinite period of time, which included a term that Dr. Maharajh's practice is restricted to male patients only.³⁷

Imposing gender restrictions on a health professional does not ensure patient safety and demonstrates a lack of understanding of the power and control dynamics within the health professional/patient relationship.

Recommendation 3. No Gender-Based Restrictions

As discussed in detail in this chapter, with case examples, the Minister's Task Force recommends immediate stoppage of any decision-making body under the RHPA placing gender restrictions on the scope of practice where a health professional has been found to have had sexualized contact with one or more patients, in contravention of any of the sections of the *Code* related to sexual abuse and/or misconduct and/or impropriety.

The *Health Professions Procedural Code* should be amended by adding a new subsection to s. 51 to clarify that, notwithstanding section 37(1) and subsection 51(2)3, where the member has committed, or has been alleged to have committed, an act of professional misconduct by sexually abusing a patient, gender restrictions on the member's ability to practise as a term,

condition or limitation on the member's certificate of registration are not to be imposed.

Recommendation 4. Ontario Safety and Patient Protection Authority (OSAPPA)

The Government of Ontario should establish OSAPPA, the Ontario Safety and Patient Protection Authority, with the mandate to uphold the standard of zero tolerance of sexual abuse of patients and receive dedicated long-term resources to support that mandate, including to provide for:

- public education and outreach, with particular attention and resources to cultural sensitivity and competency;
- educational liaison with all programs for students in the regulated health professions;
- supports to patients reporting sexual abuse by regulated health professionals; and
- complaints and investigations, but with adjudication of sexual abuse complaints by the independent OSAPPA Tribunal.

Recommendation 5. Fast Tracking Sexual Abuse Complaints

All discipline cases of sexual abuse by health care professionals should be given priority and fast tracked by the colleges during the transition to OSAPPA and any such occasion thereafter. The modernized RHPA is to place legislated onus on regulatory colleges to make immediate referrals of patients with sexual abuse complaints to OSAPPA — in person with written information provided to facilitate the patient's access to OSAPPA services, and in writing — by the most efficient possible electronic means directly to OSAPPA. Every regulatory college is to be mandated to include a record of all patient visits and other forms of inquiry vis-à-vis the sexual abuse of patients (not only referrals to a discipline panel) with documentation as to the speed and nature of referrals to OSAPPA. The modernized RHPA is to mandate OSAPPA with resources and reporting responsibility to ensure that sexual abuse complaints are processed within the required timeline.

Recommendation 6. Patient Privacy and Confidentiality

Oversight by the Ministry of Health and Long-Term Care should be vigilant, to ensure that the existing protection in section 85.3(4) of the *Health Professions Procedural Code* is upheld so that a reporting member does not give the name of the patient-complainant unless the member has the

express, written consent of the patient, for patients who are able to provide consent. For patients who are not able to provide consent for reasons of age (children) or mental or physical disability, consent must be provided by the legal guardian/power of attorney. However, when a complaint is received, the registrar of the college of the health professional making the report is to receive a copy of the mandatory report by that health professional, even when the patient is not named in the report.

Recommendation 7. Full Participation of Patients

In order to increase access to justice for patients, it is recommended that — instead of at the discretion of discipline panels to “allow” patients some greater participation in hearings, as set out in subsections 41.1(1)(b) and (2) — the *Health Professions Procedural Code* be amended to include the following provisions for complainants in sexual abuse cases:

- all complainants should have the right to participate in the proceedings of any complaints or disciplinary hearings, as a full party, with their own legal representation provided by the colleges and OSAPPA after transition;
- all complainants should have the right to a support person of her choice at the expense of the health regulatory colleges, and after transition, OSAPPA;
- the RHPA should clearly provide to all complainants in sexual misconduct/abuse proceedings the option to testify behind a screen or by closed-circuit electronic means;
- all complainants should have the opportunity, in accordance with current RHPA provisions, where the member is found guilty, to submit a victim impact statement and not be cross-examined on that statement, such statement to be taken into account in the assessment of a remedy or penalty;
- a videotape of an interview with the complainant may be admitted in evidence if the complainant, while testifying, adopts the content of the video-tape; and
- under no circumstances should the alleged perpetrator of the sexual abuse be permitted to cross-examine the complainant personally.

Recommendation 8. OSAPPA Tribunal — Adjudication

The Government of Ontario should establish a tribunal that should provide independent adjudication for OSAPPA cases, which could be a new tribunal

or developed as a specialized branch of the Ontario Human Rights Tribunal or as a thorough restructuring of the Health Professions Appeal and Review Board (HPARB).

Recommendation 9. Health Professions Appeal and Review Board – Restructuring Review

A. A review as to the possible restructuring of the Health Professions Appeal and Review Board (HPARB), taking into account the Professional Standards Authority for Health and Social Care in the United Kingdom, the Health Practitioner Disciplinary Tribunal in New Zealand and the Ontario Human Rights Tribunal, should be conducted for the Minister’s Implementation Council to assess and then advise the minister as to whether a restructured HPARB should function as the independent tribunal to decide OSAPPA cases.

B. In any event, the *Health Professions Procedural Code* should be amended to require HPARB to:

- render a decision within 120 days of receiving the request for review of a decision of a complaints committee panel;
- allow patients as full parties to review hearings, whether in person or by other means; and
- report annually on the number of appeals heard and the number of those where the board dismissed appeals by patients, such report to be made in a timely manner to be included in the public report of the Minister of Health and Long-Term Care to the appropriate committee of the Ontario Legislature.

Recommendation 10. Evidentiary Rules at Discipline Hearings in Sex Abuse Complaints

The *Health Professions Procedural Code* should be amended with a new provision that the evidentiary rules governing sexual abuse complaints and related discipline hearings are governed by the *Statutory Powers Procedures Act*.

Recommendation 11. Admissibility of Evidence

Subsection 36(3) of the RHPA should be amended so that evidence on the findings, orders or decisions in disciplinary proceedings under the RHPA are admissible in civil proceedings.

Recommendation 12. Expert Witnesses in the Dynamics of Sexual Abuse of Patients

The OSAPPA should appoint at least two independent experts with specialized backgrounds in research and/or practice related to the dynamics and impact of sexual abuse by health care professionals. These experts can present evidence at complaints, discipline and reinstatement proceedings, to ensure that the OSAPPA tribunal has the benefit of this expertise to take into consideration, rather than the prosecution and defence each appointing their own experts.

Recommendation 13. Resources for Participation of Patients in Investigation and Adjudication

Patients deserve appropriate and timely resources for full participation in the investigation and adjudication of sexual abuse complaints including access to therapy funds (during and after transition to the OSAPPA model).

A. Provincial rules and legislation should be amended to ensure that any fines imposed on a member for the sexual abuse of a patient should be designated as a separate fund under the jurisdiction of OSAPPA, to be used for support to patients, including therapy and counselling for eligible patients.

B. Subsection 85.7(4) of the *Health Professions Procedural Code* should be amended so that interim funding for patient therapy is provided prior to the hearing stage by colleges (during transition) and by OSAPPA.

Recommendation 14. Therapy and Counselling

A. A regulation pursuant to section 85.7 of the *Health Professions Procedural Code* should be made to clarify that funds are to be provided to the patient-complainant throughout a sexual abuse complaint process to cover the cost of medications, childcare and reasonable travel/accommodation expenses associated with accessing therapy related to the sexual abuse.

B. A regulation pursuant to the RHPA should stipulate that a patient is also eligible for funding for therapy or counselling if:

- there is an admission made by a member in a statement to the college (during transition) or to OSAPPA or the OSAPPA tribunal that the member sexually abused the patient;

- the member has been convicted under the *Criminal Code of Canada* of sexually assaulting a person while that person was a patient of the member; or
- OSAPPA staff determine that there is sufficient evidence to support a reasonable belief that the patient was sexually abused by a member.

Recommendation 15. Protection from Sexual Abuse by Unregulated Health Practitioners

A. The Ministry of Health and Long-Term Care (MOHLTC) and OSAPPA should commission research to determine the most effective legislative means for creating and maintaining a public record listing unregulated health practitioners who were previously licensed in Ontario or other jurisdictions, but who have lost their certificates of registration due to findings against them of sexual abuse of patients.

B. Currently unregulated health care providers — for example, sonographers — need to be identified and assigned to an existing college for regulation in the interest of patient safety, and where unregulated health care providers are contracted to or employed by regulated health professionals or health care corporations, the regulated health professionals and/or corporations are to be held responsible for acts of sexual abuse or harassment by those employees/sub-contractors by amendments to the RHPA and the *Excellent Care for All Act*.

Recommendation 16. Enforcement of Mandatory Reports of Sexual Abuse Complaints

All health care institutions and corporations providing health services to patients in Ontario, including hospitals, universities and private clinics, should become subject to fines between \$100,000 and \$250,000 for failure to make a mandatory report of alleged sexual harassment, sexual misconduct, exploitation or abuse. Despite more than 20 years of cases since the RHPA was amended to include explicit institutional obligations to report, not one institution has been held accountable for sexual abuse of patient(s) that was proven to have occurred within its jurisdiction.

Recommendation 17. Prerequisites for New or Renewed Registration

The RHPA should be amended to enhance prerequisites for new or renewed registration for regulated health professionals, to ensure that:

- powers under the RHPA (for example in in subsection 43 (1)(f)) and the *Health Professions Procedural Code* (for example, in subsection 94(1)) must be used to have all college councils change by-laws to require mandatory answering of questions by applicants/members on any complaints of sexual abuse or harassment against the applicant/member before certificates of registration are obtained initially or renewed annually;
- applications for a certificate of registration or for reinstatement of a certificate to any college under the RHPA are to require verification as to good character, including sworn statements as to previous convictions or charges of a criminal nature, any civil findings where the member has been a party in a lawsuit involving sexual abuse or harassment, and detailed reasons given for resignation or suspension if the member has resigned or was suspended from a college or any other health profession in any other jurisdiction in the world; and
- applications for reinstatement must include reference to any conditions placed by the college or OSAPPA, which the health professional was to meet, and evidence that the conditions have been met, as well as identifying the official(s) and expert(s) who deemed the evidence acceptable.

Recommendation 18. Access to Justice for Ontario Patients Pilot with Legal Aid Ontario

An Access to Justice for Patients pilot project with Legal Aid Ontario (LAO) is to be facilitated by the Inter-Ministerial Implementation Group, as per Recommendation 24. The Government of Ontario should provide adequate financial and other resources to LAO to launch and sustain this pilot project. The project will remove barriers that prevent patients in vulnerable populations from:

- getting comprehensive, understandable information and education about sexual abuse by regulated health professionals;
- reporting sexual abuse and impropriety for action to be taken; and
- receiving appropriate and timely resources so that they can fully participate in the investigation and adjudication of sexual abuse complaints.

Recommendation 18 is essential to an effective shift to the OSAPPA model by making the complaints and disciplinary process for patients more transparent and meaningful, through increased access to public legal information as well as skilled, culturally competent legal counsel. The

project should be delivered through coordinated, sustainable programs by adequately resourced community-based organizations that are oriented to patient safety and patient rights.

A. Ontario should fund the development and delivery of a five-year pilot project, using the Barbra Schlifer Commemorative Clinic as lead community partner, to develop core legal competence for a vulnerable patient population, and to engage in direct patient legal advocacy and support throughout the complaint and discipline process. This five-year project should be evaluated at the end of year three, at which time a renewal plan will be created for the remaining two years of the pilot, with another evaluation and planning stage, with the stated goal of long-term, sustained access to justice for this vulnerable population.

B. Funding for this five-year project should include the hiring of at least two full-time legal counsel (based at the Schlifer Clinic for at least the first three years of the pilot project while OSAPPA is set up) to support the development of core legal competence of legal aid clinic lawyers and other legal aid service providers throughout the province.

C. As the lead agency, the Schlifer Clinic should collaborate with other legal advocacy partners (e.g., Community Legal Education Ontario [CLEO], ARCH Disability Law Centre, the Advocacy Centre for the Elderly [ACE], Nishnawbe-Aski Legal Services, the African Canadian Legal Clinic [ACLC], Aboriginal Legal Services of Toronto, the South Asian Legal Clinic of Ontario, Justice for Children and Youth, etc.) in consultation with the Ontario Federation of Indian Friendship Centres (OFIFC) and other community-based networks, such as METRAC and Patients Canada, as appropriate, to promote cultural competency, diversity and effective outreach to patients in marginalized and hard-to-reach communities across the province.

D. The Schlifer Clinic and LAO, in collaboration with other legal advocacy partners, as appropriate, should ensure that they develop appropriate statistical and qualitative tools to measure and understand client needs. This information can be used for ongoing needs assessment, financial planning and service delivery purposes in the transition to OSAPPA and beyond.

E. The Government of Ontario will direct Legal Aid Ontario to inform patients about and direct them to the legal aid certificate programs (see below), and to train and sensitize staff at legal aid offices and legal aid clinics in the competencies required to meet the unique needs of patients who have

experienced sexual abuse by regulated health care professionals (consistent with augmenting the sensitivity training provided as part of LAO's Domestic Violence Strategy). Training should be adapted to meet the desired outcomes in this recommendation, and increased access to justice for Ontario patients should include the following actions, as needed:

- i. Expand the current summary advice legal aid certificate program to provide two hours of summary advice to potential/actual complainants, and to support this expansion with resources and action, which will include the following:
 - (a) establishing a panel of eligible lawyers throughout the province who have the core competence to provide such advice;
 - (b) proactively informing frontline service organizations of the existence of, and eligibility for, this new legal aid certificate (e.g., the Ontario Coalition of Rape Crisis Centres [OCRCC], hospitals with sexual assault services, legal aid clinics, etc.);
 - (c) proactively engaging the legal profession and inviting lawyers with the appropriate eligibility criteria to be included on the panel; and
 - (d) as part of LAO's financial eligibility test expansion, possibly relaxing the strict financial eligibility criteria (for legal aid certificates) for this vulnerable client population. The revised criteria should be consistent with LAO's June 8, 2015, announcement³⁰ to expand its certificate services in criminal law, family law and refugee/immigration law and for mental health legal proceedings, as well as its November 2014 announcement³¹ to implement a higher financial eligibility test for family law clients who have experienced domestic violence.
- ii. Expand the current legal aid certificate program to permit patients alleging sexual abuse by a regulated health professional to obtain legal counsel throughout the discipline process (i.e., from the initial complaint to the hearing and the appeal). Legal Aid Ontario should develop eligibility criteria to establish a panel of qualified lawyers who have both legal competence in the area of patient sexual abuse and sensitivity training in dealing with survivors of sexual abuse.
- iii. Adjust LAO financial eligibility criteria so that they are not a barrier to Ontario patients in this pilot.
- iv. As a priority service, encourage Ontario's 76 legal aid clinics to develop a coordinated plan on how best to deliver legal services to eligible patients who have alleged sexual abuse by regulated health care professionals, consistent with this emerging area of legal representation.

- v. Set, as a specific priority for LAO public interest work, sexual violence in the regulated health professional context for the Group Applications and Test Case Committee of LAO, recognizing that complainants are a marginalized group.

Public Education and Legal Information Resources for the New Complaints Processes

F. Ontario should fund and develop an effective public education and legal information program, co-chaired by CLEO and METRAC, that informs the Ontario public about patients' legal rights and options for recourse when they have suffered sexual abuse by a regulated health care professional. The program will include information on:

- the scope of behaviours that constitute sexual abuse;
- the health care and forensic evidence collection services provided at sexual assault/domestic violence treatment centres across Ontario;
- the option of filing and pursuing a complaint and discipline process;
- patients' rights and status within complaint and discipline proceedings;
- the legislative provisions of the RHPA and its Code vis-à-vis patient sexual abuse;
- additional legal options under criminal and civil law; and
- legal support services and legal aid-funded services.

G. In implementing this aspect of the Access to Justice pilot project, CLEO and METRAC should offer to collaborate with other organizations that have public legal education mandates (such as Luke's Place, the Legal Education and Action Fund [LEAF], Action Ontarienne contre la violence faite aux femmes [AOcVF], the Ontario Federation of Indigenous Friendship Centres and others, as appropriate), in order to:

- i. identify effective strategies for developing relevant public legal information training and resources for service providers to assist them in responding to patients' disclosure of sexual abuse by health care professionals; and
- ii. engage diverse patient communities to develop relevant public education and legal information through the selection of topics and resource formats that ensure accessibility, and specification of relevant outreach and communications methods. The program will facilitate effective distribution of information based on intersecting needs and the provision of ongoing community feedback for improving program relevance and responsiveness, and contributing to a final evaluation to measure program results and overall effectiveness.

H. Ontario-coordinated funding to support the Access to Justice pilot should explicitly support inter-sectoral coordination and sharing of information and services across multiple sectors, including the following:

- i. ServiceOntario will distribute materials to individuals and institutions across Ontario, including government offices, patient advocates and service provider organizations.
- ii. The Government of Ontario will develop a program to educate lawyers about how to most effectively represent patients who have been sexually abused by regulated health professionals with respect to the related disciplinary processes. The government will do this in partnership with an appropriate agency, such as the Law Society of Upper Canada and/or the Ontario Bar Association.
- iii. Consolidation and distribution of examples of “lessons learned” and culturally competent proven practices, including highlighting different educational models, such as community-based approaches that include models for evaluation that can measure outcomes among multiple services and sectors, and incorporate access and equity principles.

For Immediate Implementation

Develop Core Legal Competence and Accessible, High-Quality In-House Counsel

These recommendations are aimed at making the complaints and disciplinary process for patients more transparent and meaningful by enhancing access to justice, through the availability of skilled legal counsel and important public legal information, to this process. In addition, with the creation of a new complaints and investigative regime in the form of OSAPPA, the legal aid network of lawyers and services will require specialized training in order to provide quality legal services to complainants, and the sensitivities which surround representing victims of trauma.

i. Develop and fund a pilot project, using the Barbra Schlifer Commemorative Clinic as lead partner, to develop core legal competence for a vulnerable patient population, and to engage in direct patient legal advocacy and support throughout the complaint and discipline process.

Specifically:

- (a) this would be a three-year pilot project, subject to an evaluation and renewal at the end of this period, and ultimately would become a permanent service;

- (b) funding would include a component dedicated to the hiring of at least two full-time counsel, who would be charged with developing core legal competence and would help educate legal aid clinic lawyers and other legal aid service providers to develop core legal competence and sensitivity training. These lawyers would ultimately become in-house counsel at the Ontario Safety and Patient Protection Authority (OSAPPA) Patient Access Centre (see Recommendation 4). They would be available as a legal support and training resource to other legal aid clinics and legal aid services across the province. The number of counsel ultimately hired to fulfil these functions would be commensurate with the caseload. These counsel would be based at the Schlifer Clinic as part of the three-year pilot project;
- (c) the Schlifer Clinic would collaborate with other legal advocacy partners (e.g., CLEO, ARCH Disability Law Centre, the Advocacy Centre for the Elderly [ACE], Nishnawbe-Aski Legal Services, the African Canadian Legal Clinic, Aboriginal Legal Services of Toronto, the South Asian Legal Clinic of Ontario, Justice for Children and Youth, etc.) as appropriate to promote diversity and enhance effective outreach to patients in marginalized and hard-to-reach communities province-wide; and
- (d) the Schlifer Clinic and Legal Aid Ontario, in collaboration with other legal advocacy partners, as appropriate, should ensure that they develop appropriate statistical and qualitative tools to measure and understand client needs. This information can be used for ongoing needs assessment, financial planning and service delivery purposes.

Enhance Accessibility to Quality Legal Services Across Ontario

- i. The government of Ontario will provide adequate financial and other resources to LAO to fund quality legal services across the province in accordance with this recommendation.
- ii. The government of Ontario will direct Legal Aid Ontario to inform patients about and direct them to the legal aid certificate programs identified in items iii and iv (below), and to train and sensitize the staff at legal aid offices and legal aid clinics in the competencies required to meet the unique needs of patients who have experienced sexual abuse by regulated health care professionals (consistent with the sensitivity training provided as part LAO's Domestic Violence Strategy).

- iii. Expand the current summary advice legal aid certificate program to provide two hours of summary advice to potential/actual complainants; this expansion will include:
- (a) establishing a panel of eligible lawyers throughout the province who have the core competence to provide such advice;
 - (b) proactively informing frontline service organizations of the existence of, and eligibility for, this new legal aid certificate (e.g., Ontario Coalition of Rape Crisis Centres, hospitals with sexual assault services, legal aid clinics, etc.);
 - (c) proactively engaging the legal profession and inviting lawyers with the appropriate eligibility criteria) to be included on the panel; and
 - (d) as part of LAO's financial eligibility test expansion, consider relaxing the strict financial eligibility criteria (for legal aid certificates) for this vulnerable client population. The revised criteria should be consistent with LAO's June 8, 2015, announcement to expand its certificate services in criminal law, family law, refugee/immigration law and for mental health legal proceedings, as well as its November 2014 announcement to implement a higher financial eligibility test for family law clients who have experienced domestic violence.
- iv. Expand the current legal aid certificate program to permit patients alleging sexual abuse by a regulated health professional to obtain legal counsel throughout the discipline process (i.e., from the initial complaint to the hearing and the appeal). Legal Aid Ontario will develop eligibility criteria to establish a panel of qualified lawyers who have both legal competence in the area of patient sexual abuse and sensitivity training in dealing with survivors of sexual abuse, consistent with Recommendation 2.
- v. Legal Aid Ontario will consider relaxing the strict financial eligibility criteria so that it is consistent with iii (d), above.
- vi. Encourage Ontario's 76 legal aid clinics to consider delivering legal services to eligible patients alleging sexual abuse by regulated health care professionals as a priority service, consistent with this emerging area of legal representation.
- vii. Legal Aid Ontario will set, as a specific priority for its public interest work, sexual violence in the regulated health professional context for the Group Applications and Test Case Committee, recognizing that complainants are a marginalized group.

Develop and Disseminate Public Education and Legal Information Resources for the New Complaints Processes

- i. Ontario will fund and develop an effective public education and legal information program in which CLEO and METRAC will work together to inform the public of patients' legal rights and options related to disciplinary procedures when they have suffered sexual abuse by a regulated health care professional. This program will include information on:
 - the scope of behaviours that constitute sexual abuse;
 - the option of filing and pursuing a complaint and discipline process;
 - patients' rights and status within complaint and discipline proceedings;
 - the legislative provisions of the *Regulated Health Professions Act* and the *Health Professions Procedural Code* relating to patient sexual abuse;
 - additional legal options under criminal and civil law; and
 - legal support services and legal aid funded services.
- ii. CLEO and METRAC will collaborate with other organizations that have public legal education mandates, such as Luke's Place and LEAF, Action Ontarienne contre la violence faite aux femme and others as appropriate. The program will:
 - a) identify effective strategies for developing relevant public legal information training and resources for service providers to assist them in responding to patients' disclosure of sexual abuse by health care professionals; and
 - b) engage diverse patient communities to develop relevant public education and legal information through the selection of topics and resource formats that ensure accessibility, and specification of relevant outreach and communications methods. The program will facilitate effective distribution of information based on intersecting needs and the provision of ongoing community feedback for improving program relevance and responsiveness, and contributing to a final evaluation to measure program results and overall effectiveness.
- iii. ServiceOntario will distribute materials to individuals and institutions across Ontario, including government offices, patient advocates and service provider organizations.
- iv. The government of Ontario will develop a program to educate lawyers about how to most effectively represent patients who have been sexually abused by regulated health professionals with respect to the related disciplinary processes. The government will do this in partnership with an appropriate agency, such as the Law Society

of Upper Canada and/or the Ontario Bar Association.

- v. These initiatives will consolidate and distribute examples of best practices, including highlighting different educational models, such as community-based approaches. They will also offer models for evaluation that can measure outcomes among multiple services and sectors, and incorporate access and equity principles.

For Longer-Term Implementation

Integration with the Ontario Safety and Patient Protection Authority

- i. Once the OSAPPA (a centralized public agency that will handle all complaints and investigations into alleged patient sexual abuse by regulated health care professionals, up to the discipline hearing stage) is established, LAO will fund in-house counsel to provide initial summary legal advice to all prospective/actual complainants, navigate complainants through the investigatory and discipline processes and represent claimants (whether as full or limited standing parties) through any resultant discipline hearings and appeals. The number of in-house counsel to be funded will be determined commensurate with the caseload, and will be subject to an ongoing client needs assessment. It is anticipated that the initial number of counsel will be greater than two; this takes into account the steep learning curve, and will include legal counsel retained for purposes of the pilot reflected in Recommendation 1. The Ontario government will provide funding for LAO to develop appropriate statistical and qualitative tools to measure and understand client needs, in collaboration with other legal aid clinics and agencies, as it may consider appropriate. This information can be used for ongoing needs assessment, financial planning and service delivery purposes.

Endnotes

1. Legal Aid Ontario, About LAO (n.d), retrieved from <http://www.legalaid.on.ca/en/about/Default.asp>.
2. Community Legal Education Ontario, About CLEO, 2012, retrieved from <http://www.cleo.on.ca/en/about/about-cleo>.
3. Giannitsopoulou, S., "The Barbra Schlifer Clinic Received the WLAO President's Award: Read Schlifer Clinic ED, Amanda Dale's Speech! Executive Director, Amanda Dale's address to the Women's Law Association of Ontario [WLAO] on the occasion of receiving the President's Award for the Barbra Schlifer Clinic," 2011, presented at the Rosewater Supper Club, Toronto, retrieved from <http://schliferclinic.com/the-barbra-schlifer-clinic-received-the-wlao-presidents-award-read-schlifer-clinics-ed-amanda-dales-speech>.

4. METRAC Action on Violence, About (n.d.), retrieved from <http://www.metrac.org/about>.
5. Other examples of cases in which health professionals initially received suspensions, rather than revocation of their license to practice, notwithstanding findings by discipline committees of sexual touching of a patient's breast, without medical cause, include *College of Physicians and Surgeons of Ontario v Maharajh, S. N.*, 2013 ONCPSD 37 (CanLII), interim terms imposed November 5, 2013 and discipline decision released July 29, 2013; and *College of Physicians and Surgeons v Peirovy*, 2015 ONCPSD 30 (CanLII), interim terms imposed July 23, 2013, and discipline decision released July 17, 2015.
6. The College of Psychologists of Ontario, *Discipline Proceedings*, April 21, 2009, retrieved from <http://www.cpo.on.ca/WorkArea/DownloadAsset.aspx?id=628>.
7. *Health Professions Procedural Code*, Schedule 2 of the RHPA (<https://www.ontario.ca/laws/statute/91r18#BK52>).
8. *Norberg v. Wynrib*, [1992] 2 SCR 226, 1991 CanLII 7424 (SCC).
9. *College of Physicians and Surgeons of Ontario v Mussani* (2004), 74 OR (3d) 1, 2004 CanLII 48653 (Ont CA).
10. See also *McInerney v MacDonald*, [1992] 2 SCR 138, 1992 CanLII 57 (SCC).
11. See also *R v. Litchfield*, [1993] 4 SCR 333, 1993 CanLII 44 (SCC); and *R v. Matheson* (1999), 44 OR (3d) 557, 1999 CanLII 3719 (ON CA).
12. *Re Axelrod (In Bankruptcy)*(1994), 20 OR (3d) 133, 1994 CanLII 3446 (ON CA). Other cases in which courts have characterized the relationship between health professionals and patients as fiduciary include: *Huet v. Lynch*, 184 DLR (4th) 658, 2000 ABCA 97 (CanLII); *J.G. v. Tyhurst* (2003), 226 DLR (4th) 447, 2003 BCCA 224 (CanLII) ; *D.M.M. v. Pilo*, [1996] O.J. No. 938 (Gen.Div.)(Q.L.), *JK v. Alfred*, [1996] O.J. No. 2461 (Gen. Div.)(Q.L.), *C (DC) v Starzecki*, [1996] 2 W.W.R. 317 (Man. Q.B.); *Taylor v. McGillivray* (1993), 143 NBR (2d) 241, 1993 CanLII 6916 (NB QB); and *W (B) v. Mellor*, [1989] B.C.J. 1393 (S.C.)(Q.L.).
13. *Supra*, note 6.
14. *Mussani*, paragraph 71.
15. See for example, *Mussani*, paragraph 66.
16. *The College of Physicians and Surgeons of Ontario v. Powell, G. W.*, 2014 ONCPSD 8 (CanLII).
17. *Ibid.*
18. The Notice of Hearing did not include the allegation that Dr. Powell had committed an act of sexual abuse against a patient, and hence it appears that the Inquiries, Complaints and Reports Committee declined to send the Complaint to discipline on that specific allegation
19. *Ontario (College of Physicians and Surgeons of Ontario) v. Carter*, 2012 ONCPSD 14 (CanLII).
20. *College of Physicians and Surgeons of Ontario v. Minnes, B. G.*, 2014 ONCPSD 27 (CanLII).
21. *Ontario (College of Physicians and Surgeons of Ontario) v. Carter*, 2012 ONCPSD 14 (CanLII).
22. *Ibid.*, p. 6.
23. This case also involved multiple complaints relating to boundary violations alleged by staff who worked at the same hospital at which Dr. Minnes had privileges. These complaints were also validated.
24. *Mussani*, paragraph 84.
25. *Supra*, note 11, p. 23.

26. Ibid., p. 24.
27. Ibid., p. 22.
28. Ibid., pp. 7-8.
29. *Supra*, note 11.
30. Ibid., pp. 7-8. *College of Physicians and Surgeons v Schogt*, 2004 ONCPSD 16 (CanLII). involved sexualized boundary-crossi within months of the last formal psychotherapeutic treatment and resulted in an interim limitation of a a month-long suspension on the basis that the complainant was no longer a “patient” at the time of the sexualized activity. See also *College of Physicians and Surgeons v Redhead*, 2013 ONCPSD 18 (CanLII).
31. 2007 ONCPSD 6 (CanLII).
32. Ibid., pp. 37-40.
33. This was varied by an Order of the Discipline Committee dated June 8, 2011. As cited in *College of Physicians and Surgeons of Ontario v Gorman, R.*, 2013 ONCPSD 33 (CanLII).
34. *College of Physicians and Surgeons of Ontario of Ontario v. Gorman, R.*, 2013 ONCPSD 33 (CanLII).
35. *College of Physicians and Surgeons of Ontario v. Tadros*, 2015 ONCPSD 27 (CanLii).
36. *College of Physicians and Surgeons of Ontario v Maharajh, S. N.*, 2013 ONCPSD 37 (CanLII).
37. See also the case of *College of Physicians and Surgeons v Peirovy*, 2015 ONCPSD 30 (CanLII) for another example of a college imposing a gender restriction in response to allegations of sexual abuse against a patient.

Chapter 6:

Research and Education Priorities

International Context

The World Health Organization's (WHO's) violence prevention strategy stresses the importance of identifying optimal practices, compiling and disseminating information, supporting evidence-based policy-making, building capacity and advocating in order to promote the highest levels of health. These principles are embedded in our strategy to prevent sexual abuse of patients because, to be sustained, systemic, permanent and meaningful change must be measured on an ongoing basis. Such an approach will also reassure the Ontario public and government that improvements are being made in the face of historical failures to properly address these incidents and respond in affirming, respectful and patient-centred ways.

In addition, evidence-based policy-making requires establishing baseline measures, tracking progress, measuring impact, defining optimal practices and disseminating the results, in order to promote an effective strategy, with adjustments based on evidence drawn from meaningful comparative measurements in evaluations planned and implemented for five, ten, 15 and 20 years. Ongoing measurement approaches will assess the effect of these reforms and provide key information regarding the reform of the disciplinary system regarding sexual abuse of patients in Ontario, as well as to the important, deserved recovery processes of victims, their families and their communities.

Complex problems require complex solutions and a robust ecological rights framework to inform effective strategy and policy-making. The task force has adapted the WHO framework for its ecological human rights framework, which is consistent with Premier Wynne's "whole of government" approach to countering violence across all sectors and at all levels. This multi-layered, inter-ministerial and intersectoral approach engages all sectors of Ontario's government and population in understanding and addressing the sexual abuse of patients. In order to uphold the zero tolerance of sexual abuse standard, a sustainable investment in research, evaluation and

education is essential. The Task Force recommends the Minister provide support to encourage research on the complex dimensions of the problem as well as strategies across jurisdictions, robust tracking and analysis of data and complaints, formal evaluation of OSPPA, as well as mechanisms for knowledge dissemination, including an annual symposium and multisectoral educational initiatives. Without clear research, evaluation, and knowledge dissemination initiatives, any improvement in Ontario's response to sexual abuse of patients will go either undone or unrecognized, and long overdue shifts in public response and private experiences will not be identifiable. The impact of Ontario's response to the sexual abuse of patients must move beyond conjecture and more importantly, opportunities to mobilize all sectors to address the problem must not be missed.

Bold Reform Requires Effective Implementation

Recommendation 19. Minister's Implementation Council

A. The Minister of Health and Long-Term Care (MOHLTC) should immediately establish the Minister's Implementation Council for an initial renewable five-year term, to make an annual public report to the minister, who in turn should report to a standing committee of the Ontario Legislative Assembly. Reports should include a detailed summary of cases, patient evaluations of processes and responses, an audit of decisions, evaluation of OSAPPA and suggestions for more effective procedures and educational initiatives for preventing the sexual abuse of patients in the public interest. Membership in the Minister's Implementation Council should include one Ministry of Health and Long-Term Care employee/appointee at the assistant deputy minister level (or equivalent) and one at the director level in the ministry, one member of the Premier's Permanent Roundtable on Violence and one member of the Aboriginal Roundtable on Violence, two experienced executives from health regulatory colleges, one health care administrator with extensive community-based care experience, at least two survivors and two advocates working in the field of abuse prevention and/or victim support, one executive officer of OSAPPA — taking into consideration those recommended by separate letter from the task force for the minister's consideration. To succeed, each member of the Minister's Implementation Council needs to be able to interact critically with every other member in a way that protects the integrity of each; thus, all members should receive the same level of remuneration for this public service — at the level of chair — as a clear indication of the respect and need for the equivalency of the range

of expertise needed for effective collaboration and implementation of this major reform. The Implementation Council should encourage, receive and respond to reports on educational and research initiatives undertaken, as per relevant recommendations made herein.

B. That the Minister of Health and Long-Term Care include in the mandate of the Minister's Implementation Council responsibility to develop an evaluation framework for the OSAPPA with appropriate metrics, at minimum, annual reporting to the Minister on the number and type of complaints by patients, the disposition of those complaints, the fines levied for lack of mandatory reporting, general understanding of sexual abuse of patients and the response system, and other indicators of effectiveness of the reporting system and public education initiatives.

Recommendation 20. Inter-Ministerial Oversight for Implementation

The Cabinet of Ontario should immediately establish an inter-ministerial implementation initiative (group) that includes leadership from the Ministry of Health and Long Term Care in cooperation with the Ministry of Training, Colleges and Universities, the Ministry of the Attorney-General, the Minister Responsible for the Status of Women and others to be named, as decided by the ministers, to coordinate an ongoing cross-government response to preventing the sexual abuse of patients by health care professionals in Ontario — consistent with the whole-of-government response to sexualized violence and harassment in Ontario. Through the Minister of Health and Long-Term Care, leadership by this Inter-Ministerial Implementation Group would generate reforms consistent with the mandate of the Minister's Implementation Council to supervise and facilitate the development and implementation of initiatives to deal with sexual abuse by health professionals, including monitoring recommendations that flow from this report.

Ministerial Leadership in Research

The task force has concluded that it is essential that the minister provide support to encourage research on the complex dimensions of the problem. To be useful, the research agenda should include: strategies and outcome measurements across jurisdictions (provincial, national and international) with robust tracking and analysis of data and complaints; formal evaluation of OSAPPA every five years for 25 years; and mechanisms for knowledge dissemination, including an annual symposium and multi-sectoral

educational initiatives. Without such adequately resourced research, evaluation and knowledge dissemination initiatives, any improvement in Ontario's response to the sexual abuse of patients will go either undone or unrecognized, and long overdue shifts in public response and private experiences will not be identifiable. The impact of Ontario's response to the sexual abuse of patients must move beyond conjecture. More importantly, opportunities to mobilize all sectors to address the problem must not be missed. In this vein, the task force recommends a number of research leadership opportunities and modalities.

Such research should be conducted in accordance with recognized institutional ethics review policies and procedures and with appropriate consent processes and policies. Patients must be informed of such research and assured of anonymity — for example, in reviews of the new complaint system recommended, the OSAPPA.

Recommendation 21. MOHLTC Leadership in Research

The Minister of Health and Long-Term Care (MOHLTC) should immediately ensure funding to designate an ongoing annual research fund within the MOHLTC health research program to support research pertaining to sexual abuse by health care professionals including but not limited to:

- rates of and remedies for same;
- comparison of rates and dispositions of sexual abuse complaints to other offences;
- relevant organizational innovations and responses;
- links to broader societal norms, attitudes and behaviours;
- improved performance of the health care system; and
- pre-service and in-service education and training intended to prevent and rectify such behaviours.

Recommendation 22. Research and Monitoring

The Minister of Health and Long-Term Care should commission a research study to track and analyze the rates, responses and disposition of sexual abuse cases of patients by health care professionals in Ontario retrospectively and going forward 20 years, in five-year segments, recognizing the complexities of reporting, versus incidence data.

Recommendation 23. Minister's Annual Symposium

The Minister of Health and Long-Term Care should announce and support an annual international symposium to address systemic changes in the province of Ontario to prevent and provide remedies for the sexual abuse of patients by health care professionals. This would include ongoing research, professional and public education, community action and partnerships, and assessment of the RHPA. It is suggested that the minister be a keynote speaker at the symposium on sexual abuse of patients being planned by Women's College Hospital in late 2016, and contribute substantial resources of experts, information and financial support to this symposium as an initial step in MOHLTC taking responsibility for its annual symposium, beginning in 2017.

Ministerial Leadership in Education

Recommendation 24. Aboriginal Health Strategy Renewal

A. The task force recommends that the Minister of Health and Long-Term Care initiate the renewal of a comprehensive, cross-cutting inter-sectoral policy on aboriginal health to incorporate and act upon the 94 Calls to Action made by the Truth and Reconciliation Commission,³⁴ as relevant to the overall health and well being of Indigenous peoples in Ontario generally, and to the sexual abuse of patients of Aboriginal origin, in particular. Specific attention should be given to research, policy proposals and commentary principally authored by experts of Aboriginal origin, including the *Final Report of the Truth and Reconciliation Commission of Canada* (released December 15, 2015), reports from the Ontario Joint Working Group on Violence against Aboriginal Women, the Strategic Framework to End Violence against Aboriginal Women (Ontario Native Women's Association and Ontario Federation of Indigenous Friendship Centres), and the Aboriginal Sexual Violence Action Plan (Ontario Federation of Indigenous Friendship Centres).

B. The task force recommends that the minister designate an Assistant Deputy Minister to lead a five-year plan from MOHLTC officials on comprehensive, cross-cutting intersectoral policy on cultural competency in research, education and other programs addressing the sexual abuse of patients in marginalized (social and/or geographic) and/or vulnerable populations in Ontario, to be submitted to the Minister's Implementation Council.

Education for Patients and the Ontario Public

Five years is a relatively short time for major systemic reform to be actualized, but after 20 years there should be evidence of significant improvement in attitudes and actions. Regrettably, the task force sees little progress in coordinated and cohesive educational initiatives on the sexual abuse of patients. More than a decade ago, Professor Sanda Rodgers assessed the implementation of the RHPA's sexual abuse provisions, for which she surveyed materials generated by the mandatory review of the first five years of the RHPA (1994–99). She concluded:

Although the PwC Report revealed that each College showed varying strengths and weaknesses in achieving the legislative objectives, overall there had been a failure of leadership, **absence of a unified educational strategy for members of the public or the professions** and limited change to the behaviour of members of the regulatory Colleges subsequent to the new legislation.¹ [emphasis added]

The task force believes that the MOHLTC is ultimately responsible for ensuring education for patients, health professionals and health care organizations about prevention and response to sexual abuse of patients by health professionals. However, it is difficult to discern a centralized and comprehensive system of public information and education on the sexual abuse of patients by regulated health professionals. The RHPA mandated colleges to have a patient relations program, stipulating that it must include “measures for preventing or dealing with sexual abuse of patients.”² In most colleges, there is a Patient Relations Committee (PRC) mandated to inform the public of their rights under the RHPA. In 2007, the scope of PRCs broadened when the *Health System Improvements Act, 2007*, gave responsibility to the PRCs “to promote and enhance relations between the College and its members, other health profession colleges, key stakeholders and the public.”³

A deficiency in the way that government and colleges are implementing the sexual abuse prevention goals of the RHPA is that MOHLTC no longer issues detailed instructions on its expectations for sexual abuse prevention plans from the colleges, which in turn influences how well colleges and their bodies, such as the PRCs, reach out to patients and the public. Some of the colleges — the Royal College of Dental Surgeons of Ontario — for example, still invest in their PRCs.

The task force is of the opinion that, even with the transition to the OSAPPA model, there is a continuing role for PRCs and sexual abuse prevention plans, given that colleges remain the sole licensing bodies for certificates of registration to practice. As well, although altered by the OSAPPA model, colleges will continue to interact with patients in a variety of ways on a variety of issues. Referring back more than a decade for precedents, plans and reporting could again include annual updates to the minister or designate of sexual abuse prevention plans that should include, for example:

- a. a statement of philosophy, to articulate the college's position on sexual abuse;
- b. an evaluation of present practices as they relate to sexual abuse, including a review of college participation in the transition to OSAPPA and in ICRC (Investigations, Complaints and Reports Committee), as well as OSAPPA discipline processes; and
- c. a summary of communications with, and referrals of, sexual abuse complainants, to ensure smooth and timely transition to the OSAPPA model so that no patient is "left behind" or under-served.

Education for Students in the Regulated Health Professions

Based on anecdotal information provided to the task force through consultations with students in a number of regulated health profession programs and through communication with the Council of Faculties of Medicine (COFM) of the Council of Ontario Universities (COU), the task force found that some educational institutions have made some progress in addressing the issues of sexual assault of patients in codes of conduct, educational materials and overall culture and values; however, gaps remain and practices are very uneven. Some medical schools in Ontario, for example, provide explicit guidelines for undergraduates in their handbooks, as well as curricular model and teaching materials. Others do not. Recent events in some Canadian medical and dental schools suggest that broad issues associated with ethics and culture remain; these allow a context in which ignorance of the health impacts of the sexual abuse of patients and a lack of cultural competency, are more likely to occur due to uneven concern and commitments among faculty and administrators to addressing these issues as priorities in theory and praxis.

The task force sees a significant need for improved coordination of curriculum development in every educational and training program for future members of all the regulated health professions. Improved learning amongst students in the 26 regulated health professions in Ontario on the

dynamics, impact and legal framework related to the sexual abuse of patients would result from cross-discipline curricula made equally and widely available.

Given that the greatest number of patient complaints about sexual abuse are about physicians, the task force sought a meeting in May 2015 with the COFM, which was facilitated by the COU and attended by five of the six vice or assistant deans of undergraduate medical education, five vice or assistant deans of postgraduate medical education (PGME), and one acting associate dean of PGME. Although the discussion in that meeting was rather strained, the COFM deans (none of whom attended the May meeting with the task force) wrote to Minister Hoskins on June 8, 2015, advising that they were “very committed to working with the Ministry on this issue to continue to augment the longstanding work we have been doing to ensure Ontario’s undergraduate and graduate medical programs have the most current and effective content regarding the prevention of sexual abuse.” The task force recommends that this letter be placed on the agenda of the first meeting of the inter-ministerial implementation initiative (per Recommendation 20) as a standard of commitment to be actively pursued and extended to all other deans and their senior associates in all post-secondary education and training for future members of all the regulated health professions in Ontario.

Recommendation 25. Patient Safety Reporting in Health Care Educational Curricula and Systems

A. The Inter-Ministerial Implementation Group should review accreditation standards for educational institutions providing certificate, diploma, undergraduate and post-graduate programs for professions under the RHPA, with the goal of incorporating patient safety assessments — including protections against sexual abuse — in all accreditation programs. The review of curricula should include an assessment periodically of ethical standards for professional practice and strategies in place to build awareness of the impact of sexual abuse on patients, along with the responsibilities, approaches to prevention, and requirements to report and to implement tracking mechanisms regarding knowledge of, and educational institutions’ responses to, reports of sexual abuse of patients.

B. Institutions responsible for training health care professionals should have, as a minimum, explicit senior management commitments to preventing sexual abuse of patients, clear statements and explanations of sexual abuse

of patients, professional responsibilities to report as part of core training, examinations concerning professional practice and codes of ethical conduct — all embedded in performance reviews conducted periodically for funders.

Recommendation 26. Education for Patients and Professionals

The Minister of Health and Long-Term Care should introduce and — in cooperation with the Ministry of Training, Colleges and Universities and other affected ministries — support, with adequate resources, newly designed and evaluated pre-service, in-service and public education on sexual abuse of patients by health professionals, to be reviewed and reported on periodically, including:

- refreshed curriculum for pre-service education in universities and colleges;
- refreshed continuing education and training for in-service health professionals;
- cultural competency as a mandatory component in any education or training public education campaign addressing patients, families, bystanders and communities about rights and redress;³⁵
- education for hospital and other health care administrators on their legal, patient safety and reporting responsibilities; and
- mandatory training, with periodic reviews, for members of governing councils and staff of health regulatory colleges to begin immediately and to continue through transition to include OSAPPA officials and personnel.

Education for Regulated Health Professionals

Colleges are still responsible for their members, and in their responses to questions from the task force, as requested by Minister Hoskins via a letter dated December 17, 2014, colleges reported on professional education programs, including both continuing education of their members and the education of candidates for registration. Again relying on what MOHLTC used to request, colleges should return to reporting on features of their educational initiatives, including whether and to what extent they succeed in delivering programs that:

- sensitize members to cultural competency in appreciating the diversity of circumstances and the history of patients and their communities, with particular attention paid to patients of Aboriginal origin;

- induce an aura of risk as to the real and present danger of slipping into exploitation and sexually abusive behaviour;
- create an awareness of the consequences of sexually abusing patients;
- educate on the impact of sexualized acts/abuse on patients;
- increase knowledge of human sexuality, professional boundaries and appropriate practitioner and patient relations;
- educate practitioners to recognize subtle and indirect disclosure by patients of prior sexual abuse;
- educate practitioners as to how to handle the disclosure of prior sexual abuse, and how to report it; and
- educate practitioners as to the requirements of the RHPA, including statutory definitions, mandatory reporting requirements and penalties.

Education of Staff and Committee Members at Colleges and OSAPPA

Currently, and in the transition to OSAPPA, education and support to staff, members of college councils and committees (including publicly appointed members) who have contact with abused patients or investigate or hear allegations of sexual abuse, is essential. Assessments need to be done in the transition planning and implementation to develop appropriate and sustainable education by:

- identifying staff and committee members who have direct contact with the public or with abused patients;
- sensitizing such staff and committee members to issues of sexual abuse; and
- helping such staff and committee members to develop appropriate communication skills.

Conclusion

To close this chapter on research and education priorities, the task force adopted closing commentary from the June 2015 *Report of the Task Force on Misogyny, Sexism and Homophobia in Dalhousie University Faculty of Dentistry*:

Cultural change and acceptance of collective responsibility happen when individuals recognize, whether individually or collectively, that change is imperative. It must be seen as the right thing to do. Leadership within an institution motivates and nurtures change, and the credibility of leadership will inspire others to follow. The

Faculty of Dentistry will change when both its leaders and its faculty members believe that they should change and are prepared to take steps to do that. Education, research, and reflection can help, but they are not a substitute.⁴

Endnotes

1. Sanda Rodgers, "Sexual Abuse by Health Care Professionals: The Failure of Reform in Ontario" in *Health Law Journal*, Vol.12, 2004, 71, p.88, retrieved from <http://www.hli.ualberta.ca/en/Health%20Law%20Journals/~media/hli/Publications/HLJ/HLJ12-RODGERS.pdf>; quoting from "Executive Summary", *Evaluation of the Effectiveness of the Health Professional 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).
2. *Health Professions Procedural Code*, Schedule 2 of the RHPA (<https://www.ontario.ca/laws/statute/91r18#BK52>), s. 84(2).
3. *Health System Improvements Act, 2007*, section 18(2), http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=519; see also the *Health Professions Procedural Code*, s. 84(3).
4. Constance Backhouse, Donald McRae and Nitya Iyer, *Report of the Task Force on Misogyny, Sexism and Homophobia in Dalhousie University Faculty of Dentistry*, June 26, 2015, p. 77, retrieved from <http://www.dal.ca/content/dam/dalhousie/pdf/cultureofrespect/DalhousieDentistry-TaskForceReport-June2015.pdf>.

Chapter 7: Sustainable Transparency and Accountability

Improved accountability and transparency are understood to be critical to improving health care system performance generally, and patient safety specifically. We are not proposing anything new or different in this implementation strategy, but we do believe that genuine, substantive implementation — to a much greater degree than has been seen since the major amendments to the RHPA were enacted in 1994 — must now happen. We have built upon recognized best practices to leverage existing quality assurance, accountability and accreditation mechanisms as necessary components of the sustained oversight, tracking, reporting and accreditation that are essential to preventing the sexual abuse of patients.

Our observations and recommendations pertain to all of the regulated health professions under the RHPA. We are indebted to Dr. David Musson, Associate Dean, Undergraduate Medical Education at the Northern Ontario School of Medicine, for reminding the task force to look more closely at creating patient safety systems that are integral to preventing the sexual abuse of patients. In proposing a patient-centred approach to implementing our recommendations, we have drawn on generally accepted principles for sustainability, transparency and accountability to uphold a zero tolerance standard for the sexual abuse of patients in Ontario.

A Framework for Accountability

As discussed in more detail in Chapter 2, the health regulatory colleges have not consistently gathered accurate data that allow for meaningful comparisons from year to year. Information that the task force received

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For a patient to complain and then hear nothing about the outcome of what was done is in some ways just a further victimization.

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— Patient advocate

from the colleges or through the Ministry of Health and Long-Term Care (MOHLTC), therefore, allowed us to reach few firm conclusions based on data. This unfortunate reality is the foundation for our emphasis on implementing our recommendations through sustainable transparency and accountability that are built upon mandatory public reporting. The ecological human rights framework for our recommendations is predicated on seeing and understanding intersectoral forces. Viewing patient safety through this lens, we see interlocking responsibilities that are shared within a sector and that either enable or prevent the sexual abuse of patients. Promoting a culture of patient safety requires a multi-level strategy, and protecting patients from sexual abuse by health care professionals must be considered in this context. Leadership at the Ontario Cabinet level is also crucial to successful implementation.

A recent, relevant report, which evolved from the Royal College of Physicians and Surgeons of Canada's (Royal College's) March 2014 workshop "Transitioning to safe care: Culture meets Competence," proposed "to begin a national conversation around the culture of patient safety."¹ This report cites the Institute of Medicine — "Achieving a learning health care system — one in which science and informatics, patient-clinician partnerships, incentives, and culture are aligned to promote and enable continuous and real time improvement in both the effectiveness and efficiency of care — is both necessary and possible" — while noting that "an enabling culture to the realization of the health care system as a learning organization harkens back to the culture of safety being a requisite for high-reliability organizations." The report also recognizes the importance of "partnering with more targeted organizations, as context-specific approaches are more likely to effect the sustained attitudinal and behavioural changes needed to shift the culture."²

The importance of accountability is recognized to be critical in generating a system-wide perspective on health sector reforms and in linking individual improvement interventions to prevent the sexual abuse of patients through immediate, intermediate and long-term changes. This perspective is consistent with an ecological human rights framework. We believe that not being subjected to sexual violations is every patient's right, and that ensuring this standard of care is the responsibility of the Government of Ontario and all regulated health professionals in the province. In a general sense, accountability-enhancing strategies can focus on:

- preventing/reducing abuse;

- assuring compliance with procedures/standards through oversight; monitoring and reporting requirements; and
- improving performance/learning through feedback loops and transparency.

The critical elements of an accountability framework aimed at improving patient and client care are understood to include clear oversight mechanisms, performance metrics, reporting requirements, and meaningful sanctions for noncompliance.³

Recommendation 27. Patients' Safety Bill

A Patients' Safety Bill should immediately be developed by the Ontario Ministry of Health and Long-Term Care in consultation with patients' advocacy groups and the regulatory colleges as an amendment to the RHPA. The *Ontario Hospitals Act* should be amended to require all regulated health professionals and all administrators of health care facilities, including privately owned health care facilities, to post, with clear requirement to maintain: a) visibility of the Bill and b) availability upon request of print copies of the Bill. The Patients' Safety Bill and current contact information should be placed in high-visibility locations wherever health professionals are providing services. This amendment may be complementary to, but is substantially different from, the Patient Ombudsman office announced in 2015.

Recommendation 28. Patient Evaluations re Access to Justice for Better Health Care

Following every determination and resolution of a complaint about sexual abuse during the transition to the OSAPPA system, every college is to

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The unique needs, capabilities, and vulnerabilities of Ontario's Aboriginal people need to be acknowledged, recognized, engaged and partnered with when developing and delivering policies and programs to improve their health and safety in the health care system.

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– *Aboriginal community member*

ensure that an evaluation form, with introductory information supplied by MOHLTC, is provided to every patient involved in the process, and include a pre-paid return envelope addressed to the Minister's Implementation Council. The OSAPPA mandate should include an ongoing responsibility to continue and improve upon gathering feedback from patients, to enable meaningful comparisons in evaluation and annual reporting.

Recommendation 29. Reports for the Public Record — *Excellent Care for All Act*

A. The Minister of Health and Long-Term Care should introduce the reporting and disposition of sexual abuse cases as a priority Quality Improvement Indicator under the *Excellent Care For All Act* (ECFAA) pertaining to hospitals in Ontario, community and home-based care, and primary care practitioners. Results should be included in the minister's annual report to the legislative committee and — if not included — there should be an explanation required in the report.

B. The RHPA should be amended to include the requirement that every college shall make a public annual report to the Minister of Health and Long-Term Care and to OSAPPA of any complaints received concerning the sexual abuse of patients by members or former members of the college, including a summary of the timeline and description of actions taken by the college in referring on to OSAPPA. The Minister's Implementation Council should be responsible for the template for this annual report, in consultation with patients' advocacy groups, hospitals, educational institutions, OSAPPA and the colleges.

C. The Minister should recommend to the Ontario Hospital Association (OHA) to incorporate the sexual abuse of patients by health professionals into the current Quality and Patient Safety Plan (QPSP), given that one of their stated goals is "to champion the adoption of a culture of quality and patient safety." The OHA can support health care institutions in developing their annual Quality Improvement Plans (QIPs) as mandated under the ECFAA. The OHA could be instrumental in providing materials, supports and tools to health care institutions that include: a broader definition of patient safety, the psychological harm and other harms associated with sexual abuse of patients and definitions of patient, health care provider, and sexual abuse based on the RHPA. Responsibilities and accountabilities of the hospitals/other health care facilities and health providers for the prevention, identification, reporting, tracking and responding to reports of

sexual abuse of patients by health care providers should also be delineated. The OHA should be encouraged to contribute leadership in preventing the sexual abuse of patients by making a long-term commitment to developing, providing and sustaining education, quality assurance and reporting mechanisms to OHA members.

Recommendation 30. Information Accessible on the Public Record — Registers

The *Health Professions Procedural Code* should be amended to require that every college register includes disciplinary decisions in which the member was found to have committed an act of sexual abuse/misconduct/impropriety as defined in the RHPA and Code, including section 1(3)(c) (behaviour or remarks) as well as 1(3) (a) (physical sexual relations) and 1(3)(b) (touching of a sexual nature) of the Code and that staff of colleges are clearly obliged to inform anyone who inquires as to the nature of the complaint. The amendments should be designed to apply high-transparency standards to the public record of colleges during and after the transition and also to public records of the OSAPPA model.

Recommendation 31. Transparency and Notifications of Findings by Colleges and OSAPPA

The *Health Professions Procedural Code* should be amended to ensure that college and OSAPPA registers contain for the public record:

- any stipulations or programs imposed on a member related to any complaint of sexual abuse of a patient, with a notation on whether the requirements were disciplinary panel decisions, or determinations through any other means, including suspension or resignation of the member, related to sexual abuse complaints processed by a college (during transition) or OSAPPA (after transition); and
- determinations of any kind, including resignation, that colleges (which retain the authority to issue or revoke certificates to practise) should be legally obliged to inform all other licensing authorities in Canada and to keep written records verifying such notification, to be included in annual public reports to the Standing Committee on Government Agencies of the Legislative Assembly of Ontario or another appropriate standing committee that includes MOHLTC in its mandate.

Leadership Essential to Transparency

Abuse cannot thrive in a transparent environment. Yet on this point, a reality check is needed.⁴ Although mandatory reporting of sexual abuse of patients has been a legal obligation under the RHPA for more than 20 years, there has never been enforcement of this law against any institution in Ontario under the Act. Nevertheless, mandatory tracking and the review of data concerning the sexual abuse of patients are fundamental to an effective, integrated prevention strategy.

Aligned with our task force emphasis on education as key to the prevention of sexual abuse of patients, the Royal College report singled out the critical role of academic leaders (e.g., health profession deans and teaching hospital CEOs) to provide:

- leadership that “walks the talk”;
- transparent communication;
- psychological safety that facilitates the reporting of errors;
- patient and family engagement; and
- a commitment to ongoing improvement.⁵

Leadership is a crucial determinant of effectiveness in the institutions that we rely on to deliver prevention, education and mandatory reporting in health care. Patients in Ontario need leaders in these institutions who will step up to the challenges of preventing sexual abuse by regulated health professionals. It is encouraging to see the following commitment from the Ontario Hospital Association (OHA) and we hope to see it matched by positive results for patients in Ontario:

- The OHA is working to ensure that every patient receives safe, appropriate, and high-quality care, and that all health care providers work together to contribute to a high-performing health system. The *OHA's 2013-2016 Strategic Plan: A Catalyst for Change* renews the OHA's commitment to achieving a high-performing health system for the people of Ontario. It underscores three main areas: quality, integration, and value.⁶

The following recommendations provide specific actions to be taken by Ministry of Health and Long-Term Care officials, health care leaders and health care organizations. These recommendations strengthen accountability and transparency for Ontario's patients but also provide quality improvements for patient safety.

Recommendation 32. Provincial, National and International Database Access

The Ministry of Health and Long-Term Care should initiate joint and reciprocal ventures to establish, link and maintain both a national and international database, with public access and capable of identifying sexual abuse offenders who are, or were, regulated health care professionals.

Recommendation 33. Patient Safety Standards Addressing the Sexual Abuse of Patients in Hospitals, Health Care Organizations, and Long-Term Care Facilities

The OHA and other such health organizations, as relevant, should provide increased, focused and sustained leadership in the development of policy and education for all institutional members. Included should be a broader definition of patient safety that recognizes the extensive and serious range of harm associated with sexual abuse of patients. Specific and detailed standards for hospital and other health institution leaders should be established. These would leave no doubt about the definitions of patient, health care provider and sexual abuse, or the responsibilities of hospitals and other health care facilities for the prevention, identification, reporting and tracking of sexual abuse of patients by health care providers. Accountability mechanisms geared to hospitals and health care providers should be clear, resourced and implemented for the long term. Health care institutions, including hospitals, should have rigorous training, quality assurance and reporting mechanisms in place that reinforce their duties to prevent, report and track sexual abuse incidents within risk management systems that permeate every level of service within the health care institutions — with clear, enforced consequences for all executives who do not deliver on the patient safety and protection standards.

The minister should recommend to the OHA to incorporate sexual abuse of patients by health professionals into the current Quality and Patient Safety Plan (QPSP), given that one of their stated goals is “to champion the adoption of a culture of quality and patient safety.” The OHA can support health care institutions in developing their annual Quality Improvement Plans (QIPs) as mandated under the ECFAA. The OHA could be instrumental in providing materials, supports and tools to health care institutions that include: a broader definition of patient safety, the psychological harm and other harms associated with sexual abuse of patients and definitions of patient, health care provider, and sexual abuse based on the RHPA. Responsibilities and accountabilities of the hospitals/other health care facilities and health providers for the prevention, identification, reporting,

tracking and responding to reports of sexual abuse of patients by health care providers should also be delineated. In keeping with Recommendation 29, the OHA should be encouraged to contribute leadership in developing and providing education, quality assurance and reporting mechanisms to OHA members.

Effecting Change through Accreditation Processes

Accreditation Canada notes that accreditation processes are essential to improving quality and safety in Canada and more than 70 countries. According to Wendy Nicklin, President and Chief Executive Officer of Accreditation Canada, recent lawsuits have demonstrated the risks to standard-setting bodies that do not keep their standards current.⁷ We suggest that, to be current, standards for government, regulatory colleges and health professional educational programs — both undergraduate and postgraduate — must include the protection of patients from sexual abuse by health care practitioners. Leveraging accreditation in this way creates a framework through which to improve patient safety. It also provides an unambiguous standard that is widely communicated among key stakeholders. In addition to mitigating the risk of adverse events, updated accreditation standards also promote continuous improvement and the sharing of best practices.

We agree with the Royal College report's assertion that "the potential to effect change through the accreditation process can be harnessed as a function to drive not only clinical and educational innovation, but the permeation of a safety culture across the medical landscape."⁸ The Royal College report recommends leverage of its accreditation process "to improve the culture of safety by stipulating the elements an organization must have in place in order to be a base for medical training."⁹ We also see applicability well beyond the medical landscape. For this reason, we believe it is critical to have required accreditation standards for regulated health professional schools that incorporate the consistent interprofessional standards found in the RHPA that are needed to prevent the sexual abuse of patients.

Our recommendations therefore include suggestions for leveraging existing accreditation processes to prevent the sexual abuse of patients by teaching and implementing the zero tolerance standard and the RHPA's requirements. In the roundtable discussions we held with a range of health profession students in different parts of Ontario, we consistently heard from many (though not all) students that they learned little or nothing about the legal obligations under the RHPA provisions governing the sexual abuse of patients. Learning

more about the impact on patients and their families when trust in their health care provider was betrayed by sexual abuse was identified as a gap by some students.

Additionally, the Royal College report stresses metrics, transparency and accountability strategies:

the critical importance of metrics and transparency in order to achieve this culture of patient safety. A truism increasingly applied to health care is that ‘you can’t improve what you can’t measure.’ This truism is a fundamental driver of health care reform, and in part underlies the implementation of mandatory public reporting of quality indicators in many jurisdictions. While acknowledging that public reporting has inconsistent impacts, there is evidence that providing provider-specific outcome data improves clinical outcomes.¹⁰

The report also quotes from Bloom, as cited in Brinkerhoff, 2003

Accountability strategies...depend on the availability of information. This is an area where government has a primary role; one of the hallmarks of democratic governance is information availability and transparency. Data on health needs, health status, health system resource use, and performance need to be available to stakeholders if accountability relationships are to be more than pro forma or empty exercises in oversight.¹¹

Recommendation 34. Accreditation standards

The Minister of Health and Long-Term Care should recommend to Accreditation Canada the development of Required Organizational Practices (ROPs) in the Safety Culture category that are specific to the sexual abuse of patients by regulated health professionals. Sexual abuse of patients is a low-probability/high-impact risk that needs to be addressed at a strategic level as an issue of patient safety. These ROPs would clearly describe the organizational/board responsibilities in addressing sexual abuse, i.e., educational requirements for employees, mandatory reporting expectations, and tracking and reporting within and by institutions.

The ROP approach would also require the sexual abuse of patients to become a “standing agenda item” at all regular meetings of the governing body. ROPs would include: a) definitions, consistent with the RHPA, of “patient” and of “sexual abuse or exploitation”; and b) clear commitments as to what

patients should be able to expect from their health care provider within a patient safety context. ROPs would clearly describe for patients what to do if they experience sexual abuse and to whom reports must be made. Similar to the approach taken by many hospitals, for example, in protecting patient privacy, hospital boards should mainstream protection of patients from sexual abuse at all levels of governance and management and ensure implementation of relevant sections of the *Health Professions Procedural Code*, including mandatory reporting of sexual abuse complaints per section 85.1 (reporting by members) and section 85.2 (reporting by facilities).

Endnotes

1. A. Matlow, & S. Brien, *A culture of patient safety: Foundation for a Royal College patient safety roadmap*, Royal College of Physicians and Surgeons, 2015, p. 3, retrieved from http://www.royalcollege.ca/portal/page/portal/rc/common/documents/policy/culture_of_patient_safety.pdf.
2. Ibid., p. 4.
3. D. Brinkerhoff, *Accountability and Health Systems: Overview, Framework, and Strategies*, Abt Associates Inc., 2003, p. ii, retrieved from <http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf>.
4. Ibid.
5. Matlow & Brien, p. 9.
6. Ontario Hospital Association (OHA), "Quality and Patient Safety," retrieved from <http://www.oha.com/CurrentIssues/keyinitiatives/PatientSafety/Pages/Default.aspx>.
7. W. Nicklin, *The Value and Impact of Health Care Accreditation: A Literature Review*, Accreditation Canada, 2015, retrieved from <https://www.accreditation.ca/sites/default/files/value-and-impact-en.pdf>.
8. Matlow & Brien, p. 5.
9. Ibid.
10. Ibid., p. 8.
11. Brinkerhoff, p. 24.

Contributors

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Marilou McPhedran, Chair



Marilou McPhedran's work focuses on the promotion of human rights through systemic reform in law, medicine, education and governance in Canada and internationally. She has co-founded several organizations, including the Women's Legal Education and Action Fund (LEAF), the Metropolitan Action Committee on Violence Against Women and Children (METRAC), the International Women's Rights Project (University of Victoria) and the Institute for International Women's Rights (University of Winnipeg). Professor

McPhedran chaired the Independent Task Force on Sexual Abuse of Patients in 1991 and the Special Task Force on Sexual Abuse of Patients in 2000. Following the 2000 task force, she directed the National Network on Environments and Women's Health at York University and co-authored the textbook *Preventing Sexual Abuse of Patients* (2004). She also served as the corporate director of Healthy City Toronto from 1992–94, and the corporate director of Health Partnerships and International Liaison at Women's College Hospital from 1994–96. Professor McPhedran was named a member of the Order of Canada in 1985.

Sheila Macdonald, Task Force Member



Sheila Macdonald is the provincial coordinator of the Ontario Network of Sexual Assault/Domestic Violence Care and Treatment Centres (SA/DVTC), which links Ontario's 35 hospital-based sexual assault care and treatment centres. She is an adjunct lecturer in the faculty of nursing at the University of Toronto. In 2012, Ms. Macdonald received the International Association of Forensic Nurses' Virginia Lynch Pioneer Award. With more

than 15 years of clinical experience as an on-call nurse, Ms. Macdonald is an avid educator and has taught in the area of sexual assault/domestic violence across Canada as well as in South Africa, Costa Rica and the United States. She also provided leadership for the development of the Sexual Assault Nurse Examiner (SANE) role in Ontario by authoring the proposal for annual SANE training funding, submitted to the Ministry of Health and Long-Term Care.

Gail Robinson, MD (Medical Advisor)



Dr. Robinson is a professor of psychiatry and obstetrics/gynecology at the University of Toronto. She is also the co-founder of Canada's first rape crisis centre, the Toronto Rape Crisis Centre, and helped establish the College of Physicians and Surgeons of Ontario's task force on physician-patient sexual abuse. Dr. Robinson co-founded the Women's Mental Health Program at the University of Toronto, helped create the Metropolitan Task Force on Violence Against Women and Children (METRAC) and was president of its board. Dr. Robinson has won the YWCA Women of Distinction Award and the 100 Most Powerful Women in Canada Award in the champion category for her work in the field of women's mental health. She also received the Alexandra Symond's Award from the American Psychiatric Association for outstanding and sustained contributions to women's mental health and the advancement of women. In 2013, Dr. Robinson was awarded the Order of Ontario.

Susan Vella (Legal Advisor)



Susan Vella is senior counsel at Rochon Genova LLP. For 25 years, she has been a pioneer in advancing civil claims on behalf of survivors of sexual and institutionalized abuse and sexual harassment, including survivors of sexual abuse by health care professionals in both private practice and health care institutional settings. She has represented clients, including sexual assault survivors, at all levels of court, including at the Supreme Court of Canada in the landmark

vicarious liability decision of *Bazley v. Curry*, [1999] 2 SCR 534. She is the author of numerous publications on sexual abuse, including (as co-author) *Civil Liability for Sexual Abuse and Violence in Canada* (Toronto: Butterworth, 2000). Ms. Vella is a member of the Ontario Civil Rules Committee and was commission counsel at the Ipperwash Inquiry. She received the Law Society Medal and the Advocates' Society Award of Justice in recognition of her work on behalf of survivors of sexual violence.

Patricia Marshall (Zero Tolerance Standard Expert)



Patricia Marshall served as co-chair of the Canadian Panel on Violence Against Women, was METRAC's first executive director and was an invited member of the International Society for the Reform of Criminal Law. She has promoted equality and women's safety for many years, and has spoken at hundreds of conferences and courses both nationally and internationally. Ms. Marshall also co-founded the counsellor advocate program at George Brown College and created the women's safety audit, which is used in many countries. In 1986, she presented a brief for legislative reform on behalf of sexually abused patients, was a catalyst for the creation of the 1991 task force on the sexual abuse of patients, created the concept of zero tolerance of abuse and was also a member of the 2000 task force. Patricia has dedicated her Order of Ontario and her Queen's Diamond Jubilee Medal to the thousands of survivors of abuse she has worked with over the last four decades.

Michele Landsberg



Photo credit: Don Dixon

Michele Landsberg is a Canadian journalist, author, feminist and social activist. For 25 years, she wrote a column in the *Toronto Star*, pushing for progressive change on issues such as equal pay, abortion rights and racial discrimination. She was one of the first journalists in Canada to address sexual harassment in the workplace, racism in education and employment, and lack of gender equality in divorce and custody. She has won many honours, including seven

honorary degrees, the YWCA Woman of Distinction Award and two National Newspaper Awards. She is an Officer of the Order of Canada.

Wendy Komiotis



Wendy Komiotis is the executive director of METRAC, an organization whose mandate is to advance safety, justice and equity for all women and youth through prevention education and legal information, safety initiatives, research and policy. She has worked for more than 25 years in community development and management positions within women's services and community health facilities. For the past 20 years, Ms. Komiotis has facilitated trainings in equity and the prevention of discrimination for hundreds of service providers. Wendy has also taught at George Brown College in the Assaulted Women's and Children's Advocate Counsellor Program. She holds a bachelor's degree in political science and women's studies and a master's degree in adult education.

Nicole Pietsch

Nicole Pietsch is coordinator of the Ontario Coalition of Rape Crisis Centres (OCRCC) and a community research associate with The Learning Network on Violence Against Women. The OCRCC includes sexual assault centres across Ontario. Since 1998, Ms. Pietsch has assisted women and youth living with violence, including immigrant and refugee women and survivors of sexual violence. Her writing has appeared in York University's *Journal of the Association for Research on Mothering*, the University of Toronto's *Women's Health and Urban Life* and *Canadian Woman Studies/Les cahiers de la femme*. Her review of how the media and legal system interpreted youth violence, race and gender within British Columbia's Reena Virk case appeared in a collection by Canadian Scholars' Press. In 2015, her analysis of the "slutwalk" movement, "*doing something*" about "*COMING TOGETHER*": *The Surfacing of Intersections of Race, Sex and Sexual Violence in Victim-Blaming in the SlutWalk Movement*, appeared in an edited collection from Demeter Press.

Lorraine Greaves, PhD



As an educator, researcher, and administrator, Dr. Greaves has played a pioneering role in addressing issues such as addiction, tobacco use, trauma, violence against women and children, and the influences of sex and gender on health. She is the author or co-author of nine books and 90 articles, and led the first research in Canada on the economic costs of interpersonal violence. Trained as a medical sociologist in Canada and Australia, Dr. Greaves was the executive director of the British Columbia Centre of Excellence for

Women's Health and the Senior Advisor for Health Policy and Surveillance at BC Women's Hospital and Health Centre. She served as the director of the Centre for Research on Violence Against Women and Children at Western University and as executive director, Health System Strategy Division, Ontario Ministry of Health and Long-Term Care. She has received numerous awards, including an honorary doctorate from the University of Ottawa and the Vancouver YWCA Woman of Distinction award.

Amanda Dale



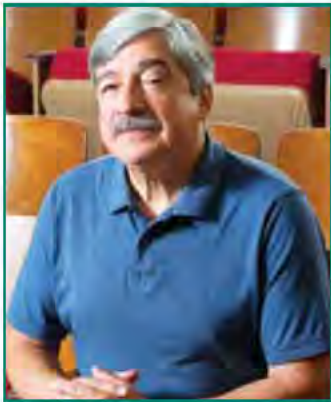
Amanda Dale is the executive director of the Barbra Schlifer Commemorative Clinic, and was the YWCA's 2013 Woman of Distinction for Social Justice. She has a master's degree in international human rights law from the University of Oxford, and for three decades has remained active in promoting women's safety, dignity and equality in Canada and around the world. Her leadership was pivotal to numerous test cases in Canada, the Jane Doe audit of the Toronto Police Service's sexual assault investigations, the successful

restriction of the use of religious arbitration in the settlement of family law matters in Ontario, the development of a women's shelter in the Arctic and the success of projects in Ghana and Sudan. She has been involved in the development of a number of organizations, including Quimaavik Women's Shelter (Nunavut), Sistering, YWCA Toronto and Inter Pares. Ms. Dale is currently enrolled in a PhD program at Osgoode Hall Law School; her work focuses on women's intersecting rights in a global context.

Mary Lou Fassel

Mary Lou Fassel is the director of legal services at the Barbra Schlifer Commemorative Clinic. Ms. Fassel oversees the development of comprehensive legal services for women survivors of violence in the areas of family, immigration and criminal law. She has designed and delivered hundreds of training programs for legal, health care and other professionals, as well as public legal education programs focusing on the legal rights of female victims of violence; has delivered numerous large-scale community development initiatives to improve service response to victims of violence; has consulted with and successfully lobbied governments for legislative and policy reforms; and has worked to increase the knowledge and expertise of those whose work affects victims of violence. In 2012, Ms. Fassel was awarded the Attorney General's Victim Services Award of Distinction and the Ontario Bar Association's Award of Excellence in the Promotion of Women's Equality.

Peter Jaffe



Peter Jaffe is a psychologist and professor in the faculty of education at Western University and the academic director of the Centre for Research & Education on Violence Against Women & Children. He has co-authored ten books, 24 chapters and over 75 articles related to violence and abuse involving children, adults, families and the justice system. Dr. Jaffe has testified at all levels of the court system across Canada and the United States on the impact of abuse and violence on victims. He has also presented workshops across the United States and Canada, as well as in Australia, New Zealand, Costa Rica and Europe, to various groups including judges, lawyers, health professionals, mental health professionals and educators. He was a founding member of Ontario's Chief Coroner's Domestic Violence Death Review Committee. In 2009, Dr. Jaffe was named an Officer of the Order of Canada for his work on violence prevention in the community.

Earl Berger, MD



Dr. Berger is the co-founder of the *Canada Health Monitor* and *The Berger Population Health Monitor*. He was also the associate director for policy at the Hay Health Care Consulting Group and has advised on mental health services, hospital and institutional reorganization, the National Strategy on HIV Infection and AIDS, the reform of Ontario's *Public Hospitals Act, 1990*, and chronic care reform in Ontario. Dr. Berger also acted as the principal investigator for the Ontario Drug System Secretariat. He has a BA (Honours) from

the University of Toronto and obtained his PhD in economics from the London School of Economics. He is a former member of the Institute of Management Consultants of Ontario, was a member of the department of economics at the University of Ghana and sat on the editorial board of *The Globe and Mail*. Dr. Berger has also written on health issues for the *Hospital Quarterly* and other publications.

Organizations

Metropolitan Action Committee on Violence Against Women and Children (METRAC)

Formed in 1984, METRAC is an award-winning not-for-profit agency devoted to advancing safety, justice and equity for women and youth affected by violence. The organization's vision is to create safe communities for *all* women and youth. It works with individuals, communities and institutions to change ideas, actions and policies, with the goal of ending violence against women and youth. Activities include public education, legal information services, peer-based youth prevention programs, and safety audits, training and education initiatives. The organization also leads community-based research and social policy initiatives to improve systemic responses to gendered violence. The work of METRAC is driven by seven key values: equity, respect, safety, excellence, innovation, feminisms and collaboration.

The Ontario Coalition of Rape Crisis Centres (OCRCC)

The Ontario Coalition of Rape Crisis Centres was formed in the mid-1970s to act as a communication network for rape crisis/sexual assault centres. The organization's mandate is to work for the prevention and eradication of sexual violence; to promote legal, social and attitudinal changes regarding sexual violence; and to encourage, direct and generate research into sexual violence. Currently, the OCRCC represents 26 sexual assault centres throughout Ontario. It also acts as an advisory body to governments, institutions and community groups. The organization is represented on a number of current and past provincial initiatives, including The Law Commission of Ontario's Community Council, the Domestic Violence Advisory Council and the Provincial Roundtable on Violence Against Women.

The Barbra Schlifer Commemorative Clinic

The Barbra Schlifer Commemorative Clinic is a specialized clinic for women experiencing violence. Barbra Schlifer was an idealistic young lawyer whose life was cut short by violence on the night of her call to the bar of Ontario. In her memory, the Barbra Schlifer Clinic assists 4,000 women a year to build lives free from violence through counselling, legal representation and language interpretation. The clinic offers legal help in family, immigration and criminal law; compassionate support from diverse, skilled counsellors; and interpretation and translation in more than 100 languages. It also advocates for law reform and social changes that benefit women, and provides professional development opportunities for service providers. The Schlifer Clinic has received the Guthrie Award for Outstanding Public Service and the Charity Intelligence Award. It is the 2015 recipient of the Women's Law Association of Ontario's President's Award in recognition of outstanding service and leadership in advancing and promoting women's safety, dignity and equality.

Appendices

Appendix A:

Terms of Reference

Background

When the *Regulated Health Professions Act, 1991* (RHPA), was passed in 1991, it was widely regarded as groundbreaking legislation. The legislative scheme provides a comprehensive framework for regulating the provision of most health services in Ontario. The RHPA was amended in 1993 following a College of Physicians and Surgeons of Ontario task force report on sexual abuse of patients and with all-party support to enact, in legislation, a comprehensive, zero tolerance policy on the sexual abuse of patients by members of regulated health professions.

The legislation currently contains numerous measures to prevent and deal with the sexual abuse of patients by regulated health professionals. Its purpose is to encourage the reporting of sexual abuse by regulated health professionals, to provide funding for therapy and counselling for patients who have been sexually abused by such professionals and, ultimately, to eradicate the sexual abuse of patients by professionals.

Purpose

The purpose of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the *Regulated Health Professions Act, 1991* (the "task force") is to advise Her Majesty the Queen in Right of Ontario as represented by the Minister of Health and Long-Term Care (the "ministry") about various issues concerning the sexual abuse of patients by regulated health professionals and in particular to make recommendations concerning any potential legislative amendments to the RHPA, as well as the *Health Professions Procedural Code* (the *Code*), which is Schedule 2 to the RHPA concerning the sexual abuse of patients.

The task force will examine the existing legislative scheme under the RHPA and provide advice and recommendations with respect to modernizing and reinforcing the province's ongoing commitment to a zero tolerance policy on the sexual abuse of patients by regulated health professionals.

Mandate

In undertaking this work, the task force shall consider best practices from an operational and legislative standpoint from leading jurisdictions around the world. The task force shall consider how the current legislative scheme may be enhanced, such that every interaction between a patient or witness and a health regulatory college is sensitive and timely. The task force should undertake its work while bearing in mind that patient experience is its primary focus, while also respecting the fundamental guiding principle set out in the RHPA regarding the self-regulatory model for all health regulatory colleges in the province.

The task force shall examine, discuss and provide advice and make recommendations respecting the appropriateness and effectiveness of the following areas in the legislation:

1. The current definition of “sexual abuse” contained in the *Code*.
2. The current list of frank sexual acts set out in subsection 51 (5) of the *Code* whereby a member’s certificate of registration must be mandatorily revoked for a minimum of five years if he or she is found to have sexually abused a patient by engaging in one of those acts.
3. Provisions related to discipline and disciplinary orders made by college discipline panels involving regulated health professionals who have been found to have committed an act of professional misconduct by sexually abusing a patient, including the appropriateness, breadth and scope of terms, conditions and limitations imposed on certificates of registration and any guidance the task force may provide regarding the purposes for which or the circumstances in which these restrictions should be imposed. In making its recommendations, the task force should give consideration to relevant jurisprudence that has considered decisions of colleges’ discipline panels in relation to professional misconduct involving sexual abuse of a patient.
4. Interim legislative tools that are currently available to address instances involving potential sexual abuse of a patient prior to disciplinary proceedings (e.g., the use of interim orders for suspension and/or terms, conditions or limitations imposed on an individual’s certificate of registration pending the outcome of disciplinary proceedings) and the provisions of the *Code* related to the timeliness of disciplinary proceedings for cases involving sexual abuse of a patient.

5. The operations and requirements of the colleges' patient relations programs, including the education and training of college staff to ensure that patients who may have been sexually abused by regulated health professionals are treated with sensitivity and respect in their dealings with the college.
6. The requirement for a college program to provide funding for therapy and counselling for patients who have been sexually abused by regulated health professionals.
7. The current mandatory reporting schemes involving patient sexual abuse by regulated health professionals and facilities including the possibility of a mandatory disclosure of such information to law enforcement entities with a view towards increased transparency and accountability, including consideration of the role of the patient who may have been sexually abused in relation to such disclosures.
8. Actual or potential barriers relating to the reporting of patient sexual abuse and actual or potential barriers relating to sexually abused patients participating in college discipline proceedings, and measures that could reduce or eliminate such barriers.

The task force shall also consider and provide advice and make recommendations respecting:

1. How comprehensive, understandable, publicly accessible information provided by the colleges in the following areas could be improved and supported:
 - sexual abuse of patients by regulated health professionals;
 - information about existing supports for such patients;
 - funding for their therapy and counselling;
 - patient relations programs; and
 - patient impact statements.
2. The ministerial oversight role with respect to these matters.
3. Any other related issue that the Task Force considers necessary to address in the course of carrying out its functions.

In carrying out its mandate, the Task Force shall also have due consideration for any other expert advisory bodies and/or external review(s) being concurrently undertaken as advised by the Ministry of Health and Long-Term Care and which may have the potential to overlap with the subject matter of the task force's mandate. The task force shall endeavour, where

possible, to coordinate and to minimize the potential for overlap and/or duplication with such other advisory bodies or external reviews.

Project Timelines and Deliverables

The task force may consult with interested parties including but not limited to:

- health regulatory colleges and professional associations representing regulated health care professionals;
- individuals who have experienced sexual abuse by regulated health professionals;
- organizations representing individuals who have experienced sexual abuse, sexual assault or other types of sexual violation;
- organizations where regulated health professionals are employed or hold privileges to practise; and
- individual regulated health professionals or group practices where regulated health professionals provide health care.

The task force is a short-term advisory body and will act in an advisory capacity only.

Within two weeks' time following the date on which the task force holds its first meeting, the task force shall provide a work plan to the ministry setting out a detailed overview of how the task force intends to fulfill its mandate and to deliver its written report to the minister within the specified timeframe as set out in these terms of reference.

Following the completion of its consultations and analysis of the relevant subject matter, the task force shall provide its final written report to the ministry detailing its advice and recommendations with respect to the matters set out above by no later than December 31, 2015.

The Task Force's advice and recommendations in its written report shall be limited to the items set out above, in accordance with the Task Force's mandate.

The task force's written report to the minister shall be in a form and manner specified by the ministry.

The ministry is not required to act on the task force's advice and recommendations as set out in the task force's written report.

Membership

The minister would appoint the members of the task force pursuant to section 9 of the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26. The minister may also designate one or two of the members as Co-Chairs of the task force.

The task force would comprise up to three members. All members, including the co-chairs, would serve at the minister's pleasure for a period commencing January 5, 2015, and ending December 31, 2015, unless the member's appointment is revoked at an earlier date by the minister without cause and/or without notice.

Subject to the prior written approval of the ministry, the ministry will compensate the task force members on a per diem basis in accordance with all applicable government directives, policies and guidelines. The ministry will also reimburse all task force members for eligible travel, meal and accommodation expenses in accordance with the Management Board of Cabinet, Travel, Meal and Hospitality Expenses Directive.

Chair

In addition to the responsibilities of a member of the task force, the chair shall preside at all meetings of the task force, and are responsible for the general supervision of the affairs and business of the task force.

Meeting Schedule

The task force shall meet periodically at times to be determined by the task force members for the purposes of carrying out its mandate. The task force shall also meet when asked to do so by the ministry. The task force shall conduct its meetings in the manner it considers appropriate.

In accordance with the requirements of the Travel, Meal and Hospitality Expenses Directive, task force meetings will be conducted by teleconference or by videoconference as much as possible. Additional meetings or meetings via teleconference or videoconference may be held as requested by the ministry. Members may be asked to review and comment on relevant documents circulated between meetings.

Accountability/Reporting

The task force reports through its chair to the Assistant Deputy Minister of the Health Workforce Planning and Regulatory Affairs Division of the ministry.

Adherence to Appointee Directives

All task force members shall comply with the provisions contained in the Management Board of Cabinet's Agencies and Appointments Directive.

Confidentiality, Access and Privacy

All confidential information, as defined in the members' Terms and Conditions of Appointment pertaining to the task force, including notes written by individual members in connection with their work on behalf of the task force, may be subject to the provisions of *Ontario's Freedom of Information and/or the Protection of Privacy Act* and *Personal Health Information Protection Act, 2004*, and may be subject to disclosure in accordance with these Acts.

In addition to the provisions of the members' Terms and Conditions of Appointment pertaining to confidentiality and access and privacy, each member shall be responsible for the following in order to ensure compliance with the confidentiality, access and privacy provisions requirements:

- a. Members shall create a separate email address to use to conduct Task Force business.
- b. Members may conduct business related to the committee at their primary place of employment or in their personal dwelling, as long as all confidential information pertaining to the committee is saved and stored separately from other business and personal activities, either in a separate electronic or physical, paper folder.

Conflict of Interest

As detailed in the members' Terms and Conditions of Appointment, any actual, potential or perceived conflict of interest arising in regard to any matter under consideration by the task force must be disclosed to the ministry as soon as any such actual, potential or perceived conflict of interest becomes apparent to the member.

Administrative Support

Administrative support for the task force will be provided through the Health Workforce Planning and Regulatory Affairs Division. Administrative support will include coordination of booking of meetings, preparation of agendas and support in arranging meetings. The ministry will provide the panel with access to a senior policy analyst to provide liaison between the ministry and the panel, and a coordinator in order to fulfill the committee's role.

Amendment to Terms of Reference

The minister may amend the task force's Terms of Reference from time to time and in the minister's sole discretion.

Appendix B:

Recommendations

1. Definitions of Patient and Boundaries

The RHPA, *Health Professions Procedural Code*, should be amended to define “patient” as well as to specify clear boundaries and time periods for sexual contact between members and their former patients. Therefore the Minister’s Task Force recommends:

- an amendment to the interpretation clause of the RHPA, section 1.(1) by adding, after the definition for “Minister”: “patient” means an individual who at any time has received, or is receiving, health care from a member, or has been assessed by the member, or is otherwise under, or assigned to, the care of the member, including psychotherapy delivered through a therapeutic relationship or counselling for emotional, social, educational or spiritual matters delivered through a confidential treatment context; and
- an amendment on clearer boundaries so that decision-makers in colleges and/or OSAPPA processes find that a member has committed an act of professional misconduct by sexually abusing:
 - i. a patient concurrent with a health care relationship; or
 - ii. an individual who was a patient within two years from the sexual abuse; or
 - iii. a person to whom a member has provided treatment by means of a psychotherapy technique delivered through a therapeutic relationship, including counselling delivered through a therapeutic relationship.

2. Mandatory Revocation: Zero Tolerance Standard

The *Health Professions Procedural Code* of the RHPA should be amended to add to specific acts defined in section 51.5 that trigger mandatory revocation of the certificate of registration of a member who has been found guilty of a recurrent pattern of sexual abuse under section 1(3) (b) or (c) of the *Code* (touching of a sexual nature or behaviour or remarks of a sexual nature by the regulated health professional).

The member's college must revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following:

- i. sexual intercourse;
- ii. genital to genital, genital to anal, oral to genital, or oral to anal;
- iii. digital penetration or penetration with an object of the mouth; vagina or anus without medical/health care justification;
- iv. masturbation of the member by, or in the presence of, the patient;
- v. masturbation of the patient by the member;
- vi. masturbation of the patient in the presence of the member;
- vii. touching of a patient's breasts without medical/health care justification; or
- viii. simulated sexual intercourse with the patient.

3. No Gender-Based Restrictions

As discussed in detail in Chapter 5, with case examples, the Minister's Task Force recommends immediate stoppage of any decision-making body under the RHPA placing gender restrictions on the scope of practice where a health professional has been found to have had sexualized contact with one or more patients, in contravention of any of the sections of the *Code* related to sexual abuse and/or misconduct and/or impropriety.

The *Health Professions Procedural Code* should be amended by adding a new subsection to s. 51 to clarify that, notwithstanding section 37(1) and subsection 51(2)3, where the member has committed, or has been alleged to have committed, an act of professional misconduct by sexually abusing a patient, gender restrictions on the member's ability to practise as a term, condition or limitation on the member's certificate of registration are not to be imposed.

4. Ontario Safety and Patient Protection Authority (OSAPPA)

The Government of Ontario should establish OSAPPA, the Ontario Safety and Patient Protection Authority, with the mandate to uphold the standard of zero tolerance of sexual abuse of patients and receive dedicated long-term resources to support that mandate, including to provide for:

- public education and outreach, with particular attention and resources to cultural sensitivity and competency;
- educational liaison with all programs for students in the regulated health professions;

- supports to patients reporting sexual abuse by regulated health professionals; and
- complaints and investigations, but with adjudication of sexual abuse complaints by the independent OSAPPA Tribunal.

5. Fast Tracking Sexual Abuse Complaints

All discipline cases of sexual abuse by health care professionals should be given priority and fast tracked by the colleges during the transition to OSAPPA and any such occasion thereafter. The modernized RHPA is to place legislated onus on regulatory colleges to make immediate referrals of patients with sexual abuse complaints to OSAPPA — in person with written information provided to facilitate the patient’s access to OSAPPA services, and in writing — by the most efficient possible electronic means directly to OSAPPA. Every regulatory college is to be mandated to include a record of all patient visits and other forms of inquiry vis-à-vis the sexual abuse of patients (not only referrals to a discipline panel) with documentation as to the speed and nature of referrals to OSAPPA. The modernized RHPA is to mandate OSAPPA with resources and reporting responsibility to ensure that sexual abuse complaints are processed within the required timeline.

6. Patient Privacy and Confidentiality

Oversight by the Ministry of Health and Long-Term Care should be vigilant, to ensure that the existing protection in section 85.3(4) of the *Health Professions Procedural Code* is upheld so that a reporting member does not give the name of the patient–complainant unless the member has the express, written consent of the patient, for patients who are able to provide consent. For patients who are not able to provide consent for reasons of age (children) or mental or physical disability, consent must be provided by the legal guardian/power of attorney. However, when a complaint is received, the registrar of the college of the health professional making the report is to receive a copy of the mandatory report by that health professional, even when the patient is not named in the report.

7. Full Participation of Patients

In order to increase access to justice for patients, it is recommended that — instead of at the discretion of discipline panels to “allow” patients some greater participation in hearings, as set out in subsections 41.1(1)(b) and (2)

— the *Health Professions Procedural Code* be amended to include the following provisions for complainants in sexual abuse cases:

- all complainants should have the right to participate in the proceedings of any complaints or disciplinary hearings, as a full party, with their own legal representation provided by the colleges and OSAPPA after transition;
- all complainants should have the right to a support person of her choice at the expense of the health regulatory colleges, and after transition, OSAPPA;
- the RHPA should clearly provide to all complainants in sexual misconduct/abuse proceedings the option to testify behind a screen or by closed-circuit electronic means;
- all complainants should have the opportunity, in accordance with current RHPA provisions, where the member is found guilty, to submit a victim impact statement and not be cross-examined on that statement, such statement to be taken into account in the assessment of a remedy or penalty;
- a videotape of an interview with the complainant may be admitted in evidence if the complainant, while testifying, adopts the content of the videotape; and
- under no circumstances should the alleged perpetrator of the sexual abuse be permitted to cross-examine the complainant personally.

8. OSAPPA Tribunal — Adjudication

The Government of Ontario should establish a tribunal that should provide independent adjudication for OSAPPA cases, which could be a new tribunal or developed as a specialized branch of the Ontario Human Rights Tribunal or as a thorough restructuring of the Health Professions Appeal and Review Board (HPARB).

9. Health Professions Appeal and Review Board – Restructuring Review

A. A review as to the possible restructuring of the Health Professions Appeal and Review Board (HPARB), taking into account the Professional Standards Authority for Health and Social Care in the United Kingdom, the Health Practitioner Disciplinary Tribunal in New Zealand and the Ontario Human Rights Tribunal, should be conducted for the Minister’s Implementation Council to assess and then advise the minister as to whether a restructured HPARB should function as the independent tribunal to decide OSAPPA cases.

B. In any event, the *Health Professions Procedural Code* should be amended to require HPARB to:

- render a decision within 120 days of receiving the request for review of a decision of a complaints committee panel;
- allow patients as full parties to review hearings, whether in person or by other means; and
- report annually on the number of appeals heard and the number of those where the board dismissed appeals by patients, such report to be made in a timely manner to be included in the public report of the Minister of Health and Long-Term Care to the appropriate committee of the Ontario Legislature.

10. Evidentiary Rules at Discipline Hearings in Sex Abuse Complaints

The *Health Professions Procedural Code* should be amended with a new provision that the evidentiary rules governing sexual abuse complaints and related discipline hearings are governed by the *Statutory Powers Procedures Act*.

11. Admissibility of Evidence

Subsection 36(3) of the RHPA should be amended so that evidence on the findings, orders or decisions in disciplinary proceedings under the RHPA are admissible in civil proceedings.

12. Expert Witnesses in the Dynamics of Sexual Abuse of Patients

The OSAPPA should appoint at least two independent experts with specialized backgrounds in research and/or practice related to the dynamics and impact of sexual abuse by health care professionals. These experts can present evidence at complaints, discipline and reinstatement proceedings, to ensure that the OSAPPA tribunal has the benefit of this expertise to take into consideration, rather than the prosecution and defence each appointing their own experts.

13. Resources for Participation of Patients in Investigation and Adjudication

Patients deserve appropriate and timely resources for full participation in the investigation and adjudication of sexual abuse complaints including access to therapy funds (during and after transition to the OSAPPA model).

A. Provincial rules and legislation should be amended to ensure that any fines imposed on a member for the sexual abuse of a patient should be designated as a separate fund under the jurisdiction of OSAPPA, to be used for support to patients, including therapy and counselling for eligible patients.

B. Subsection 85.7(4) of the *Health Professions Procedural Code* should be amended so that interim funding for patient therapy is provided prior to the hearing stage by colleges (during transition) and by OSAPPA.

14. Therapy and Counselling

A. A regulation pursuant to section 85.7 of the *Health Professions Procedural Code* should be made to clarify that funds are to be provided to the patient-complainant throughout a sexual abuse complaint process to cover the cost of medications, childcare and reasonable travel/accommodation expenses associated with accessing therapy related to the sexual abuse.

B. A regulation pursuant to the RHPA should stipulate that a patient is also eligible for funding for therapy or counselling if:

- there is an admission made by a member in a statement to the college (during transition) or to OSAPPA or the OSAPPA tribunal that the member sexually abused the patient;
- the member has been convicted under the *Criminal Code of Canada* of sexually assaulting a person while that person was a patient of the member; or
- OSAPPA staff determine that there is sufficient evidence to support a reasonable belief that the patient was sexually abused by a member.

15. Protection from Sexual Abuse by Unregulated Health Practitioners

A. The Ministry of Health and Long-Term Care (MOHLTC) and OSAPPA should commission research to determine the most effective legislative means for creating and maintaining a public record listing unregulated health practitioners who were previously licensed in Ontario or other jurisdictions, but who have lost their certificates of registration due to findings against them of sexual abuse of patients.

B. Currently unregulated health care providers — for example, sonographers — need to be identified and assigned to an existing college for regulation in the interest of patient safety, and where unregulated health care providers

are contracted to or employed by regulated health professionals or health care corporations, the regulated health professionals and/or corporations are to be held responsible for acts of sexual abuse or harassment by those employees/sub-contractors by amendments to the RHPA and the *Excellent Care for All Act* (ECFAA).

16. Enforcement of Mandatory Reports of Sexual Abuse Complaints

All health care institutions and corporations providing health services to patients in Ontario, including hospitals, universities and private clinics, should become subject to fines between \$100,000 and \$250,000 for failure to make a mandatory report of alleged sexual harassment, sexual misconduct, exploitation or abuse. Despite more than 20 years of cases since the RHPA was amended to include explicit institutional obligations to report, not one institution has been held accountable for sexual abuse of patient(s) that was proven to have occurred within its jurisdiction.

17. Prerequisites for New or Renewed Registration

The RHPA should be amended to enhance prerequisites for new or renewed registration for regulated health professionals, to ensure that:

- powers under the RHPA (for example in in subsection 43 (1)(f)) and the *Health Professions Procedural Code* (for example, in subsection 94(1)) must be used to have all college councils change by-laws to require mandatory answering of questions by applicants/members on any complaints of sexual abuse or harassment against the applicant/member before certificates of registration are obtained initially or renewed annually;
- applications for a certificate of registration or for reinstatement of a certificate to any college under the RHPA are to require verification as to good character, including sworn statements as to previous convictions or charges of a criminal nature, any civil findings where the member has been a party in a lawsuit involving sexual abuse or harassment, and detailed reasons given for resignation or suspension if the member has resigned or was suspended from a college or any other health profession in any other jurisdiction in the world; and
- applications for reinstatement must include reference to any conditions placed by the college or OSAPPA, which the health professional was to meet, and evidence that the conditions have been met, as well as identifying the official(s) and expert(s) who deemed the evidence acceptable.

18. Access to Justice for Ontario Patients Pilot with Legal Aid Ontario

An Access to Justice for Patients pilot project with Legal Aid Ontario (LAO) is to be facilitated by the Inter-Ministerial Implementation Group, as per Recommendation 20. The Government of Ontario should provide adequate financial and other resources to LAO to launch and sustain this pilot project. The project will remove barriers that prevent patients in vulnerable populations from:

- getting comprehensive, understandable information and education about sexual abuse by regulated health professionals;
- reporting sexual abuse and impropriety for action to be taken; and
- receiving appropriate and timely resources so that they can fully participate in the investigation and adjudication of sexual abuse complaints.

Recommendation 18 is essential to an effective shift to the OSAPPA model by making the complaints and disciplinary process for patients more transparent and meaningful, through increased access to public legal information as well as skilled, culturally competent legal counsel. The project should be delivered through coordinated, sustainable programs by adequately resourced community-based organizations that are oriented to patient safety and patient rights.

A. Ontario should fund the development and delivery of a five-year pilot project, using the Barbra Schlifer Commemorative Clinic as lead community partner, to develop core legal competence for a vulnerable patient population, and to engage in direct patient legal advocacy and support throughout the complaint and discipline process. This five-year project should be evaluated at the end of year three, at which time a renewal plan will be created for the remaining two years of the pilot, with another evaluation and planning stage, with the stated goal of long-term, sustained access to justice for this vulnerable population.

B. Funding for this five-year project should include the hiring of at least two full-time legal counsel (based at the Schlifer Clinic for at least the first three years of the pilot project while OSAPPA is set up) to support the development of core legal competence of legal aid clinic lawyers and other legal aid service providers throughout the province.

C. As the lead agency, the Schlifer Clinic should collaborate with other legal advocacy partners (e.g., Community Legal Education Ontario [CLEO], ARCH Disability Law Centre, the Advocacy Centre for the Elderly [ACE],

Nishnawbe-Aski Legal Services, the African Canadian Legal Clinic [ACLC], Aboriginal Legal Services of Toronto, the South Asian Legal Clinic of Ontario, Justice for Children and Youth, etc.) in consultation with the Ontario Federation of Indian Friendship Centres (OFIFC) and other community-based networks, such as METRAC and Patients Canada, as appropriate, to promote cultural competency, diversity and effective outreach to patients in marginalized and hard-to-reach communities across the province.

D. The Schlifer Clinic and LAO, in collaboration with other legal advocacy partners, as appropriate, should ensure that they develop appropriate statistical and qualitative tools to measure and understand client needs. This information can be used for ongoing needs assessment, financial planning and service delivery purposes in the transition to OSAPPA and beyond.

E. The Government of Ontario will direct Legal Aid Ontario to inform patients about and direct them to the legal aid certificate programs (see below), and to train and sensitize staff at legal aid offices and legal aid clinics in the competencies required to meet the unique needs of patients who have experienced sexual abuse by regulated health care professionals (consistent with augmenting the sensitivity training provided as part of LAO's Domestic Violence Strategy). Training should be adapted to meet the desired outcomes in this recommendation, and increased access to justice for Ontario patients should include the following actions, as needed:

- i. Expand the current summary advice legal aid certificate program to provide two hours of summary advice to potential/actual complainants, and to support this expansion with resources and action, which will include the following:
 - (a) establishing a panel of eligible lawyers throughout the province who have the core competence to provide such advice;
 - (b) proactively informing frontline service organizations of the existence of, and eligibility for, this new legal aid certificate (e.g., the Ontario Coalition of Rape Crisis Centres [OCRCC], hospitals with sexual assault services, legal aid clinics, etc.);
 - (c) proactively engaging the legal profession and inviting lawyers with the appropriate eligibility criteria to be included on the panel; and
 - (d) as part of LAO's financial eligibility test expansion, possibly relaxing the strict financial eligibility criteria (for legal aid certificates) for this vulnerable client population. The revised criteria should be consistent with LAO's June 8, 2015, announcement to expand its certificate services in criminal law,

family law and refugee/immigration law and for mental health legal proceedings, as well as its November 2014 announcement to implement a higher financial eligibility test for family law clients who have experienced domestic violence.

- ii. Expand the current legal aid certificate program to permit patients alleging sexual abuse by a regulated health professional to obtain legal counsel throughout the discipline process (i.e., from the initial complaint to the hearing and the appeal). Legal Aid Ontario should develop eligibility criteria to establish a panel of qualified lawyers who have both legal competence in the area of patient sexual abuse and sensitivity training in dealing with survivors of sexual abuse.
- iii. Adjust LAO financial eligibility criteria so that they are not a barrier to Ontario patients in this pilot.
- iv. As a priority service, encourage Ontario's 76 legal aid clinics to develop a coordinated plan on how best to deliver legal services to eligible patients who have alleged sexual abuse by regulated health care professionals, consistent with this emerging area of legal representation.
- v. Set, as a specific priority for LAO public interest work, sexual violence in the regulated health professional context for the Group Applications and Test Case Committee of LAO, recognizing that complainants are a marginalized group.

Public Education and Legal Information Resources for the New Complaints Processes

F. Ontario should fund and develop an effective public education and legal information program, co-chaired by CLEO and METRAC, that informs the Ontario public about patients' legal rights and options for recourse when they have suffered sexual abuse by a regulated health care professional. The program will include information on:

- the scope of behaviours that constitute sexual abuse;
- the health care and forensic evidence collection services provided at sexual assault/domestic violence treatment centres across Ontario;
- the option of filing and pursuing a complaint and discipline process;
- patients' rights and status within complaint and discipline proceedings;
- the legislative provisions of the RHPA and its Code vis-à-vis patient sexual abuse;
- additional legal options under criminal and civil law; and
- legal support services and legal aid-funded services.

G. In implementing this aspect of the Access to Justice pilot project, CLEO and METRAC should offer to collaborate with other organizations that have public legal education mandates (such as Luke’s Place, the Legal Education and Action Fund [LEAF], Action Ontarienne contre la violence faite aux femmes [AOcVF], the Ontario Federation of Indigenous Friendship Centres and others, as appropriate), in order to:

- i. identify effective strategies for developing relevant public legal information training and resources for service providers to assist them in responding to patients’ disclosure of sexual abuse by health care professionals; and
- ii. engage diverse patient communities to develop relevant public education and legal information through the selection of topics and resource formats that ensure accessibility, and specification of relevant outreach and communications methods. The program will facilitate effective distribution of information based on intersecting needs and the provision of ongoing community feedback for improving program relevance and responsiveness, and contributing to a final evaluation to measure program results and overall effectiveness.

H. Ontario-coordinated funding to support the Access to Justice pilot should explicitly support inter-sectoral coordination and sharing of information and services across multiple sectors, including the following:

- i. ServiceOntario will distribute materials to individuals and institutions across Ontario, including government offices, patient advocates and service provider organizations.
- ii. The Government of Ontario will develop a program to educate lawyers about how to most effectively represent patients who have been sexually abused by regulated health professionals with respect to the related disciplinary processes. The government will do this in partnership with an appropriate agency, such as the Law Society of Upper Canada and/or the Ontario Bar Association.
- iii. Consolidation and distribution of examples of “lessons learned” and culturally competent proven practices, including highlighting different educational models, such as community-based approaches that include models for evaluation that can measure outcomes among multiple services and sectors, and incorporate access and equity principles.

19. Minister's Implementation Council

A. The Minister of Health and Long-Term Care (MOHLTC) should immediately establish the Minister's Implementation Council for an initial renewable five-year term, to make an annual public report to the minister, who in turn should report to a standing committee of the Ontario Legislative Assembly. Reports should include a detailed summary of cases, patient evaluations of processes and responses, an audit of decisions, evaluation of OSAPPA and suggestions for more effective procedures and educational initiatives for preventing the sexual abuse of patients in the public interest. Membership in the Minister's Implementation Council should include one Ministry of Health and Long-Term Care employee/appointee at the assistant deputy minister level (or equivalent) and one at the director level in the ministry, one member of the Premier's Permanent Roundtable on Violence and one member of the Aboriginal Roundtable on Violence, two experienced executives from health regulatory colleges, one health care administrator with extensive community-based care experience, at least two survivors and two advocates working in the field of abuse prevention and/or victim support, one executive officer of OSAPPA — taking into consideration those recommended by separate letter from the task force for the minister's consideration. To succeed, each member of the Minister's Implementation Council needs to be able to interact critically with every other member in a way that protects the integrity of each; thus, all members should receive the same level of remuneration for this public service — at the level of chair — as a clear indication of the respect and need for the equivalency of the range of expertise needed for effective collaboration and implementation of this major reform. The Implementation Council should encourage, receive and respond to reports on educational and research initiatives undertaken, as per relevant recommendations made herein.

B. That the Minister of Health and Long-Term Care include in the mandate of the Minister's Implementation Council responsibility to develop an evaluation framework for the OSAPPA with appropriate metrics, at minimum, annual reporting to the Minister on the number and type of complaints by patients, the disposition of those complaints, the fines levied for lack of mandatory reporting, general understanding of sexual abuse of patients and the response system, and other indicators of effectiveness of the reporting system and public education initiatives.

20. Inter-Ministerial Oversight for Implementation

The Cabinet of Ontario should immediately establish an inter-ministerial implementation initiative (group) that includes leadership from the Ministry of Health and Long Term Care in cooperation with the Ministry of Training, Colleges and Universities, the Ministry of the Attorney-General, the Minister Responsible for the Status of Women and others to be named, as decided by the ministers, to coordinate an ongoing cross-government response to preventing the sexual abuse of patients by health care professionals in Ontario — consistent with the whole-of-government response to sexualized violence and harassment in Ontario. Through the Minister of Health and Long-Term Care, leadership by this Inter-Ministerial Implementation Group would generate reforms consistent with the mandate of the Minister's Implementation Council to supervise and facilitate the development and implementation of initiatives to deal with sexual abuse by health professionals, including monitoring recommendations that flow from this report.

21. MOHLTC Leadership in Research

The Minister of Health and Long-Term Care (MOHLTC) should immediately ensure funding to designate an ongoing annual research fund within the MOHLTC health research program to support research pertaining to sexual abuse by health care professionals including but not limited to:

- rates of and remedies for same;
- comparison of rates and dispositions of sexual abuse complaints to other offences;
- relevant organizational innovations and responses;
- links to broader societal norms, attitudes and behaviours;
- improved performance of the health care system; and
- pre-service and in-service education and training intended to prevent and rectify such behaviours.

Such research should be conducted in accordance with recognized institutional ethics review policies and procedures and with appropriate consent processes and policies. Patients must be informed of such research and assured of anonymity.

22. Research and Monitoring

The Minister of Health and Long-Term Care should commission a research study to track and analyze the rates, responses and disposition of sexual abuse cases of patients by health care professionals in Ontario retrospectively and going forward 20 years, in five-year segments, recognizing the complexities of reporting, versus incidence data.

23. Minister's Annual Symposium

The Minister of Health and Long-Term Care should announce and support an annual international symposium to address systemic changes in the province of Ontario to prevent and provide remedies for the sexual abuse of patients by health care professionals. This would include ongoing research, professional and public education, community action and partnerships, and assessment of the RHPA. It is suggested that the minister be a keynote speaker at the symposium on sexual abuse of patients being planned by Women's College Hospital in 2016, and contribute substantial resources of experts, information and financial support to this symposium as an initial step in MOHLTC taking responsibility for its annual symposium, beginning in 2017.

24. Aboriginal Health Strategy Renewal

A. The task force recommends that the Minister of Health and Long-Term Care initiate the renewal of a comprehensive, cross-cutting inter-sectoral policy on aboriginal health to incorporate and act upon the 94 Calls to Action made by the Truth and Reconciliation Commission, as relevant to the overall health and well being of Indigenous peoples in Ontario generally, and to the sexual abuse of patients of Aboriginal origin, in particular. Specific attention should be given to research, policy proposals and commentary principally authored by experts of Aboriginal origin, including the *Final Report of the Truth and Reconciliation Commission of Canada* (released December 15, 2015), reports from the Ontario Joint Working Group on Violence against Aboriginal Women, the Strategic Framework to End Violence against Aboriginal Women (Ontario Native Women's Association and Ontario Federation of Indigenous Friendship Centres), and the Aboriginal Sexual Violence Action Plan (Ontario Federation of Indigenous Friendship Centres).

B. The task force recommends that the minister designate an Assistant Deputy Minister to lead a five-year plan from MOHLTC officials on comprehensive, cross-cutting intersectoral policy on cultural competency in research, education and other programs addressing the sexual abuse of patients in marginalized (social and/or geographic) and/or vulnerable populations in Ontario, to be submitted to the Minister's Implementation Council.

25. Patient Safety Reporting in Health Care Educational Curricula and Systems

A. The Inter-Ministerial Implementation Group should review accreditation standards for educational institutions providing certificate, diploma, undergraduate and post-graduate programs for professions under the RHPA, with the goal of incorporating patient safety assessments — including protections against sexual abuse — in all accreditation programs. The review of curricula should include an assessment periodically of ethical standards for professional practice and strategies in place to build awareness of the impact of sexual abuse on patients, along with the responsibilities, approaches to prevention, and requirements to report and to implement tracking mechanisms regarding knowledge of, and educational institutions' responses to, reports of sexual abuse of patients.

B. Institutions responsible for training health care professionals should have, as a minimum, explicit senior management commitments to preventing sexual abuse of patients, clear statements and explanations of sexual abuse of patients, professional responsibilities to report as part of core training, examinations concerning professional practice and codes of ethical conduct — all embedded in performance reviews conducted periodically for funders.

26. Education for Patients and Professionals

The Minister of Health and Long-Term Care should introduce and — in cooperation with the Ministry of Training, Colleges and Universities and other affected ministries — support, with adequate resources, newly designed and evaluated pre-service, in-service and public education on sexual abuse of patients by health professionals, to be reviewed and reported on periodically, including:

- refreshed curriculum for pre-service education in universities and colleges;
- refreshed continuing education and training for in-service health professionals;

- cultural competency as a mandatory component in any education or training public education campaign addressing patients, families, bystanders and communities about rights and redress;
- education for hospital and other health care administrators on their legal, patient safety and reporting responsibilities; and
- mandatory training, with periodic reviews, for members of governing councils and staff of health regulatory colleges to begin immediately and to continue through transition to include OSAPPA officials and personnel.

27. Patients' Safety Bill

A Patients' Safety Bill should immediately be developed by the Ontario Ministry of Health and Long-Term Care in consultation with patients' advocacy groups and the regulatory colleges as an amendment to the RHPA. The *Ontario Hospitals Act* should be amended to require all regulated health professionals and all administrators of health care facilities, including privately owned health care facilities, to post, with clear requirement to maintain: a) visibility of the Bill and b) availability upon request of print copies of the Bill. The Patients' Safety Bill and current contact information should be placed in high-visibility locations wherever health professionals are providing services. This amendment may be complementary to, but is substantially different from, the Patient Ombudsman office announced in 2015.

28. Patient Evaluations re Access to Justice for Better Health Care

Following every determination and resolution of a complaint about sexual abuse during the transition to the OSAPPA system, every college is to ensure that an evaluation form, with introductory information supplied by MOHLTC, is provided to every patient involved in the process, and include a pre-paid return envelope addressed to the Minister's Implementation Council. The OSAPPA mandate should include an ongoing responsibility to continue and improve upon gathering feedback from patients, to enable meaningful comparisons in evaluation and annual reporting.

29. Reports for the Public Record — *Excellent Care for All Act*

A. The Minister of Health and Long-Term Care should introduce the reporting and disposition of sexual abuse cases as a priority Quality

Improvement Indicator under the *Excellent Care For All Act* (ECFAA) pertaining to hospitals in Ontario, community and home-based care, and primary care practitioners. Results should be included in the minister's annual report to the legislative committee and — if not included — there should be an explanation required in the report.

B. The RHPA should be amended to include the requirement that every college shall make a public annual report to the Minister of Health and Long-Term Care and to OSAPPA of any complaints received concerning the sexual abuse of patients by members or former members of the college, including a summary of the timeline and description of actions taken by the college in referring on to OSAPPA. The Minister's Implementation Council should be responsible for the template for this annual report, in consultation with patients' advocacy groups, hospitals, educational institutions, OSAPPA and the colleges.

C. The Minister should recommend to the Ontario Hospital Association (OHA) to incorporate the sexual abuse of patients by health professionals into the current Quality and Patient Safety Plan (QPSP), given that one of their stated goals is "to champion the adoption of a culture of quality and patient safety." The OHA can support health care institutions in developing their annual Quality Improvement Plans (QIPs) as mandated under the ECFAA. The OHA could be instrumental in providing materials, supports and tools to health care institutions that include: a broader definition of patient safety, the psychological harm and other harms associated with sexual abuse of patients and definitions of patient, health care provider, and sexual abuse based on the RHPA. Responsibilities and accountabilities of the hospitals/other health care facilities and health providers for the prevention, identification, reporting, tracking and responding to reports of sexual abuse of patients by health care providers should also be delineated. The OHA should be encouraged to contribute leadership in preventing the sexual abuse of patients by making a long-term commitment to developing, providing and sustaining education, quality assurance and reporting mechanisms to OHA members.

30. Information Accessible on the Public Record — Registers

The *Health Professions Procedural Code* should be amended to require that every college register includes disciplinary decisions in which the member was found to have committed an act of sexual abuse/misconduct/impropriety as defined in the RHPA and Code, including section 1(3)(c)

(behaviour or remarks) as well as 1(3) (a) (physical sexual relations) and 1(3)(b) (touching of a sexual nature) of the Code and that staff of colleges are clearly obliged to inform anyone who inquires as to the nature of the complaint. The amendments should be designed to apply high-transparency standards to the public record of colleges during and after the transition and also to public records of the OSAPPA model.

31. Transparency and Notifications of Findings by Colleges and OSAPPA

The *Health Professions Procedural Code* should be amended to ensure that college and OSAPPA registers contain for the public record:

- any stipulations or programs imposed on a member related to any complaint of sexual abuse of a patient, with a notation on whether the requirements were disciplinary panel decisions, or determinations through any other means, including suspension or resignation of the member, related to sexual abuse complaints processed by a college (during transition) or OSAPPA (after transition); and
- determinations of any kind, including resignation, that colleges (which retain the authority to issue or revoke certificates to practise) should be legally obliged to inform all other licensing authorities in Canada and to keep written records verifying such notification, to be included in annual public reports to the Standing Committee on Government Agencies of the Legislative Assembly of Ontario or another appropriate standing committee that includes MOHLTC in its mandate.

32. Provincial, National and International Database Access

The Ministry of Health and Long-Term Care should initiate joint and reciprocal ventures to establish, link and maintain both a national and international database, with public access and capable of identifying sexual abuse offenders who are, or were, regulated health care professionals.

33. Patient Safety Standards Addressing the Sexual Abuse of Patients in Hospitals, Health Care Organizations, and Long-Term Care Facilities

The OHA and other such health organizations, as relevant, should provide increased, focused and sustained leadership in the development of policy and education for all institutional members. Included should be a broader definition of patient safety that recognizes the extensive and serious range

of harm associated with sexual abuse of patients. Specific and detailed standards for hospital and other health institution leaders should be established. These would leave no doubt about the definitions of patient, health care provider and sexual abuse, or the responsibilities of hospitals and other health care facilities for the prevention, identification, reporting and tracking of sexual abuse of patients by health care providers. Accountability mechanisms geared to hospitals and health care providers should be clear, resourced and implemented for the long term. Health care institutions, including hospitals, should have rigorous training, quality assurance and reporting mechanisms in place that reinforce their duties to prevent, report and track sexual abuse incidents within risk management systems that permeate every level of service within the health care institutions — with clear, enforced consequences for all executives who do not deliver on the patient safety and protection standards.

The minister should recommend to the OHA to incorporate sexual abuse of patients by health professionals into the current Quality and Patient Safety Plan (QPSP), given that one of their stated goals is “to champion the adoption of a culture of quality and patient safety.” The OHA can support health care institutions in developing their annual Quality Improvement Plans (QIPs) as mandated under the ECFAA. The OHA could be instrumental in providing materials, supports and tools to health care institutions that include: a broader definition of patient safety, the psychological harm and other harms associated with sexual abuse of patients and definitions of patient, health care provider, and sexual abuse based on the RHPA. Responsibilities and accountabilities of the hospitals/other health care facilities and health providers for the prevention, identification, reporting, tracking and responding to reports of sexual abuse of patients by health care providers should also be delineated. In keeping with Recommendation 29, the OHA should be encouraged to contribute leadership in developing and providing education, quality assurance and reporting mechanisms to OHA members.

34. Accreditation standards

The Minister of Health and Long-Term Care should recommend to Accreditation Canada the development of Required Organizational Practices (ROPs) in the Safety Culture category that are specific to the sexual abuse of patients by regulated health professionals. Sexual abuse of patients is a low-probability/high-impact risk that needs to be addressed at a strategic level as an issue of patient safety. These ROPs would clearly describe the

organizational/board responsibilities in addressing sexual abuse, i.e., educational requirements for employees, mandatory reporting expectations, and tracking and reporting within and by institutions.

The ROP approach would also require the sexual abuse of patients to become a “standing agenda item” at all regular meetings of the governing body. ROPs would include: a) definitions, consistent with the RHPA, of “patient” and of “sexual abuse or exploitation”; and b) clear commitments as to what patients should be able to expect from their health care provider within a patient safety context. ROPs would clearly describe for patients what to do if they experience sexual abuse and to whom reports must be made. Similar to the approach taken by many hospitals, for example, in protecting patient privacy, hospital boards should mainstream protection of patients from sexual abuse at all levels of governance and management and ensure implementation of relevant sections of the *Health Professions Procedural Code*, including mandatory reporting of sexual abuse complaints per section 85.1 (reporting by members) and section 85.2 (reporting by facilities).

Appendix C: Correspondence

Date	Sent to	Letter
<p>February 9, 2015</p>	<p>Thomas Corcoran, Chair, Health Professions Regulatory Advisory Council</p>	<p>The Premier recently announced several initiatives to raise awareness of sexual violence and harassment, enhance prevention initiatives to combat sexual discrimination, harassment and violence, and improve support for victims. Initiatives span the province and include a request to Ministers to bring forward options to enhance support for victims of sexual violence in various sectors, including health care.</p> <p>In December 2014, the Minister of Health and Long-Term Care, Dr. Eric Hoskins, established a Task Force on the Prevention of Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i>. The Minister asked the Hon. Roy McMurtry, Prof. Marilou McPhedran and Ms. Sheila Macdonald to serve on the Task Force. The Task Force will review the <i>Regulated Health Professions Act, 1991</i>, which governs all regulated health professions in the province, to ensure it is effective in preventing and dealing with the sexual abuse of patients by regulated health professionals.</p> <p>In order for the Task Force to carry out its work, your assistance is required. The Health Professions Regulatory Advisory Council (HPRAC) has played an important advisory role to the Minister on the matters that the Task Force is considering. As a result, the Task Force is requesting that you provide a summary of HPRAC responses to the Minister related in any way to the sexual abuse of patients. If you have other data or information that is relevant to the work of the Task Force, please share it.</p> <p>Although this request may require a considerable amount of staff, time and resources to fulfill, the Task Force is working within a compressed timeline at the Minister's request and would appreciate receiving this information (through SATaskforce@ontario.ca) before February 27, 2015.</p>

Date	Sent to	Letter
<p>February 11, 2015</p>	<p>Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division</p>	<p>As you know, in December 2014, the Minister of Health and Long-Term Care, Dr. Eric Hoskins, established a Task Force on the Prevention of Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i>.</p> <p>In order for the Task Force to carry out its advisory work, your assistance is required and very much appreciated.</p> <p>At this time, the Task Force is requesting that you liaise with your colleagues within the Ministry of Health and Long-Term Care (MOHLTC), across social service ministries, and within any other ministries that may have information to share or a stake in the work of the Task Force. Specifically, we are interested in research or program development planned, in progress, published (including references if available) or implemented since 2003 on the prevalence or incidence of sexual abuse by health professionals; and other data or information that is relevant to the work of the Task Force.</p> <p>Similarly, the Terms of Reference guiding our work ask us to consider other expert advisory bodies and/or external review(s) being concurrently undertaken by your Ministry which may have the potential to overlap with our work. Please provide an overview of any other such reviews or advisory bodies currently at work.</p> <p>Through early consultations, the Task Force has become aware of a review being conducted on the complaint processes at the College of Physicians and Surgeons of Ontario. The review is also to consider information from the Canadian Medical Protective Association (CMPA) about the factors that affect costs at various stages of the complaints process. A final report is due to the Deputy Minister of the MOHLTC by April 30, 2015. If possible, please provide further details of this initiative so that we may assess potential areas of overlap and alignment in keeping with our Terms of Reference.</p> <p>The Task Force is working within a compressed timeline at the Minister's request and would appreciate receiving this information (through SATaskforce@ontario.ca) before March 6, 2015.</p>

Date	Sent to	Letter
<p>February 27, 2015</p>	<p>Dr. Eric Hoskins, Minister of Health and Long-Term Care</p>	<p>As your Task Force on the Prevention of the Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i>, we would appreciate your input on several matters.</p> <p>In November 2000, the previously constituted Special Task Force on the Sexual Abuse of Patients delivered its report to the then-Minister of Health and Long-Term Care. At her direction, the report was also delivered to the then-Chair of the Health Professions Regulatory Advisory Council (HPRAC) as HPRAC was at that time conducting the mandated five-year review of the amendments to the RHPA, which took effect in 1994. The report, entitled “<i>What about accountability to the patient?</i>”, contained 34 recommendations.</p> <p>Almost 15 years have passed since those recommendations were made. It would be very much appreciated if the ministry would report on the responses and action taken (or not) to each of the recommendations, including rationale where the recommendations were not accepted.</p> <p>We would like to ensure that you are aware that we are asking HPRAC to clarify whether and when since 2000 HPRAC has been asked to provide advice relating to preventing the sexual abuse of patients.</p> <p>Section 84(4) of Schedule 2, the Health Professions Procedural Code, indicates that each regulatory college is obligated to provide HPRAC with a written report describing its patient relations program and advise HPRAC in writing when changes are made to the program. What has been the outcome of this legislation?</p> <p>In addition, and to better understand HPRAC’s advisory relationship, please provide details on HPRAC’s funding since 2000 including, on a yearly basis, its deliverables and other output.</p> <p>On the current enquiry related to the review of complaint processes at the College of Physicians and Surgeons of Ontario that is being undertaken by Mr. Stephen Goudge, please provide details on the current government terms of payment to the Canadian Medical Protective Association (CMPA), and if they have changed since 2000 please provide more details. Is there an accountability mechanism in place by which the CMPA reports to the government?</p> <p>As the Task Force is working within a compressed timeline at the Minister’s request, we would appreciate receiving this information (through SATaskforce@ontario.ca) before March 20, 2015.</p> <p>We take seriously the mandate you have given to this Task Force and wish to thank you and your officials in advance for the work that will be undertaken.</p>

Date	Sent to	Letter
<p>February 27, 2015</p>	<p>Thomas Corcoran, Chair, Health Professions Regulatory Advisory Council</p>	<p>Further to our letter of February 11, 2015 regarding the Minister's Task Force on the Prevention of the Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i> (the Task Force), we would appreciate your input on additional areas of enquiry.</p> <p>In November 2000, the previously constituted Special Task Force on the Sexual Abuse of Patients co-delivered its report to the then-Minister of Health and Long-Term Care and the then-Chair of the Health Professions Regulatory Advisory Council (HPRAC). The report, entitled "What About Accountability to the Patient?", contained 34 recommendations. As current Chair of HPRAC, please provide details on your knowledge of responses and action taken (or not) on each of the recommendations.</p> <p>Additionally, since 2000, please advise whether and when HPRAC has been asked to provide advice relating to preventing the sexual abuse of patients.</p> <p>Sections 84(4) of Schedule 2, the <i>Health Professions Procedural Code</i>, indicates that each regulatory college is obligated to provide HPRAC with a written report describing its patient relations program and advise HPRAC in writing when changes are made to the program. How does your Council use this information vis-à-vis your advisory role to the Minister of Health and Long-Term Care? Please provide copies of any reports received under this provision.</p> <p>As the Task Force is working within a compressed timeline at the Minister's request, the Task Force would appreciate receiving this information (through SATaskforce@ontario.ca) before March 19, 2015.</p>

Date	Sent to	Letter
June 3, 2015	Dr. Eric Hoskins, Minister of Health and Long-Term Care	<p>I have yet to hear from your office as to an extension of the Task Force mandate and naming of a co-chair for the Phase 2 proposed to you in our discussion on May 11th regarding the interim recommendations of the Task Force. With our current mandate about to end, we are intensely in the process of honing our recommendations in order to deliver a report to you by July 2, 2015, when our 177-day appointments to the Task Force end.</p> <p>As discussed on May 11th, a critical part of our recommended approach is to catalyze substantial changes in key areas of Ontario jurisdiction. For example, substantial change is needed in the education of future regulated health professionals and continuing education after certification regarding sexual abuse and preventative actions as well as the range of support provided to victims of sexual abuse by health professionals and others in positions of trust, but it is well understood that such change does not fall fully within your ministerial jurisdiction.</p> <p>As mentioned to you in our personal meeting on May 11th, inter-ministerial silo-crossing is the recommended catalyst for changes beyond your authority and I am writing to ask for permission to seek opportunities to engage in discussions with key staff in the offices of the Hon. Reza Moridi, Minister of Training, Colleges and Universities (MTCU), the Hon. Madeleine Meilleur, Attorney General of Ontario and the Hon. Tracy MacCharles, Minister of Children and Youth Services and Minister Responsible for Women's Issues, including the Premier's Permanent Roundtable on Violence Against Women.</p> <p>As such, we would appreciate the support of your office in facilitating this direct contact with staff of your Cabinet colleagues in the very near future, and in pursuing a ministerial meeting in person with you and these colleagues to optimal effect on our recommendations in our imminent report.</p>

Date	Sent to	Letter
<p>June 3, 2015</p>	<p>Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division</p>	<p>In order to complete the advisory work of the Task Force on the Prevention of Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i>, your assistance is required and appreciated.</p> <p>The Task Force is interested in learning about any action taken as a result of the recommendations produced by the Health Professions Regulatory Advisory Council (HPRAC) between 2000 and 2009. HPRAC produced five documents during the years of 2000-2009;</p> <ul style="list-style-type: none"> • A Report to the Minister of Health and Long-Term Care on the Health Professions Regulatory Colleges' Patients Relations Programs (May 2008), • Regulation of Health Professions in Ontario: New Directions (April 2006), • Evaluation of the Effectiveness of the Patient Relations Program of the Ontario Colleges of Health (March 2001), • Adjusting the Balance: A Review of the Regulated Health Professions Act (March 2001), and • Effectiveness of Colleges' Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature (December 2000). <p>All of these reports presented a number of recommendations, many of which dealt directly with issues of sexual abuse in the health professions. HPRAC has provided the Task Force with a summary of referral recommendations related to sexual abuse, however, HPRAC has indicated that an enquiry about any action made relating to these recommendations should be directed to the Ministry. We are interested in determining what steps have been taken by the Ministry of Health and Long-Term Care as a result of the advice provided in these reports.</p> <p>The Task Force is working within a compressed timeline at the Minister's request and would appreciate receiving this information (through SATaskforce@ontario.ca) before June 10, 2015.</p>

Date	Response from	Letter
<p>February 27, 2015</p>	<p>Thomas Corcoran, Chair, Health Professions Regulatory Advisory Council</p>	<p>On behalf of the Health Professions Regulatory Advisory Council (HPRAC), I have included a response to your request, dated February 9, 2015.</p> <p>Please find attached a high-level summary of recommendations HPRAC has provided to the Minister of Health and Long-Term Care since 1993 related to the sexual abuse of patients. Certain reports which are relevant to your inquiry do not include specific recommendations but were included nonetheless. All efforts have been taken to adhere as closely as possible to HPRAC's original reports while still providing a useful summary for the Task Force. If you would like information on the actions the Ministry of Health and Long-Term Care has taken related to HPRAC's recommendations, please contact Denise Cole, the Assistant Deputy Minister of the ministry's Health Human Resources Strategy Division.</p> <p>Please note that, except for the most recent HPRAC report referred to in the attached summary, all reports were prepared prior to a change in HPRAC's mandate. In 2009, Bill 179, the <i>Regulated Health Professions Statute Law Amendment Act, 2009</i>, which received Royal Assent in December 2009, changed the mandate of HPRAC significantly. Whereas in the previous statute, the Minister was obligated to refer to HPRAC any matter requested by a Council of a health college or a person concerning major issues of health professions regulation, the new statute requires that the Minister may choose to make a specific referral to HPRAC on matters arising from such requests, and may or may not refer requests to HPRAC for a review. These matters include:</p> <ul style="list-style-type: none"> • Whether unregulated health professions should be regulated; • Whether regulated health professions should no longer be regulated; • Amendments to the <i>Regulated Health Professions Act, 1991</i> (RHPA); • Amendments to a health profession's Act or a regulation under any of those Acts. <p>Additionally, while it was previously the statutory duty of HPRAC to monitor each college's patient relations program and to advise the Minister about its effectiveness, the amendments to the statute now specify that the Minister must make a specific referral to HPRAC in order to receive a report on colleges' patient relations programs. These changes came into force in December 2009.</p> <p>As noted in the response provided, each report referenced includes a link to a full copy of the report and contains information related to HPRAC's process, methodology and rationale for the recommendations given. I would be more than happy to discuss the recommendations outlined in the document attached with the Task Force but must underscore that I have been Chair of HPRAC since 2011 and was directly responsible for the last report – the Spousal Patient.</p>

Date	Response from	Letter
April 9, 2015	Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division	<p>I am writing further to your letter of February 11, 2015 and my March 6, 2015 e-mail to Laura Niles.</p> <p>As requested, my office has liaised with relevant divisions within the Ministry of Health and Long-Term Care and with key Ontario ministries to compile information on research or program development planned, in progress, published or implemented since 2003 on the prevalence or incidence of sexual abuse by health professionals, and other data or information that is relevant to the work of the Task Force. Attached is a table that provides the information requested; for ease of reference, documents have been embedded in some instances.</p> <p>Also attached are the Terms of Reference for the review of the College of Physicians and Surgeons of Ontario's complaints process, which provides the information requested about its purpose and scope.</p>
July 3, 2015	Dr. Eric Hoskins, Minister of Health and Long-Term Care	<p>I am responding to the letter dated February 27, 2015, from the Minister's Task Force on the Prevention of the Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i> (Task Force) requesting additional information from the Ministry on several matters. Please accept my apologies for the delay in providing you with my response. I trust that the following information will be of assistance to the work of the Task Force.</p> <p>1. Previous Reports</p> <p><i>'What about accountability to the patient?'</i></p> <p>The Task Force asked for information on action taken with respect to the 34 recommendations contained in a report entitled "<i>What about accountability to the patient?</i>" produced by the Special Task Force on the Sexual Abuse of Patients constituted in 2000 (2000 Special Task Force).</p> <p>The 2000 Special Task Force was created in order to provide advice and recommendations on professional misconduct involving the sexual abuse of patients to the Health Professions Regulatory Advisory Council (HPRAC). In doing so, the 2000 Special Task Force held public hearings, answered questions related to sexual abuse of patients, and in general, assisted HPRAC as subject matter experts.</p> <p>At that time, HPRAC was undertaking a mandated five-year review of the <i>Regulated Health Professions Act, 1991</i> (RHPA), which was to include providing advice to the then-Minister of Health and Long-Term Care on the effectiveness of each college's complaints and discipline procedures relating to sexual abuse.</p> <p>The recommendations made by the 2000 Special Task Force were considered to be part of the advice provided by HPRAC in its final report to the Minister entitled the <i>Effectiveness of Colleges' Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature</i>, dated December 2000.</p>

Date	Response from	Letter
<p>July 3, 2015 (continued)</p>	<p>Dr. Eric Hoskins, Minister of Health and Long-Term Care</p>	<p>Further advice was provided to the then-Minister by HPRAC in its subsequent report <i>Adjusting the Balance</i>, delivered in 2001. In that report, HPRAC made a number of recommendations related to patient relations, the sexual abuse provisions of the legislation and the college's complaints and discipline processes.</p> <p>However, with a change in government in 2003, HPRAC was requested to provide advice on the currency of, and any recommended additions related to, HPRAC's advice contained in <i>Adjusting the Balance</i> and related reports in 2005 as part of a ministerial referral.</p> <p><i>New Directions</i></p> <p>In response to the 2005 referral, HPRAC provided the then-Minister of Health and Long-Term Care with comprehensive advice in its report entitled <i>Regulation of Health Professions in Ontario: New Directions</i> (New Directions) in 2006. As a result of the advice contained in the New Directions report, amendments were made to the RHPA through the <i>Health System Improvements Act, 2007</i>. These changes made included:</p> <ul style="list-style-type: none"> • allowing for the use of alternative dispute resolution processes as an acceptable way of resolving a complaint, with the exception of where the complaint included an allegation of sexual abuse; • clarifying the intent of the colleges' patient relations program was to have components that both prevent and deal with the sexual abuse of patients; and, • permitting that the funding provided for therapy or counselling could be used to pay for therapy or counselling which occurred at any time after the sexual abuse took place. <p>Although not specifically intended to address the sexual abuse of patients by regulated health professionals, the amendments to the RHPA in 2007 also included:</p> <ul style="list-style-type: none"> • ensuring more information about individual providers would be posted on the colleges' public registers; • mandating that public registers and other committee information be posted on colleges' websites; • requiring each college committee to monitor and evaluate its own processes and outcomes and annually submit a report of its activities to the Council of the College in a form acceptable to the Council; and, • requiring the Inquiries, Complaints and Reports Committee (ICRC) to consider all available prior decisions of the ICRC, its predecessors (Complaints and Executive Committee), and the Discipline Committee, involving the individual provider, unless the decision was not to take any action based on a frivolous or vexatious complaint.

Date	Response from	Letter
<p>July 3, 2015 (continued)</p>	<p>Dr. Eric Hoskins, Minister of Health and Long-Term Care</p>	<p>These amendments were aimed at ensuring:</p> <ul style="list-style-type: none"> • all patients had access to additional information about the individual providers from whom they were receiving care; • information on statutory programs such as funding for therapy and counselling was more easily accessible; • appropriate information was being collected and provided in college's annual reports by all college committees; and, • decision-making by the ICRC considered the past conduct of the member. <p>Included in the 2006 <i>New Directions</i> report was HPRAC's recommendation that the Patient Relations Committee of each college be disbanded and an outreach program take its place. Further, it recommended that each college should, itself, determine the most administratively effective place within each college to manage its statutory obligations under the legislation with respect to the mandated components of the patient relations program and the required funding for the sexual abuse therapy and counselling program.</p> <p>The ministry did not accept this recommendation from HPRAC as it was concerned that the intended focus of the Patient Relations Committee would be lost by any such change. The Patient Relations Committee and its programs were specifically created as a vehicle for addressing the issue of sexual abuse of patients by regulated health professionals.</p> <p>2. Patient Relations Programs</p> <p>The Task Force has asked about subsection 84(4) of the <i>Health Professions Procedural Code</i> (the Code), which is Schedule 2 to the RHPA. Under this subsection, each college is required to give HPRAC a written report describing its patient relation program and, when changes are made to the program, a written report describing the changes.</p> <p>Among the issues that the Minister may seek the advice of HPRAC about is each college's patient relations program and its effectiveness (s. 11(2)(e) of the RHPA).</p> <p>In May of 2008, HPRAC provided advice to the Minister on the patient relations programs of the colleges in a report entitled, <i>A Report to the Minister of Health and Long-Term Care on the Health Profession Regulatory Colleges' Patient Relations Programs</i>. In that report, HPRAC noted that all colleges were in compliance with the provisions related to the patient relations programs. Based on HPRAC's advice, the ministry took no further action with regard to those provisions.</p>

Date	Response from	Letter
<p>July 3, 2015 (continued)</p>	<p>Dr. Eric Hoskins, Minister of Health and Long-Term Care</p>	<p>In 2009, statutory amendments were undertaken to the RHPA that altered the mandate of HPRAC. These changes included the removal of HPRAC's express duty to monitor each college's patient relations program. However, as noted above, it remains one of the matters about which the Minister can request advice from HPRAC. Since 2009, no ministerial referral with respect to the patient relations programs of the colleges has been made to HPRAC.</p> <p>As such, colleges are still required under subsection 84(4) of the Code to provide HPRAC with the specified information, such as when changes are made to a colleges' patient relations program. It is my understanding that you have also requested that HPRAC provide you with information on the patient relations programs of colleges and that information was provided to you.</p> <p>3. HPRAC Funding and Deliverables</p> <p>Enclosed in this letter are copies of HPRAC's annual reports. These reports provide detailed information with respect to expenditures, referrals and activities.</p> <p>4. Canadian Medical Protective Association</p> <p>The Task Force asked for information with respect to a parallel review of complaints and discipline matters in relation to the RHPA. Specifically, you have asked about the current government terms of payment to the Canadian Medical Protective Association (CMPA), including if any changes have been made since 2000, and any accountability mechanisms in place under which the CMPA reports to the government.</p> <p>In accordance with the negotiated agreement between the ministry and the Ontario Medical Association (OMA), the ministry subsidizes the cost to physicians for their medical liability protection. The subsidy applies to membership fees paid to the CMPA or any other medical protective association through which an Ontario physician chooses to purchase medical liability coverage.</p> <p>The ministry has no direct accountability agreement with the CMPA. The ministry subsidizes the difference between the negotiated physician contribution (which varies by specialty), and the annual fees set each year by the CMPA. Ontario physicians pay for their medical liability protection directly to the CMPA or an organization of their choosing. The ministry then provides a partial reimbursement of fees (subsidy) to the physicians, delivered through its Medical Liability Protection Reimbursement Program (MLPRP). Reimbursements are made directly to physicians through the MLPRP.</p>

Date	Response from	Letter
July 3, 2015 (continued)	Dr. Eric Hoskins, Minister of Health and Long-Term Care	<p>While a tripartite Memorandum of Understanding (MOU) previously existed between the ministry, the OMA and the CMPA, it served only to set out specific confidentiality measures to protect the CMPA's business as well as the application of fee credits or debits that might be available through the annual CMPA fee setting process resulting in the final aggregate fee requirement which informs the ministry's planning and forecasting for the appropriate fiscal period. The ministry provides the funding difference between the negotiated value of the physician portion and the membership fee set by the CMPA.</p> <p>From extension to extension of the MOU through to the most recent but expired MOU (March 31, 2014), there has been no change to this subsidy process nor the accountability arrangement save for the change in the physician portion/ government subsidy values.</p> <p>Since 1987 the ministry provided subsidy to fees for any amount over the "base rate" established for each "Type of Work" (similar to physician specialty). This base rate was not changed until a negotiated agreement between the ministry and the OMA (2012 Physician Services Agreement) set out a new base rate, with incremental increases over 10 years.</p> <p>I would like to take this opportunity to thank the Task Force for its work. I look forward to receiving its advice and recommendations.</p>
March 20, 2015	Thomas Corcoran, Chair, Health Professions Regulatory Advisory Council	<p>On behalf of the Health Professions Regulatory Advisory Council (HPRAC), I am responding to your letter dated February 27, 2015.</p> <p>Regarding your inquiry about my knowledge, as current Chair of HPRAC, of responses and actions taken on each of the recommendations in the 2000 "What about Accountability to the Patient?" report, I would suggest you contact the Ministry of Health and Long-Term Care. Any actions in response to this report would have been taken by the ministry.</p> <p>In terms of HPRAC's advice since 2000 relating to preventing the sexual abuse of patients, please see the summary of recommendations HPRAC has made on this issue, which was attached to our February 27, 2015, letter to the Task Force.</p> <p>As per your request, attached are copies of the patient relations reports that were made available to us per section 84(4) of the <i>Health Professions Procedural Code</i>, which is Schedule 2 of the <i>Regulated Health Professions Act, 1991</i> (RHPA). We have also provided a brief outline of the information provided. As noted in our February 27, 2015 letter to the Task Force, while it was previously the statutory duty of HPRAC to monitor each college's patient relations program and to advise the Minister about its effectiveness, the amendments to the RHPA in 2009 now specify that the Minister must make a specific referral to HPRAC in order to receive a report on a College's patient relations programs. During my tenure as Chair, HPRAC has received no such referral.</p>

Date	Response from	Letter
July 2, 2015	Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division	<p>I am responding to the letter dated June 3, 2015, from the Minister's Task Force on the Prevention of the Sexual Abuse of Patients and the <i>Regulated Health Professions Act, 1991</i> (Task Force) requesting information on the action taken by the ministry as a result of the recommendations produced by the Health Professions Regulatory Advisory Council (HPRAC). My apologies for the delay in responding, however, time was needed to gather the information.</p> <p>The 2000 Special Task Force was created in order to assist HPRAC with advice related to professional misconduct involving the sexual abuse of patients, and to provide advice and recommendations to HPRAC on this issue. In doing so, the 2000 Special Task Force held public hearings, answered questions related to sexual abuse of patients, and in general, assisted HPRAC as subject matter experts.</p> <p>At that time, HPRAC was undertaking a mandated five-year review of the <i>Regulated Health Professions Act, 1991</i> (RHPA), which was to include providing advice to the then-Minister of Health and Long-Term Care on the effectiveness of each college's complaints and discipline procedures relating to sexual abuse.</p> <p>The recommendations made by the 2000 Special Task Force were considered to be part of the advice provided by HPRAC in its final report to the then-Minister entitled the <i>Effectiveness of Colleges' Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature</i> dated December 2000.</p> <p>Further advice was provided to the then-Minister by HPRAC in <i>Evaluation of the Effectiveness of the Patient Relations Program of the Ontario Colleges of Health</i>, delivered in March 2001, and its report <i>Adjusting the Balance</i>, also delivered in March 2001. HPRAC made a number of recommendations related to patient relations, the sexual abuse provisions of the legislation and the colleges' complaints and discipline processes.</p> <p>Since that advice was given to a previous government, any decisions or intentions on the previous government's part to act on any of the recommendations ended when the election was called in 2003 and a change in government occurred.</p> <p>In 2005 and 2006, HPRAC conducted a review of the RHPA as part of a ministerial referral. In particular, HPRAC was asked to provide advice on the currency of, and any recommended additions related to, HPRAC's advice contained in <i>Adjusting the Balance</i> and related reports. In response, HPRAC provided the then-Minister of Health and Long-Term Care with comprehensive advice in its report entitled <i>Regulation of Health Professions in Ontario: New Directions</i> (New Directions). As a result of the advice contained in the 2006 New Directions report, amendments were made to the RHPA through the Health System Improvements Act, 2007.</p>

Date	Response from	Letter
<p>July 2, 2015 (continued)</p>	<p>Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division</p>	<p>Included in the 2006 New Directions report was HPRAC's recommendation that the patient relations committee of each college be disbanded and an outreach program take its place. Further, it recommended that each college should, itself, determine the most administratively effective place within each college to manage its statutory obligations under the legislation with respect to the mandated components of the patient relations program and the required funding for the sexual abuse therapy and counselling program.</p> <p>The ministry did not accept this recommendation from HPRAC as it was concerned that the intended focus of the patient relations committee would be lost by any such change. The patient relations committee and its programs were specifically created as a vehicle for addressing the issue of sexual abuse of patients by regulated health professionals.</p> <p>In 2007, following receipt of the New Directions report, the RHPA was amended in order to (among other things):</p> <ul style="list-style-type: none"> • allow for the use of alternative dispute resolution processes as an acceptable way of resolving a complaint, with the exception of where the complaint included an allegation of sexual abuse; • clarify the intent of the colleges' patient relations program as having components that both prevent and deal with the sexual abuse of patients; and, • permit that the funding provided for therapy or counselling could be used to pay for therapy or counselling which occurred at any time after the sexual abuse took place. <p>Although not specifically intended to address the sexual abuse of patients by regulated health professionals, the amendments to the RHPA in 2007 also included:</p> <ul style="list-style-type: none"> • ensuring more information about individual providers would be posted on the colleges' public registers; • mandating that public registers and other committee information be posted on colleges' websites; • requiring each college committee to monitor and evaluate its own processes and outcomes and annually submit a report of its activities to the Council of the College in a form acceptable to the Council; and, • requiring the Inquiries, Complaints and Reports Committee (ICRC) to consider all available prior decisions of the ICRC, its predecessors (Complaints and Executive Committee), and the Discipline Committee, involving the individual provider, unless the decision was not to take any action based on a frivolous or vexatious complaint.

Date	Response from	Letter
<p>July 2, 2015 (continued)</p>	<p>Denise Cole, Assistant Deputy Minister, Health Human Resources Strategy Division</p>	<p>These amendments were aimed at ensuring:</p> <ul style="list-style-type: none"> • all patients had access to additional information about the individual providers from whom they were receiving care; • information on statutory programs such as funding for therapy and counselling was more easily accessible; • appropriate information was being collected and provided in colleges' annual reports by all college committees; and, • decision-making by the ICRC considered the past conduct of the member. <p>In May of 2008, HPRAC provided advice to the then-Minister on the patient relations programs of the colleges in a report entitled, <i>A Report to the Minister of Health and Long-Term Care on the Health Profession Regulatory Colleges' Patient Relations Programs</i>. In that report, HPRAC noted that all colleges were in compliance with the provisions related to the patient relations programs. Based on HPRAC's advice, the ministry took no further action with regard to those provisions.</p> <p>I trust that this information is of assistance as the Task Force finalizes its report.</p>

Appendix D: Summary of Questions to Health Regulatory Colleges, February 6, 2015, to July 22, 2015

Date	Sent to	Questions
<p>February 6, 2015</p>	<p>All regulatory colleges</p>	<p>1. Using the attached Excel spreadsheet #1, summarize the complaints and outcomes from 2004 to present related to sexual abuse, boundary violations of a sexual nature or other matters that pertain to the mandate of the Task Force.</p> <p>Please use the spreadsheet to report the following:</p> <ul style="list-style-type: none"> • To the extent possible, a description of the complainant (e.g., age, gender, location in the province, self-disclosure as to protected characteristics in the <i>Human Rights Code</i>, etc.); • Use of interim legislative tools (e.g., interim orders for suspension and/or terms, conditions or limitations imposed on a certificate of registration pending the outcome of disciplinary proceedings), if any; • Instances where competence measures have been considered in cases where there has been an allegation of sexual abuse or sexual impropriety, if any; and • Instances where the complainant is named as a party and/or where the complainant is allowed to examine witnesses and/or to have their own legal counsel, if any. <p>In addition, please provide a written response to the following questions:</p> <ul style="list-style-type: none"> • How many complaints related to sexual abuse and/or boundary violations, in total, were received in each year from 2004 to present? • What is the average length of time between complaint submission and complaint resolution for all complaints received? What is the average length of time between complaint submission and complaint resolution for complaints related to sexual abuse and/or boundary violations? <ul style="list-style-type: none"> o What percentage of the complaints are withdrawn? o What percentage of the complaints are abandoned? o What percentage of the complaints are closed prior to the end of the complaints process for any other reason?

Date	Sent to	Questions
<p>February 6, 2015 (continued)</p>	<p>All regulatory colleges</p>	<ul style="list-style-type: none"> • What is your policy and process for cases where a member of the profession resigns or is no longer available following the submission of a complaint? <p>2. Using the attached spreadsheet #2, summarize the complaints and outcomes from 2004 to present where the subject of the complaint is the regulatory college or its processes.</p> <p>In addition, please provide a written response on the following matters:</p> <ul style="list-style-type: none"> • Since 2010, what is the average length of time, in each year, between complaint submission and complaint resolution for complaints of this type? <ul style="list-style-type: none"> o What percentage of the complaints are withdrawn? o What percentage of the complaints are abandoned? o What percentage of the complaints are closed prior to the end of the process for any other reason? • If your organization has developed policy for complaints where the subject of the complaint is the regulatory college or its processes, the task force would appreciate a copy of the document and/or a summary of the policy. • If no formal policy is in effect, how are these complaints generally handled? • If a complainant is not satisfied with the action of your organization in response to a complaint of this nature, what recourse would a complainant have? <p>3. Please describe how individuals are made aware of the process for making a complaint. Is assistance provided if it is required when an individual is making a complaint? Are there other types of supports available to individuals?</p> <p>4. When a complaint of any kind is investigated, what information is shared with the complainant? For example, in cases where the subject of the complaint is a member of your organization, is the submission of the member to the Inquiries, Complaints and Reports Committee (ICRC) shared with the complainant?</p> <p>5. What internal process is used when appointing an ICRC panel? For example, what criteria are used to determine the suitability of panel members? Do panel members receive training to investigate complaints of sexual abuse or boundary violations of a sexual nature? Who conducts the training and what materials are provided? How do panel members stay current in their approach to these complaints?</p> <p>6. Please describe what you do to obtain feedback on complainants' level of satisfaction with respect to the complaints process. Do you assess the level of satisfaction of individuals who make enquiries but are not referred to the complaints process?</p>

Date	Sent to	Questions
February 6, 2015 (continued)	All regulatory colleges	<ol style="list-style-type: none"> 7. Has your organization identified areas within your legislated or discretionary processes where improvements could be made for victims of sexual abuse or boundary violations of a sexual nature? Please describe. 8. Identify the most recent occasion when a sexual abuse complaint was referred to an alternative dispute resolution process. 9. Please summarize the information included in your annual reports for 2011, 2012, 2013 and 2014 to the Minister of Health and Long-Term Care regarding sexual abuse. 10. Please provide as many details as possible regarding the curriculum offered in the Ontario educational institutions that prepare your members for practice related to sexual assault, sexual abuse of patients and boundary violations, including amount of time spent on the topic and whether the student is tested on the topic. In addition, please provide details on other ways your members demonstrate knowledge of Ontario jurisprudence related to sexual abuse of patients, practitioner-patient boundaries and other relevant ethical topics (e.g., entrance exam, jurisprudence exam, application for registration, continuing education, etc.). 11. Provide current membership numbers for 2013/14 including gender breakdown. 12. Describe any research or program development planned, in progress, published or implemented since 2004 on the prevalence or incidence of sexual abuse by health professionals. 13. Provide contact information for a staff member who can be reached if questions arise. 14. If there is other data or information that is relevant to the work of the Task Force, as outlined in the Minister's letter to you of December 17, 2014, please share it. <p>Spreadsheet #1 – Summary of Complaints and Disciplinary Cases Related to Sexual Abuse or Boundary Violations of a Sexual Nature (2004 to Present)</p> <ul style="list-style-type: none"> • Date of complaint • Time between occurrence and complaint submission • Manner of submission • Complainant description • Complaint summary • Are there any other findings related to sexual abuse or boundary violations of a sexual nature for this member? • If Yes, provide details of other complaints • Investigation summary • Outcome – dismissed? • Rationale for dismissal

Date	Sent to	Questions																																																												
February 6, 2015 (continued)	All regulatory colleges	<ul style="list-style-type: none"> • Outcome – sent to discipline? • Outcome – other action? • Use of interim tool • Competence measure considered? • Complainant named as a party? • Complainant allowed to examine witnesses? • Complainant allowed to have own legal counsel? • Decision and order (if any) • Referral to counselling? • Follow-up with complainant? Provide details 																																																												
May 26, 2015	College of Physicians and Surgeons of Ontario	<p>1. Please provide the following information at <i>an aggregate level for each year</i>. Please enter data so that it is possible to follow any one year's reports. For example, if a case was referred to discipline in 2009 but was first reported in 2005, the "referred to discipline" data should be recorded for 2005*:</p> <table border="1" data-bbox="708 743 1325 1528"> <thead> <tr> <th data-bbox="708 743 932 793">CPSO</th> <th colspan="5" data-bbox="932 743 1325 793">Calendar year</th> </tr> <tr> <td data-bbox="708 793 932 869"></td> <th data-bbox="932 793 1013 869">2000</th> <th data-bbox="1013 793 1094 869">2005</th> <th data-bbox="1094 793 1175 869">2009</th> <th data-bbox="1175 793 1256 869">2010</th> <th data-bbox="1256 793 1325 869">2014</th> </tr> <tr> <td data-bbox="708 869 932 911"></td> <th data-bbox="932 869 1013 911">#</th> <th data-bbox="1013 869 1094 911">#</th> <th data-bbox="1094 869 1175 911">#</th> <th data-bbox="1175 869 1256 911">#</th> <th data-bbox="1256 869 1325 911">#</th> </tr> </thead> <tbody> <tr> <td data-bbox="708 911 932 1016">College members</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="6" data-bbox="708 1016 1325 1058">Reports/cases that included initial allegations that would, on their face (<i>i.e., prior to any findings</i>) appear to describe sexual abuse as defined by the RHPA, Sched. 2, s. 1(3).</td> </tr> <tr> <td data-bbox="708 1058 932 1100">Total</td> <td></td> <td></td> <td>50*</td> <td>55*</td> <td>50*</td> </tr> <tr> <td data-bbox="708 1100 932 1163">Unique physicians with initial allegations</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="708 1163 932 1331">Referred to discipline with specific allegations of sexual abuse under the RHPA.</td> <td></td> <td></td> <td>18*</td> <td>21*</td> <td>17*</td> </tr> <tr> <td data-bbox="708 1331 932 1436">Unique physicians referred to discipline.</td> <td></td> <td></td> <td>9*</td> <td>16*</td> <td>11*</td> </tr> <tr> <td data-bbox="708 1436 932 1528">That resulted in revocation of licence.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p data-bbox="708 1528 1325 1667">* We appreciate that CPSO provided information about completed investigations and referrals to discipline in its response to the task force questions of February 6, 2015, and this is entered provisionally. But we are unsure whether the same logic set out here was followed. If not, please provide the data as requested here.</p> <p>2. Please explain the circumstances under which a specified allegation of sexual abuse under the RHPA can be withdrawn, as occurred in the following cases:</p>	CPSO	Calendar year						2000	2005	2009	2010	2014		#	#	#	#	#	College members						Reports/cases that included initial allegations that would, on their face (<i>i.e., prior to any findings</i>) appear to describe sexual abuse as defined by the RHPA, Sched. 2, s. 1(3).						Total			50*	55*	50*	Unique physicians with initial allegations						Referred to discipline with specific allegations of sexual abuse under the RHPA.			18*	21*	17*	Unique physicians referred to discipline.			9*	16*	11*	That resulted in revocation of licence.					
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That resulted in revocation of licence.																																																														

Date	Sent to	Questions
May 26, 2015 (continued)	College of Physicians and Surgeons of Ontario	<ul style="list-style-type: none"> i. Anastasio, JR ii. Bonin, MMJ iii. Cameron, RS iv. Choptiany, PJ v. Gutman, MM vi. Hajcsar, E vii. Irvine, RA viii. Kanhai, DV ix. Krishnalingham, C x. Le, D xi. Nanka-Bruce, R (2003) xii. Parikh, MS xiii. Taynen, HD xiv. Tennen, J <p>3. In the following cases, penalty hearings were ordered but no results were provided. Please identify whether penalty hearings took place (and, if so, with what results), or remain pending with/without a date:</p> <ul style="list-style-type: none"> xv. Gale, JS xvi. Lambert, DS xvii. Lukezich, JT xviii. Minnes, BG xix. Noriega, EH xx. Redhead, CA xxi. Sliwin, SJ <p>4. In the case of Karkanis, SJG, Divisional Court has ordered a re-hearing. Has the date been set?</p> <p>5. Has Lee, SJ, gone to appeal yet? If so, was there a result? If not, is a date set?</p> <p>6. Under what circumstances can complaints related to sexual abuse, and made since the RHPA came into force, go to discipline without specified allegations of sexual abuse under the RHPA, as occurred in the following cases:</p> <ul style="list-style-type: none"> xxii. Im, CCS xxiv. Powell, GW xxv. White, KP xxvi. Wong, BT-P <p>7. Regarding reinstatements:</p> <ul style="list-style-type: none"> i. How many reinstatement applications have been made following mandatory revocations? ii. If reinstatement was allowed, please provide details of the circumstances and reasons for the decision and advise as to whether any complaints regarding this member were received subsequent to reinstatement. iii. If complaints regarding a reinstated member were received subsequent to reinstatement, please provide details on what action, if any, has been taken by the College.

Date	Sent to	Questions
May 26, 2015 (continued)	College of Physicians and Surgeons of Ontario	iv. If a reinstatement application was made but denied by the College, were there any appeals and if so, what was the outcome? 8. Regarding mandatory reports: i. How many members or facilities were identified to have been in a position to make mandatory reports (s. 85.1 and s. 85.2 of the <i>Procedural Code</i>) but did not do so? ii. Did the College initiate any actions towards members who, or facilities that, did not make mandatory reports although they were identified as having been in a position to do so? If so, what action was taken in each case?
May 27, 2015	<ul style="list-style-type: none"> - College of Chiropractors of Ontario - College of Dental Hygienists of Ontario - College of Massage Therapists of Ontario - College of Nurses of Ontario - Ontario College of Pharmacists - College of Psychologists of Ontario - Royal College of Dental Surgeons of Ontario 	<p><i>With respect to mandatory license revocations that have been ordered subsequent to findings of sexual abuse of patients:</i></p> <ol style="list-style-type: none"> 1. How many reinstatement applications have been made following mandatory revocations? 2. If reinstatement was allowed, please provide details of the circumstances and reasons for the decision and advise as to whether any complaints regarding this member were received subsequent to reinstatement. 3. If complaints regarding a reinstated member were received subsequent to reinstatement, please provide details on what action, if any, has been taken by the College. <p><i>With respect to mandatory reports:</i></p> <ol style="list-style-type: none"> 1. How many members or facilities were identified to have been in a position to make mandatory reports (under s. 85.1 and s. 85.2 of the <i>Procedural Code</i>) but did not do so? 2. Did the College initiate any actions towards members who, or facilities that, did not make mandatory reports although they could have been identified as having been in a position to do so? If so, what action was taken in each case?
June 3, 2015	<ul style="list-style-type: none"> - College of Chiropractors of Ontario - College of Dietitians of Ontario - College of Medical Radiation Technologists of Ontario - College of Occupational Therapists of Ontario - College of Optometrists of Ontario - College of Physiotherapists of Ontario - College of Respiratory Therapists of Ontario 	<p><i>With respect to mandatory reports:</i></p> <ol style="list-style-type: none"> 1. Has your College identified any members who (or facilities that) were in a position to make mandatory reports to the College (per s. 85.1 and s. 85.2 of the <i>Procedural Code</i>) but did not do so? If so, how many? If facilities, please indicate whether these were hospitals or other facilities. 2. Did the College initiate any actions towards members who (or facilities that) did not make mandatory reports although they could have been identified as having been in a position to do so? If so, what action was taken in each case?

Date	Sent to	Questions
June 5, 2015	All regulatory colleges	<p>Therefore, we wish to be absolutely certain of the following:</p> <ol style="list-style-type: none"> 1. That we have been informed of all initial allegations (complaints or reports) that were made to your College about sexual abuse or boundary violations of a sexual nature involving patients. To that end: <ol style="list-style-type: none"> a. Please confirm that you have provided full information about each of the following: <ol style="list-style-type: none"> i. Initial allegations that: <ul style="list-style-type: none"> - were dismissed at the investigation stage; or - are still being investigated/pending investigation. ii. Complaints/reports that were sent after investigation to the ICRC and: <ul style="list-style-type: none"> - were resolved at that level, e.g., by undertakings or other decisions; - were sent on to committees other than the Discipline Committee; or - for which an ICRC decision is still pending. iii. Complaints/reports that were referred to the Discipline Committee, and hearings: <ul style="list-style-type: none"> - were concluded; or - are still pending. b. Please send information for any of the above about which you have not already informed us, using the spreadsheet tool you were originally sent. (It is also appended here.) 2. That we are not inadvertently double counting as might have happened, e.g., if a College indicated that a member had other complaints made against him/her but did not tell us where else in the spreadsheet those complaints appeared. To that end, please provide a final count, from your records, of: <ol style="list-style-type: none"> a. The total number of patients, across all of the reference years (2004 to most recent), that were referred to in all complaints or reports made to your College about sexual abuse or boundary violations of a sexual nature. b. The total number of College members, across all of the reference years, that were referred to in all complaints or reports made to your College about sexual abuse or boundary violations of a sexual nature.
June 9, 2015	College of Physicians and Surgeons of Ontario	<ol style="list-style-type: none"> 1. Please provide the number of mandatory reports the College has received filed by health care facilities under s. 85.2 of the <i>Procedural Code</i>, and provide a breakdown of the number of mandatory reports received by facility and year.

Date	Sent to	Questions
June 9, 2015 (continued)	College of Physicians and Surgeons of Ontario	<p>2. Please provide the outcome of each mandatory report, including any related decision (including reasons for decision, and cautions) issued by the Inquiries, Complaints and Reports Committee (ICRC) under s. 26 and/or s. 27 of the <i>Procedural Code</i> and, where applicable, any decision, reasons for decision, and reasons for penalty issued by the Discipline Committee. Kindly ensure that you include specific information as to any fines levied in relation to a facility's failure to comply with its mandatory obligation to report.</p> <p>3. Please provide the decisions (including reasons) issued by the ICRC and, where applicable, the Discipline Committee, relating to a member's failure to comply with the mandatory reporting obligations under s. 85.1 of the <i>Procedural Code</i>.</p> <p>4. Having reference to the allegations made by the complainant during the course of her testimony in <i>Redhead</i> relating to having had a "sexual affair" with Dr. G. at around the same time as her sexual contact with Dr. Redhead, and her further testimony of having been asked by Dr. G. whether he could provide her phone number to Dr. Redhead so that they could have some "fun" given Dr. Redhead's unhappiness in his marital relationship, did the College undertake an investigation into the alleged professional misconduct of Dr. G. and, if so:</p> <ol style="list-style-type: none"> When did this investigation occur? What caused the College to conduct the investigation and under what provision(s) of the <i>Procedural Code</i> was the investigation conducted? What was the outcome of that investigation and resulting decision from the ICRC and, if applicable, the Discipline Committee? In the event that no investigation was undertaken, please advise of all the reasons supporting the lack of an investigation.
July 22, 2015	College of Physicians and Surgeons of Ontario	<p>The Task Force received a submission from the Health Professions Appeal and Review Board (HPARB) regarding cases involving sexual abuse. There were four cases in the submission where HPARB referred the matter back to the Complaints Committee of the CPSO for further investigation/reconsideration. We would like to request additional information on the results of the subsequent investigations by the Complaints Committee.</p> <p>The four cases are:</p> <ul style="list-style-type: none"> · S.B. v J.D. (2014 CanLii 65723) · J.B. v R.C. (2012 CanLii 59092) · Applicant v P.W.O. (2010 CanLii 46649) · M.G. v O.T. (2010 CanLii 59597) <p>The Task Force is hoping to find out if the Complaints Committee has completed an additional investigation for these cases, and if so, what the decision of the Complaints Committee is following that investigation.</p>

Appendix E:

Consultation Summary

Overview

This document summarizes the consultation activity generated by the Minister's Task Force on the Prevention of the Sexual Abuse of Patients and the *Regulated Health Professions Act, 1991* (RHPA).

Stakeholder input informs the task force's recommendations to the Minister of Health and Long-Term Care. The task force conducted an extensive consultation program in the process of examining the existing legislative scheme under the RHPA and as it developed its advice and recommendations to the Minister on modernizing the RHPA. Appendix A outlines the task force's mandate.

The consultation program was multi-pronged and included regional stakeholder engagement activities, a student and faculty engagement strategy, public and private consultation sessions, media advertisements and a variety of meetings involving specific stakeholders.

Components: Goals and Objectives

Preliminary Stakeholder Engagement

The task force sent out a public call for participation in consultation sessions, with options for participation, in order to reach the broadest range of participants and provide the most open, clear form of communication while still maintaining the privacy of participating individuals. A media protocol was developed in conjunction with the Ministry of Health and Long-Term Care.

In order to raise awareness about the task force and solicit participation at public consultation sessions, a database of stakeholders was developed. To ensure that the broader community of interest had the opportunity to participate in this initiative, stakeholders were identified by both the ministry and task force members. Those with a potential interest in the work of the task force, or expertise related to the subject matter, were added to an

extensive list of regulatory-affiliated stakeholders. In addition, as the public became aware of the task force proceedings, individuals and organizations contacted the task force and asked to be added to the database. The task force made vigorous efforts to reach relevant stakeholder groups and individuals across the province.

The following stakeholder groups were invited to become involved in the work of this task force:

- sexual abuse/victim groups and networks;
- women's groups and networks;
- Aboriginal groups and networks;
- regulatory colleges;
- regulated health professions' associations;
- academics/experts/lawyers/organizations;
- trade unions representing regulated health professionals; and some faculty members who provide education to regulated health profession students.

These stakeholders were emailed and advised about public consultation sessions.

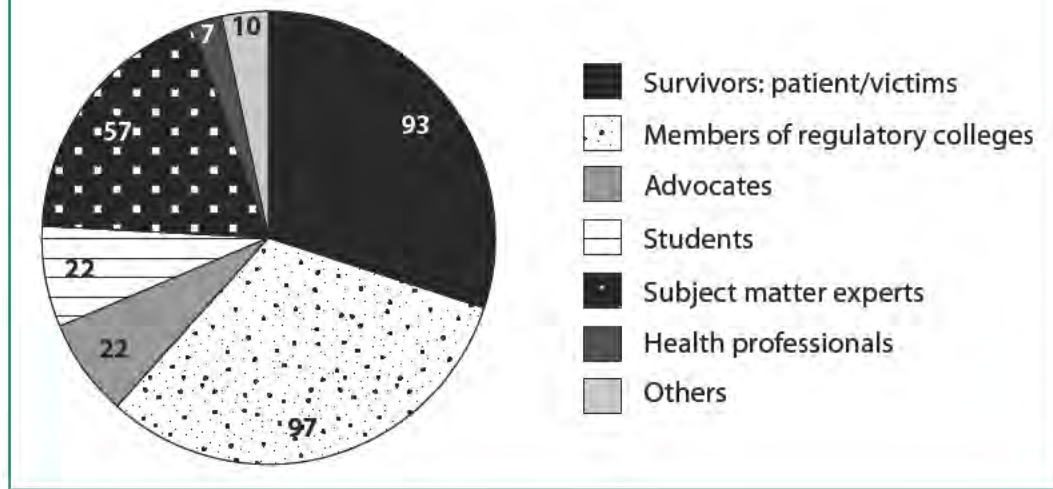
The task force also established a dedicated email address and toll-free telephone number in order to consolidate communications, both incoming and outgoing. By July 10, 2015, approximately 17 written submissions were received through the email address, or were mailed to the office.

Ongoing Stakeholder Engagement

In order to increase the public's awareness of the work of the task force, and to better connect with patient-victims of sexual abuse, a variety of methods and strategies were used. For example, all regulatory colleges were asked to distribute an invitation to participate to former sexual abuse complainants. The task force also leveraged the expertise and network of the Ontario Coalition of Rape Crisis Centres (OCRCC) and METRAC to reach out directly to patients through a variety of direct and social media methods.

Outreach partners and ministry staff logged all interactions with stakeholders on individual excel spreadsheets. These were consolidated on a weekly basis for ongoing data analysis. The volume of inquiries is captured in Figure 1.

Figure 1: Types of Stakeholders Contacted



Public and Private Consultation Sessions

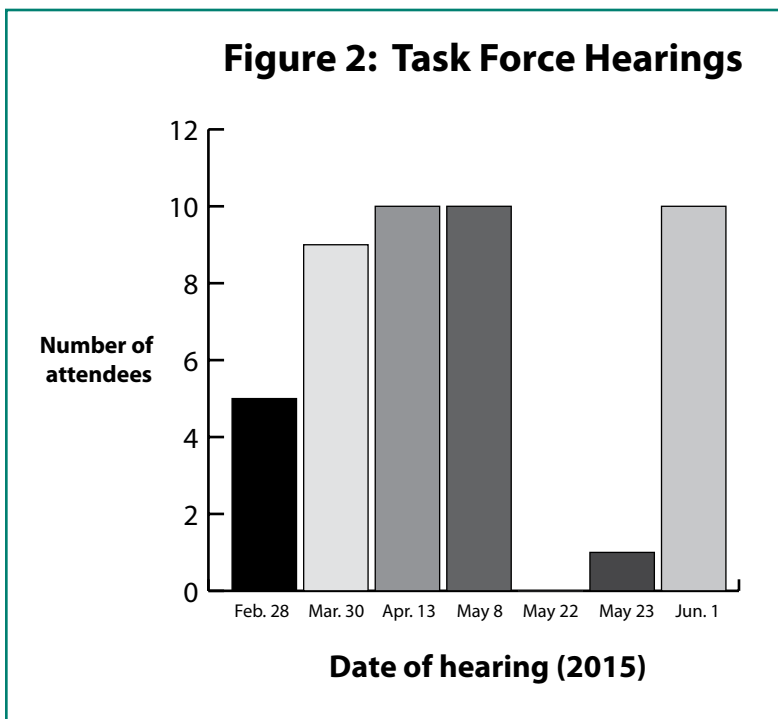
Based on the experiences of a task force member who had helped develop the 1991 and 2000 related reports, the task force determined that in-person consultation would be imperative in fulfilling its mandate. Potential participants were notified of the hearings through newspaper announcements, emailed invitations or other means, with options to contact the task force via its email address or toll-free telephone number. Requests for accommodation (e.g., translation, hotel accommodation, travel funding) were considered.

Consultation sessions were held in downtown Toronto. Those who were unable to attend in person, however, were given one or more alternative options to participate (e.g., via teleconference or written submission). The task force asked that the consultation sessions be held in the conference facilities of a centrally located hotel in order to provide a neutral public venue, rather than in a government building or location associated with government business. Each participant was given approximately 25 minutes to share his or her thoughts with the task force.

The public and private consultation sessions provided an opportunity for anyone affected by an alleged incident of patient sexual abuse by a regulated health professional the opportunity to be heard by the task force. The objective was to hear from victims, families of victims, organizations representing victims, perpetrators and anyone else who had been affected

in any way and wished to come forward and provide input. Task force recommendations would be informed and enriched by hearing the perspectives and experiences of these individuals and organizations. The task force committed to providing participants a safe, supported and anonymous environment in which to share their perspectives or experiences. Security was present on site for both private and public sessions.

The task force held seven public and private consultation sessions (see Figure 2). Each session included a “private” component, in which the participants met anonymously with the task force. These meetings were closed to the public and only included the task force and individual participants. Consultations also included a “public” component that was open to the media and others to hear presentations; these public sessions were videotaped. Each participant was given a notice of consent and was advised that the task force was not obligated to follow up on complaints or reports. Because of the sensitive nature of the hearings, referral-to-counselling services were available onsite for participants.



In total,¹ the following organizations, experts and private individuals made presentations to the task force during the private and public consultation sessions:

	Organizations or Experts	# Presenting Privately/# Presenting Publicly	Individuals	# Presenting Privately/# Presenting Publicly
Feb 28, 2015	5	0/5	0	0/0
Mar 30, 2015	3	0/3	6	4/3
Apr 13, 2015	3	2/1	7	5/2
May 8, 2015	2	1/2	8	8/2
May 22-23, 2015	0	0/0	1	1/0
Jun 1, 2015	2	0/2	8	5/3
TOTAL	15	3/13	30	23/10

The following organizations, experts or members of the public made public presentations to the task force during these consultation sessions and were videotaped for the public record:

- Sanda Rodgers, Professor Emerita, Faculty of Law, University of Ottawa (February 28, 2015)
- Dr. Gail Erlick Robinson, Professor of Psychiatry, University of Toronto (February 28, 2015)
- Krittika Ghosh, Senior Coordinator, Violence Against Women, Ontario Council of Agencies Serving Immigrants (OCASI) (February 28, 2015)
- Nicole Pietsch, Coordinator, Ontario Coalition of Rape Crisis Centres (OCRCC) (February 28, 2015)
- Dr. Katie Bingham, Psychiatry Resident, Co-Chief Resident, UHN (February 28, 2015)
- Cynamin Maxwell and Maria Olaya, Toronto Rape Crisis Centre (March 30, 2015)
- Anastasia Harripaul and Tim Lenartowych, Registered Nurses' Association of Ontario (RNAO) (March 30, 2015)
- Ann Van Regan, advocate (March 30, 2015)
- Sharon Danley, survivor of patient sexual abuse (March 30, 2015)
- Stephanie Williams, Ontario Federation of Indigenous Friendship Centres (March 30, 2015)
- Deborah (March 30, 2015)
- Donna (March 13, 2015)
- Ellie (March 13, 2015)
- Michael Decter, Patients Canada (April 13, 2015)
- Bob Ebrahimzadeh (May 8, 2015)
- Iuliana Baciu, Christian Horizons (May 8, 2015)
- L.A. Doyle, Bit by Bit Trauma Training (May 8, 2015)
- Nadia (May 8, 2015)
- Deborah (June 1, 2015)

- Robert (June 1, 2015)
- Shona Casola, Autism Ontario (June 1, 2015)
- Mike Pett and Roslyn Shields, CAMH (June 1, 2015)
- Dr. Alan Ennis (June 1, 2015)

1:1 Interviews with Some Victims of Patient Sexual Abuse

At the request of the task force, the Metropolitan Action Committee on Violence Against Women and Children (METRAC) and OCRCC conducted personal interviews with select victims of patient sexual abuse in order to provide detailed examples to be included in the report to the minister. Interviews took place outside the purview of the ministry. The task force also invited some patients to be interviewed by Michele Landsberg (see Chapter 3).

Individual Meetings with Selected Stakeholders

The task force identified several stakeholders whose perspectives were required in order to fill gaps in knowledge. Other stakeholders requested meetings with the task force. Detailed minutes were taken, which related discussion to the Terms of Reference.

The task force met with regulatory colleges, including the College of Pharmacists of Ontario, the College of Massage Therapists of Ontario, the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Nurses of Ontario and the College of Psychologists of Ontario. The task force also met with the Federation of Health Regulatory Colleges of Ontario. Other stakeholders included the Canadian Federation of Students (including a nursing student); and the chair of the Health Professions Regulatory Advisory Council.

Education Engagement Strategy

The task force identified the need to learn more about the perspective of students and faculty on the prevention of the sexual abuse of patients. An education engagement strategy was therefore developed to reach out to this cohort, and an additional database was developed. Approximately 47 student and faculty representative organizations were contacted by email and/or telephone, and asked to use their networks to provide information to their members.

Work focused on the following:

- **Information dissemination**, in order to raise awareness of the work of the task force; solicit participation at hearings; solicit input on related curriculum and the experience of health profession students; and to advise of the potential for participation at a roundtable on education. The targeted populations included Ontario university students and college students; students and student groups with a focus on sexual abuse and sexual assault; faculty of Ontario universities and colleges; and students of professions of particular interest. Students and faculty were provided with information on the task force, its membership, its mandate and ways to get involved, including (i) appearing before the task force, in order to be heard about an incident of patient sexual abuse; (ii) attending a roundtable on education (see details below); and (iii) submitting written comments on the delivery of education related to sexual abuse and sexual abuse of patients.
- **Information gathering (curriculum)**, in order to gain insight on the experiences of students and faculty in receiving or providing education on boundaries, transference and projection in relation to sexual contact with patients, amount of time spent on the topic, practitioner-patient boundaries; whether course work relating to sexual abuse is mandatory and whether students are tested on the topic. In addition, students were invited to provide written feedback through the same standardized form provided to all stakeholders wishing to make a written submission and seeking guidance. The task force also wrote to the Ontario Deans of Medicine and met in person with the Council of Faculties of Medicine (COFM) in order to better understand the relevant curriculum being delivered to medical school students.
- **Information gathering (culture)**, to gain insight into the unique events that are currently taking place on university campuses related to sexual assault, sexual abuse, consent, etc. Developing a relationship with the Canadian Federation of Students, an association representing the majority of university students in Ontario, resulted in a presentation to the task force on the subject, and in other kinds of participation.
- **Information gathering (roundtables)**, to provide a different forum in which to gather unique information on the experiences of students and faculty in receiving or providing education on boundaries, transference and projection in relation to sexual contact with

patients. The task force met with students and faculty on a regional basis (see details below).

- **Other engagement activity**, in order to fill information gaps or provide a required perspective (e.g., engagement with Dr. Daniel Haas, Dean of Dentistry at the University of Toronto and the Vice-Chair of the Council of Health Sciences at the University of Toronto; and Dr. Trevor Young, Dean of Medicine at the University of Toronto).

Roundtables on Education

To further consult with regulated health professions' faculty and students on their experiences and relevant curriculum, the task force held roundtables at the following universities:

- University of Toronto (March 14, 2015)
- McMaster University (April 7, 2015)
- University of Ottawa (April 24, 2015)
- Ryerson University (May 12, 2015)
- Lakehead University (May 22, 2015)

Students met with the task force separately; this encouraged candid and uninhibited discussion. Approximately 36 students, faculty and university administrators met with the task force at these venues. A set of questions was devised and utilized at each roundtable in order to guide and standardize the discussions. Students and faculty were invited via the student engagement strategy (see above), as well as through partnering with leaders at each university in order to co-facilitate the discussion. In order to provide a comparator to better assess the outcome of the roundtables in Ontario, a meeting was also held at McGill University in Montreal.

Roundtable for Public Members of Regulatory College Councils

The perspective of public members appointed to serve on health regulatory college councils was prioritized by the task force, in order to learn more about the prevention of the sexual abuse of patients vis-à-vis the implementation of the RHPA.

All public members of all Ontario regulatory colleges were invited to a roundtable discussion, which took place on April 14, 2015. In addition, and in order to reach and encourage the participation of all public members, regulatory college registrars were asked to send the invitation to their public members.

The roundtable facilitated discussion centred on the themes of the task force's Terms of Reference; questions (see below) were pre-circulated to participants. Approximately 46 public members from a wide cross-section of regulatory colleges attended the roundtable meeting.

The following question sets were also developed and distributed:

Question Set "A" for members who did not attend the roundtable:

1. For how long, measured in months, have you served as a public member of a regulatory college?
2. Can you suggest improvements to the orientation you received when you joined the college as a public member: a) generally about the college; b) specifically in relation to complaints regarding sexual abuse of patients? (Please be specific.)
3. Were you advised by the college that it had a policy of zero tolerance of sexual abuse of patients?
4. If you have been involved in any aspect of the college's complaint/discipline process in relation to the sexual abuse of complaints, please circle the answer closest to your experience and provide more detail if possible.
5. Please indicate whether you agree that as a public member of a college, you have a particular responsibility to represent the public interest in the system of self-regulation by health professionals.
6. Do you think that you are fairly compensated by the Government of Ontario for your contributions as a public member? If you answered "No," what is the range of payment that you would consider to be fair compensation?

Question Set "B" for members who attended the roundtable (for focus group discussion) and non-attending members:

1. Does the public need to be better informed about the colleges' complaints and discipline procedures? If yes, what suggestions do you have?
2. Based on your experience as a public member, does training and education of regulated health professionals on preventing sexual abuse of patients need to be improved? If yes, what suggestions do you have?
3. Do you agree that colleges' complaints and discipline processes are sensitive and respectful towards patients who complain to a

college about sexual abuse? Do you have any specific suggestions for improvement?

4. Do you have any specific suggestions for improvement in orientation for new public members to college processes?
5. Do you have any specific suggestions for improvement in training and ongoing support for public members in their role as decision-makers in complaints and discipline processes related to sexual abuse of patients by one or more regulated health professionals?
6. Do you have any comments or suggestions on improving colleges' processes that we have not yet discussed?

Roundtable for Aboriginal Stakeholders (Northern Region)

The task force identified the need to liaise with those with an interest in protecting the well-being of patients of Aboriginal origin. Capturing an understanding of how patients have been affected by sexual abuse by health professionals, and hearing from leaders regarding opportunities for prevention and change, is foundational to the task force's deliberations. The task force teamed up with the City of Thunder Bay Aboriginal Liaison Office (Ann Magiskan and Joyce Hunter) in order to facilitate a discussion between stakeholders and task force members. The meeting took place on June 9, 2015, in Thunder Bay. It was facilitated by Dr. Cynthia Esquimaux Wesley (Vice-Provost, Lakehead University), and 11 attendees were present.

Roundtables for Lawyers

The task force held the first roundtable with lawyers who have recognized expertise in the field at the Ontario Bar Association on May 12, 2015. This roundtable was held to promote discussion and facilitate input from various legal perspectives that would inform task force recommendations on ways that the current legislation can best ensure that every interaction by patients and witnesses with health regulatory colleges in relation to issues involving sexual abuse and colleges' processes are sensitive, accessible and timely, and identification of best practices from leading jurisdictions around the world.

Approximately 25 lawyers attended the meeting. To promote candid and uninhibited discussion, the task force committed to following the Chatham House Rule (i.e., no attribution would be made; however, individual statements and themes were recorded. If someone wished attribution or to be quoted, the task force would comply). A series of questions were

circulated prior to the meeting and were discussed in 15-minute intervals (per issue).

The task force held a second roundtable on June 8, 2015, with a select group of lawyers and researchers who were intimately familiar with sexual abuse and sexual violence cases within civil, criminal and/or administrative law. This consultation sought to obtain information on such cases involving health care professionals and to solicit legal advice on making changes to the RHPA.

This roundtable was hosted by N. Jane Pepino, Aird & Berlis, LLP, with Marilou McPhedran and Susan Vella acting as co-chairs. It was attended by Susan Chapman, Mary Eberts, Mary Lou Fassel, Lorraine Greaves, Patricia Marshall, Gail Robinson, Sanda Rodgers and Wendy Sutton. Once again, the task force committed to the absence of attribution in order to facilitate unrestricted discussion.

Roundtable for Violence Against Women Group

The task force invited the newly constituted permanent stakeholder group Roundtable on Violence Against Women to meet to discuss common issues and to better inform the the task force recommendations to the minister. Specifically, the task force asked meeting attendees to share their experiences with patient–victims, explore items and issues that require change and discuss the challenges that are currently present. The meeting took place on May 11, 2015.

Roundtable for Policy Advisors

The task force engaged a number of professionals who have extensive experience developing or working with policy to discuss their opinions on task force recommendations. The topics explored included alternative regulatory models, reporting mechanisms and dissemination of procedures to the public. This meeting took place on June 5, 2015, and approximately eight attendees were present.

Roundtable for Non-Governmental Organizations (NGOs)

Throughout the process of engaging stakeholders, the task force placed a high priority on advocates. Accordingly, it invited representatives of NGOs that advocate for vulnerable groups, especially those with a focus on survivors of violence and abuse of women. In this meeting, NGO representatives were asked to provide their perspectives on recommendations

to be put forth by the task force, the role played by civil society in supporting these recommendations, and ensuring long-term accountability. This meeting took place on June 15, 2015, and was attended by Marilou McPhedran, Sheila Macdonald, Diane O’Reggio, Tamar Witelson, Sharon Danley, Erin Harris, Wendy Komiotis and Patricia Marshall.

Media

On an ad hoc basis, when requested, the task force provided information to the media on its work, its mandate and its public consultation sessions.

In addition, the task force ran three advertisements in leading newspapers, in English and French, to publicize the public and private consultation sessions (see below).

Date of Hearing	Date Advertisement Appeared — English	Date Advertisement Appeared — French	Name of Newspaper
Apr 13, 2015	Apr 7, 2015		<i>Toronto Star</i>
		Apr 7, 2015	<i>Metro</i> <i>L’Express</i> ²
May 8, 2015	Apr 29, 2015		<i>Toronto Star</i>
		Apr 28, 2015	<i>Metro</i> <i>L’Express</i>
		Apr 29, 2015	<i>Le Metropolitain</i> ²
May 22-23, 2015	May 13, 2015		<i>Thunder Bay Chronicle</i>
	May 15, 2015		<i>Thunder Bay Source</i> ³
		May 13, 2015	<i>Thunder Bay Chronicle</i>

The ministry also sent messages on Twitter on behalf of the task force. By the beginning of June, the ministry reported 8 re-Tweets and 7 favourites.

If you've been affected by sexual abuse as a patient – we want to hear from you

Sexual abuse of patients is a form of violence and a breach of trust. The Government of Ontario has set up a task force to gather information about sexual abuse of patients in Ontario and the *Regulated Health Professions Act, 1991*, to ensure the legislation is effective in upholding zero tolerance of sexual abuse of patients and supporting those affected.

If you are:

- an individual who has been affected by patient sexual abuse
- a group (such as a professional association or advocacy group) or an individual with an interest in preventing sexual abuse of patients

you are invited to join the discussion.

Your privacy and safety will be respected. You can choose a public or private hearing with the task force.

The next consultation will be:

Monday April 13
Marriott Courtyard Toronto Downtown,
475 Yonge St., Toronto, Ontario M4Y 1X7
10:00 a.m. start

There is another consultation planned in May 2015.

If you want to participate, please confirm a time and date with the coordinator. Presentations are by appointment only; spaces are limited.

For more information, contact the task force at SATaskforce@ontario.ca or at 1-844-821-6151.

We thank you for your interest and concern.

Marilou McPhedran,
Co-Chair of the Minister's Task Force

Paid for by the Government of Ontario



Si vous avez subi une agression sexuelle en tant que patiente, à vous la parole.

Les agressions sexuelles infligées à des patients sont une forme de violence et d'abus de confiance. Le gouvernement de l'Ontario a établi un groupe d'étude chargé de rassembler des renseignements sur les agressions sexuelles infligées à des patients en Ontario et d'examiner la portée de la *Loi de 1991 sur les professions de la santé réglementées* afin de s'assurer que cette dernière est efficace et qu'elle permet d'éliminer toute tolérance concernant les agressions sexuelles infligées à des patientes et de soutenir les personnes affectées par ce problème.

Nous vous invitons à vous joindre à la discussion si vous êtes :

- une personne qui a été affectée par le problème des agressions sexuelles infligées à des patients;
- un groupe (comme une association professionnelle ou un groupe de défense des intérêts) ou une personne s'intéressant à la prévention des agressions sexuelles envers les patients.

Nous tenons à protéger votre vie privée et votre sécurité. Vous pouvez choisir de vous exprimer au cours d'une audience publique ou en privé.

La prochaine consultation aura lieu :

Lundi 13 avril

Marriott Courtyard Toronto Downtown
475, rue Yonge, Toronto (Ontario) M4Y 1X7
Début à 10 h

Une autre consultation est prévue en mai 2015.

Si vous souhaitez y participer, veuillez confirmer la plage horaire auprès de la coordonnatrice. Les présentations se font sur rendez-vous seulement, et le nombre de participants est limité.

Pour de plus amples renseignements, communiquez avec le groupe d'étude, par courriel à l'adresse SATaskforce@ontario.ca ou par téléphone, au 1 844 821-6151.

Nous vous remercions de votre intérêt et de votre participation.

Marilou McPhedran,
coprésidente du Groupe d'étude du ministre

Payé par le gouvernement de l'Ontario



Endnotes

- 1 Some participants presented both privately and publicly.
- 2 *L'Express* and *Le Métropolitain* are weekly papers.
- 3 *Thunder Bay Source* is a community paper.

Appendix F:

Relevant Sections of the *Regulated Health Professions Act, 1991*, and the *Health Professions Procedural Code*

Relevant excerpts from the *Regulated Health Professions Act, 1991* (RHPA) (last amendment 2015, c.18. ss. 2, 3; and its Code, deemed by s. 4 of the RHPA to be part of each health profession Act and to apply to all the health regulatory colleges).

When the RHPA and its Code came into effect in 1994, new provisions related to the sexual abuse of patients were introduced, including the following:

- the term “sexual abuse of patients” was defined and specified as an act of professional misconduct;
- mandatory penalties, including mandatory reprimands and mandatory revocation for five years of a health professional’s certificate of registration (licence) for certain specified types of sexual abuse;
- mandatory reporting by regulated health professionals of other health professionals in relation to the sexual abuse of patients, other prescribed acts of misconduct, incompetence and incapacity;
- mandatory reporting of persons operating facilities where health professionals practise (e.g., hospitals and clinics);
- protections against reprisals for persons required to comply with the mandatory reporting;
- requirement for each college to establish a program to provide funding for treating sexually abused patients through therapy and counselling; and
- requirement for each college to establish a patient relations program for outreach and education on sexual abuse (initially patient relations committees had this responsibility; some of these committees still exist, but their authority has been reduced).

As more health regulatory colleges have been added to the RHPA, the law has been amended from time to time, but there have been only a few major amendments that directly address the sexual abuse of patients. These include:

- the introduction, in 2007, of a new committee, the ICRC (Inquiries, Complaints and Reports Committee, previously known as the Complaints Committee) to be established by each college, with authority given to the ICRC chair to select a panel from among members of the ICRC to investigate a complaint (s. 25 of the RHPA Code). The ICRC may, where an allegation has been referred to a Discipline Committee, make an interim order directing the registrar to suspend or impose conditions on a member’s certificate of registration if the conduct of the member exposes or is likely to expose his or her patients to harm or injury;

- also in 2007, consistent with the new ICRC replacing the Complaints Committee, oversight powers of the Health Professions Review and Appeal Board were defined to allow it to review certain decisions of the ICRC (as it had of the defunct Complaints Committee) at the request of the complainant (patient) or the member who is the subject of the complaint (regulated health professional), each having party status in board proceedings. The board retains authority to review either or both of the adequacy of the college investigation or the reasonableness of the college decision;
- an amendment, in 2007, that prevents a college registrar from referring allegations of sexual abuse to an alternative dispute resolution process (this was a recommendation of the 2000 task force on the sexual abuse of patients);
- mandatory reporting, based on reasonable grounds to believe that a member has sexually abused a patient, was expanded in 2007 to include mandatory reporting where reasonable grounds to believe that a member is incompetent, incapacitated or has sexually abused a patient, with provision for immediate filing of a report if reasonable grounds to believe that the member will continue to sexually abuse or that the incompetence or incapacity is likely to expose a patient to harm or injury;
- fines against individuals and corporations found guilty of certain offences under the RHPA, including sexual abuse of one or more patients, were increased in 2007 and 2009;
- a reduction, in 2009, of the scope of authority for the Health Professions Regulatory Advisory Council (HPRAC); HPRAC had been the oversight body and accountability mechanism for monitoring colleges on cases and policies related to the sexual abuse of patients. HPRAC's "duties" are now solely to "advise the Minister and no other person on any issue...but only if the Minister decides to refer the issue to HPRAC...and in no other circumstances";
- the introduction, in 2013, of an option to allow college councils to activate a "spousal exemption" for conduct, behaviour or remarks that would otherwise constitute sexual abuse if the patient was the member's spouse and the member was not engaged in the practice of the profession at the time the conduct, behaviour or remark occurred; and
- the addition, in 2015, of a new prohibition regarding sexual orientation and gender identity treatments.

In s. 1 of the RHPA, "Interpretation," a number of key terms that are relevant to responding to cases where sexual abuse of patients is alleged are defined, but "patient" is not defined in the RHPA. The task force recommends that a definition of "patient" be added (see also Chapter 1, and Appendix G, of this report).

Some relevant terms that are defined in s. 1 of the RHPA include the following:

"Board" means the Health Professions Appeal and Review Board;

"Code" means the Health Professions Procedural Code in Schedule 2 of the RHPA;

"College" means the College of a health profession or group of health professions established or continued under a health profession Act

“Council” means the Council of the College

“member” means a member of the College

“Minister” means the Minister of Health and Long-Term Care

“quality assurance program” means a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members

3. Duty of Minister

It is the duty of the Minister to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. 1991, c. 18, s. 3.

4. Code

The Code shall be deemed to be part of each health profession Act. 1991, c. 18, s. 4.

5. Powers of Minister

(1) The Minister may,

(a) inquire into or require a Council to inquire into the state of practice of a health profession in a locality or institution;

(b) review a Council’s activities and require the Council to provide reports and information;

(c) require a Council to make, amend or revoke a regulation under a health profession Act, the Drug and Pharmacies Regulation Act or the Drug Interchangeability and Dispensing Fee Act;

(d) require a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health profession Acts, the Drug and Pharmacies Regulation Act or the Drug Interchangeability and Dispensing Fee Act. 1991, c. 18, s. 5 (1); 2009, c. 26, s. 24 (1).

(2) If the Minister requires a Council to do anything under subsection (1), the Council shall, within the time and in the manner specified by the Minister, comply with the requirement and submit a report. 1991, c. 18, s. 5 (2).

(3) If the Minister requires a Council to make, amend or revoke a regulation under clause (1) (c) and the Council does not do so within sixty days, the Lieutenant Governor in Council may make, amend or revoke the regulation. 1991, c. 18, s. 5 (3).

(4) Subsection (3) does not give the Lieutenant Governor in Council authority to do anything that the Council does not have authority to do. 1991, c. 18, s. 5 (4).

College supervisor

5.0.1 (1) The Lieutenant Governor in Council may appoint a person as a College supervisor, on the recommendation of the Minister, where the Minister considers it appropriate or necessary and where, in the Minister's opinion, a Council has not complied with a requirement under subsection 5 (1). 2009, c. 26, s. 24 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (1) is repealed and the following substituted: (See: 2014, c. 14, Sched. 2, ss. 9, 13)

College supervisor

(1) The Lieutenant Governor in Council may appoint a person as a College supervisor, on the recommendation of the Minister, where the Minister considers it appropriate or necessary. 2014, c. 14, Sched. 2, s. 9.

Reports

Annual report

6. (1) Each College and the Advisory Council shall report annually to the Minister on its activities and financial affairs. 1998, c. 18, Sched. G, s. 2 (1).

(2) Repealed: 2007, c. 10, Sched. M, s. 2 (1).

Audited financial statement

(3) Each College's annual report shall include an audited financial statement. 1998, c. 18, Sched. G, s. 2 (2).

Content and form

(4) The Minister may specify the content and form of the annual reports submitted by the College and the Advisory Council and, where the Minister has done so, the annual reports shall contain that content and be in that form. 2007, c. 10, Sched. M, s. 2 (2).

Minister may publish information

(5) The Minister may, in every year, publish information from the annual reports of the Colleges. 2007, c. 10, Sched. M, s. 2 (2).

No personal information

(6) Information from the annual reports published by the Minister shall not include any personal information. 2007, c. 10, Sched. M, s. 2 (2).

Additional audits

(7) The College and the Advisory Council shall be subject, at any time, to any other audits relating to any aspect of its affairs as the Minister may determine to be appropriate, conducted by an auditor appointed by or acceptable to the Minister. 2009, c. 26, s. 24 (3).

Auditor to submit results

(8) The auditor shall submit the results of any audit performed under subsection (7) to the Minister and the College. 2009, c. 26, s. 24 (3).

Advice for Minister only

(2) Unless the Minister or this Act provides otherwise, the Advisory Council shall provide its advice to the Minister and no other person, and shall not provide advice on any issue other than the issue referred to it by the Minister. 2009, c. 26, s. 24 (5).

Form and manner

(3) If the Minister refers an issue to the Advisory Council for advice, the Advisory Council shall provide its advice to the Minister only in the form and manner specified by the Minister. 2009, c. 26, s. 24 (5).

Jurisdictions of Colleges

(2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College.

7. Advisory Council

(1) The Advisory Council is established under the name Health Professions Regulatory Advisory Council in English and Conseil consultatif de réglementation des professions de la santé in French.

Composition

(2) The Advisory Council shall be composed of at least five and no more than seven persons who shall be appointed by the Lieutenant Governor in Council on the Minister's recommendation.

Chair and vice-chair

(3) The Lieutenant Governor in Council shall designate one member of the Advisory Council to be the chair and one to be the vice-chair. 1991, c. 18, s. 7.

8. Qualification of members

A person may not be appointed as a member of the Advisory Council if the person,

- (a) is employed under Part III of the Public Service of Ontario Act, 2006 or by a Crown agency as defined in the Crown Agency Act; or
- (b) is or has been a member of a Council or College. 1991, c. 18, s. 8; 2006, c. 35, Sched. C, s. 116 (1).

9. Terms of members

(1) Members of the Advisory Council shall be appointed for terms of two years. 1991, c. 18, s. 9 (1).

Replacement members

(2) A person appointed to replace a member of the Advisory Council before the member's term expires shall hold office for the remainder of the term. 1991, c. 18, s. 9 (2).

Reappointments

(3) Members of the Advisory Council are eligible for reappointment. 1991, c. 18, s. 9 (3).

(4) REPEALED: 2007, c. 10, Sched. M, s. 3.

10. Remuneration and expenses

The members of the Advisory Council shall be paid the remuneration and expenses the Lieutenant Governor in Council determines. 1991, c. 18, s. 10.

Duties of the Advisory Council

11. (1) The Advisory Council's duties are to advise the Minister and no other person on any issue from the matters described in clauses (2) (a) to (f), but only if the Minister decides to refer the issue to the Advisory Council in writing, seeking its advice, and in no other circumstances. 2009, c. 26, s. 24 (4).

Matters that may be referred

(2) The matters that the Minister may refer to the Advisory Council are,
(a) whether unregulated professions should be regulated;
(b) whether regulated professions should no longer be regulated;
(c) suggested amendments to this Act, a health profession Act or a regulation under any of those Acts and suggested regulations under any of those Acts;
(d) matters concerning the quality assurance programs undertaken by Colleges;
(e) each College's patient relations program and its effectiveness; and
(f) any matter the Minister considers desirable to refer to the Advisory Council relating to the regulation of the health professions. 2009, c. 26, s. 24 (4).

Referrals to the Advisory Council

12. (1) The Minister may refer any issue within the matters described in clauses 11 (2) (a) to (e) to the Advisory Council that a Council or person asks the Minister to refer, and the Minister may refer any other issue to the Advisory Council that the Minister determines is appropriate. 2009, c. 26, s. 24 (5).

13. Notice of amendments to Councils

(1) If the Minister refers a suggested amendment to this Act, a health profession Act or a regulation under any of those Acts or a suggested regulation under any of those Acts to the Advisory Council, the Minister shall give notice of the suggestion to the Council of every College within ten days after referring it.

Submissions to Advisory Council

(2) A Council may make written submissions to the Advisory Council with respect to a suggestion within forty-five days after receiving the Minister's notice of the suggestion or within any longer period the Advisory Council may specify. 1991, c. 18, s. 13.

14. Function is advisory only

The function of the Advisory Council is advisory only and no failure to refer a matter or to comply with any other requirement relating to a referral renders anything invalid. 1991, c. 18, s. 14.

15. Procedure

(1) The Advisory Council shall sit in Ontario where and when the chair designates.

Idem

(2) The Advisory Council shall conduct its proceedings in the manner it considers appropriate. 1991, c. 18, s. 15.

16. Employees

(1) Such employees as are considered necessary for the proper conduct of the affairs of the Advisory Council may be appointed under Part III of the Public Service of Ontario Act, 2006. 2006, c. 35, Sched. C, s. 116 (2).

Experts

(2) The Advisory Council may engage experts or professional advisors to assist it. 1991, c. 18, s. 16 (2).

17. Secretary

(1) The Advisory Council shall appoint one of its employees as the Secretary.

Jurisdictions of Colleges

(2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College.

Definitions

(3) In this section,

“aboriginal healer” means an aboriginal person who provides traditional healing services; (“guérisseur autochtone”)

“aboriginal midwife” means an aboriginal person who provides traditional midwifery services. (“sage-femme autochtone”) 1991, c. 18, s. 35.

Sexual orientation and gender identity treatments

29.1 (1) No person shall, in the course of providing health care services, provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age. 2015, c. 18, s. 2.

Exemption, aboriginal healers and midwives

35. (1) This Act does not apply to,

(a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or

(b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community.

36. Confidentiality

(1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies*

Regulation Act and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

- (a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;
- (b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
- (c) to a body that governs a profession inside or outside of Ontario;
- (d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);
Note: On a day to be named by proclamation of the Lieutenant Governor, clause (d) is repealed and the following substituted: (See: 2014, c. 14, Sched. 2, ss. 10, 13)
- (d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Health Protection and Promotion Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);
- (d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;
- (d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;
- (e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;
- (f) to the counsel of the person who is required to keep the information confidential under this section;
- (g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;
- (h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

- (i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons; or
- (j) with the written consent of the person to whom the information relates. 2007, c. 10, Sched. M, s. 7 (1).

Evidence in civil proceedings

(3) No record of a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*. 1991, c. 18, s. 36 (3); 1996, c. 1, Sched. G, s. 27 (2).

38. Immunity

No action or other proceeding for damages shall be instituted against the Crown, the Minister, a College supervisor appointed under section 5.0.1 or his or her staff, an employee of the Crown, the Advisory Council, a College, a Council, or a member, officer, employee, agent or appointee of the Advisory Council, a College, a Council, a committee of a Council or a panel of a committee of a Council for an act done in good faith in the performance or intended performance of a duty or in the exercise or the intended exercise of a power under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or a regulation or a by-law under those Acts or for any neglect or default in the performance or exercise in good faith of the duty or power. 1991, c. 18, s. 38; 1998, c. 18, Sched. G, s. 8; 2007, c. 10, Sched. M, s. 10; 2009, c. 26, s. 24 (8).

43.1. Regulations

Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations governing funding under programs required under section 85.7 of the Code, including regulations,

- (a) prescribing the maximum amount or a means of establishing the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse;
- (b) prescribing the period of time during which funding may be provided for a person in respect of a case of sexual abuse. 1993, c. 37, s. 3.

REFERENCES TO HEALTH PROFESSIONALS

	Column 1	Column 2
1.	person registered as a chiroprapist under the <i>Chiroprapist Act</i>	member of the College of Chiroprapists of Ontario
2.	person registered as a dental technician under the <i>Dental Technicians Act</i>	member of the College of Dental Technologists of Ontario
3.	person licensed as a denture therapist under the <i>Denture Therapists Act</i>	member of the College of Denturists of Ontario
4.	person registered as a chiropractor under the <i>Drugless Practitioners Act</i>	member of the College of Chiropractors of Ontario
5.	person registered as a masseur under the <i>Drugless Practitioners Act</i>	member of the College of Massage Therapists of Ontario
6.	Repealed. See: Table of Public Statute Provisions Repealed Under Section 10.1 of the <i>Legislation Act, 2006</i> – December 31, 2011.	
7.	person registered as a physiotherapist under the <i>Drugless Practitioners Act</i>	member of the College of Physiotherapists of Ontario
7.1	person registered under the <i>Drugless Practitioners Act</i>	member of the College of Naturopaths of Ontario
8.	person registered as a dental hygienist under Part II of the <i>Health Disciplines Act</i>	member of the College of Dental Hygienists of Ontario
9.	person licensed under Part II of the <i>Health Disciplines Act</i>	member of the Royal College of Dental Surgeons of Ontario
10.	person licensed under Part III of the <i>Health Disciplines Act</i>	member of the College of Physicians and Surgeons of Ontario
11.	person who is the holder of a certificate issued under Part IV of the <i>Health Disciplines Act</i>	member of the College of Nurses of Ontario
12.	person licensed under Part V of the <i>Health Disciplines Act</i>	member of the College of Optometrists of Ontario
13.	person licensed under Part VI of the <i>Health Disciplines Act</i>	member of the Ontario College of Pharmacists
14.	Person registered under the <i>Ophthalmic Dispensers Act</i>	member of the College of Opticians of Ontario
15.	person registered under the <i>Psychologists Registration Act</i>	member of the College of Psychologists of Ontario
16.	person registered under the <i>Radiological Technicians Act</i>	member of the College of Medical Radiation Technologists of Ontario

SCHEDULE 1 – SELF GOVERNING HEALTH PROFESSIONS

Health Profession Acts	Health Profession
Audiology and Speech-Language Pathology Act, 1991	Audiology and Speech-Language Pathology
Chiropody Act, 1991	Chiropody
Chiropractic Act, 1991	Chiropractic
Dental Hygiene Act, 1991	Dental Hygiene
Dental Technology Act, 1991	Dental Technology
Dentistry Act, 1991	Dentistry
Denturism Act, 1991	Denturism
Dietetics Act, 1991	Dietetics
Homeopathy Act, 2007	Homeopathy
Kinesiology Act, 2007	Kinesiology
Massage Therapy Act, 1991	Massage Therapy
Medical Laboratory Technology Act, 1991	Medical Laboratory Technology
Medical Radiation Technology Act, 1991	Medical Radiation Technology
Medicine Act, 1991	Medicine
Midwifery Act, 1991	Midwifery
Naturopathy Act, 2007	Naturopathy
Nursing Act, 1991	Nursing
Occupational Therapy Act, 1991	Occupational Therapy
Opticianry Act, 1991	Opticianry
Optometry Act, 1991	Optometry
Pharmacy Act, 1991	Pharmacy
Physiotherapy Act, 1991	Physiotherapy
Psychology Act, 1991	Psychology
Psychotherapy Act, 2007	Psychotherapy
Respiratory Therapy Act, 1991	Respiratory Therapy
Traditional Chinese Medicine Act, 2006	Traditional Chinese Medicine
1991, c. 18, Sched. 1; 1998, c. 18, Sched. G, s. 9;	

SCHEDULE 2 – HEALTH PROFESSIONS PROCEDURAL CODE

Note: This Code is deemed by section 4 of the *Regulated Health Professions Act, 1991* to be part of each health profession Act.

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COLLEGE

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 - 2.1 Duty of College
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Interpretation

- 1. (1) In this Code,
 - "alternative dispute resolution process" [the definitions are repeated in full]
 - "Board"
 - "certificate of registration"
 - "Council"
 - "incapacitated"
 - "member"
 - "Minister"
 - "patient relations program"
 - "quality assurance program"
 - "Registrar"
 - "registration"

Sexual abuse of a patient

- (3) In this Code,
 - "sexual abuse" of a patient by a member means,

- (a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
 - (b) touching, of a sexual nature, of the patient by the member, or
 - (c) behaviour or remarks of a sexual nature by the member towards the patient.
- 1993, c. 37, s. 4.

Exception

- (4) For the purposes of subsection (3), “sexual nature” does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. 1993, c. 37, s. 4.

Exception, spouses

- (5) If the Council has made a regulation under clause 95 (1) (0.a), conduct, behaviour or remarks that would otherwise constitute sexual abuse of a patient by a member under the definition of “sexual abuse” in subsection (3) do not constitute sexual abuse if,
- (a) the patient is the member’s spouse; and
 - (b) the member is not engaged in the practice of the profession at the time the conduct, behaviour or remark occurs. 2013, c. 9, s. 1 (1).

Definition

- (6) For the purposes of subsection (5), “spouse”, in relation to a member, means,
- (a) a person who is the member’s spouse as defined in section 1 of the Family Law Act, or
 - (b) a person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years. 2013, c. 9, s. 1 (1).

1.1. Statement of purpose, sexual abuse provisions

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. 1993, c. 37, s. 5.

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

3. Objects of College

(1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.

3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.
- 4.1. To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.
5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
9. To promote inter-professional collaboration with other health profession colleges.
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Meetings

7. (1) The meetings of the Council shall be open to the public and reasonable notice shall be given to the members of the College, to the Minister, and to the public. 2007, c. 10, Sched. M, s. 20 (1).

Exclusion of public

- (2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,
 - (a) matters involving public security may be disclosed;
 - (b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;
 - (c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;
 - (d) personnel matters or property acquisitions will be discussed;
 - (e) instructions will be given to or opinions received from the solicitors for the College; or

(f) the Council will deliberate whether to exclude the public from a meeting or whether to make an order under subsection (3). 1991, c. 18, Sched. 2, s. 7 (2); 2007, c. 10, Sched. M, s. 20 (2).

Orders preventing public disclosure

(3) In situations in which the Council may exclude the public from meetings, it may make orders it considers necessary to prevent the public disclosure of matters disclosed in the meeting, including banning publication or broadcasting of those matters. 1991, c. 18, Sched. 2, s. 7 (3).

Remuneration and expenses

8. Council members appointed by the Lieutenant Governor in Council shall be paid, by the Minister, the expenses and remuneration the Lieutenant Governor in Council determines. 1991, c. 18, Sched. 2, s. 8; 2006, c. 19, Sched. L, s. 10 (1).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

10. Committees

(1) The College shall have the following committees:

1. Executive Committee.
2. Registration Committee.
3. Inquiries, Complaints and Reports Committee.
4. Discipline Committee.
5. Fitness to Practise Committee.
6. Quality Assurance Committee.
7. Patient Relations Committee. 1991, c. 18, Sched. 2, s. 10 (1); 2007, c. 10, Sched. M, s. 21 (1).

Transitional

(1.1) For greater certainty, where, at the time subsection 21 (1) of Schedule M to the *Health System Improvements Act, 2007* comes into force, any matter that is before the Board based on anything done by the Committee formerly known as the Complaints Committee shall proceed as if the Board had the authority to do anything it could have done before the coming into force of sections 30 to 32 of that Schedule. 2007, c. 10, Sched. M, s. 21 (2).

Same

(1.2) Where a regulation made under the *Regulated Health Professions Act, 1991* or a health profession Act that was made before the coming into force of subsection 21 (1) of Schedule M to the *Health System Improvements Act, 2007* refers to the Complaints Committee, the reference shall be deemed to be to the Inquiries, Complaints and Reports Committee. 2009, c. 26, s. 24 (12).

Annual reports

11. (1) Each committee named in subsection 10 (1) shall monitor and evaluate their processes and outcomes and shall annually submit a report of its activities to the Council in a form acceptable to the Council. 2007, c. 10, Sched. M, s. 22.

Exclusions from reports

(2) The Inquiries, Complaints and Reports Committee shall not submit a report that contains information, other than information of a general statistical nature, relating to,

(a) a referral by the Inquiries, Complaints and Reports Committee to the Discipline or Fitness to Practise Committee until a panel of the Discipline or Fitness to Practise Committee disposes of the matter;

(b) an approval for the Registrar to appoint an investigator until the investigation is completed and reported by the Registrar and the Inquiries, Complaints and Reports Committee decides not to make a referral with respect to the matter to the Discipline Committee or, if the Inquiries, Complaints and Reports Committee makes a referral with respect to the matter to the Discipline Committee, until a panel of the Discipline Committee disposes of the matter; or

(c) an interim order made by the Inquiries, Complaints and Reports Committee in respect of a member until a panel of the Discipline Committee disposes of the matter. 2007, c. 10, Sched. M, s. 22.

(d) matters concerning the quality assurance programs undertaken by Colleges;

(e) each College's patient relations program and its effectiveness; and

(f) any matter the Minister considers desirable to refer to the Advisory Council relating to the regulation of the health professions. 2009, c. 26, s. 24 (4).

Members

13. (1) A person registered by the College is a member.

Suspended members

(2) A person whose certificate of registration is suspended is not a member. 1991, c. 18, Sched. 2, s. 13.

Note: On a day to be named by proclamation of the Lieutenant Governor, Schedule 2 is amended by adding the following section:

Professional liability insurance

13.1 (1) No member of a College in Ontario shall engage in the practice of the health profession unless he or she is personally insured against professional liability under a professional liability insurance policy or belongs to a specified association that provides the member with personal protection against professional liability. 2009, c. 26, s. 24 (13).

Insurance requirements

(2) A member mentioned in subsection (1) shall comply with the requirements respecting professional liability insurance or protection against professional liability

specified by the College and prescribed in the regulations made under the health profession Act governing the member's health profession or set out in the by-laws. 2009, c. 26, s. 24 (13).

Professional misconduct

(3) In addition to the grounds set out in subsection 51 (1), a panel of the Discipline Committee shall find that a member has committed an act of professional misconduct if the member fails to comply with subsection (1) or (2). 2009, c. 26, s. 24 (13).

See: 2009, c. 26, ss. 24 (13), 27 (2).

Continuing jurisdiction

14. (1) A person whose certificate of registration is revoked or expires or who resigns as a member continues to be subject to the jurisdiction of the College for professional misconduct or incompetence referable to the time when the person was a member and may be investigated under section 75. 2007, c. 10, Sched. M, s. 23 (1).

Idem

(2) A person whose certificate of registration is suspended continues to be subject to the jurisdiction of the College for incapacity and for professional misconduct or incompetence referable to the time when the person was a member or to the period of the suspension and may be investigated under section 75. 1991, c. 18, Sched. 2, s. 14 (2); 2007, c. 10, Sched. M, s. 23 (2).

Registration hearings or reviews

22.(3) The following provisions also apply with necessary modifications to a hearing:

1. Section 45 (hearings open).
2. Section 47 (sexual misconduct witnesses).
3. Section 48 (transcript of hearings). 1991, c. 18, Sched. 2, s. 22 (3).

Same

(3.1) The following provisions of the Statutory Powers Procedure Act also apply with necessary modifications to a review by the Board:

1. Section 21.1 (correction of errors).
2. Section 25.1 (rules). 1998, c. 18, Sched. G, s. 12.

Findings of Fact

(4) The findings of fact in a hearing shall be based exclusively on evidence admissible or matters that may be noticed under sections 15, 15.1, 15.2 and 16 of the *Statutory Powers Procedure Act*. 1991, c. 18, Sched. 2, s. 22 (4); 2007, c. 10, Sched. M, s. 27 (1).

Disposal by Board

(6) The Board shall, after the hearing or review, make an order doing any one or more of the following:

1. Confirming the order made by the panel.
2. Requiring the Registration Committee to make an order directing the Registrar to issue a certificate of registration to the applicant if the applicant successfully completes any examinations or training the Registration Committee may specify.
3. Requiring the Registration Committee to make an order directing the Registrar to issue a certificate of registration to the applicant and to impose any terms, conditions and limitations the Board considers appropriate.
4. Referring the matter back to the Registration Committee for further consideration by a panel, together with any reasons and recommendations the Board considers appropriate. 1991, c. 18, Sched. 2, s. 22 (6); 2007, c. 10, Sched. M, s. 27 (3).

23. Register

(1) The Registrar shall maintain a register. 2007, c. 10, Sched. M, s. 28.

Contents of register

(2) The register shall contain the following:

1. Each member's name, business address and business telephone number, and, if applicable, the name of every health profession corporation of which the member is a shareholder.
2. The name, business address and business telephone number of every health profession corporation.
3. The names of the shareholders of each health profession corporation who are members of the College.
4. Each member's class of registration and specialist status.
5. The terms, conditions and limitations that are in effect on each certificate of registration.
6. A notation of every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and has not been finally resolved, until the matter has been resolved.
7. The result, including a synopsis of the decision, of every disciplinary and incapacity proceeding, unless a panel of the relevant committee makes no finding with regard to the proceeding.
8. A notation of every finding of professional negligence or malpractice, which may or may not relate to the member's suitability to practise, made against the member, unless the finding is reversed on appeal.
9. A notation of every revocation or suspension of a certificate of registration.
10. A notation of every revocation or suspension of a certificate of authorization.
11. Information that a panel of the Registration, Discipline or Fitness to Practise Committee specifies shall be included.
12. Where findings of the Discipline Committee are appealed, a notation that they are under appeal, until the appeal is finally disposed of.

13. Where, during or as a result of a proceeding under section 25, a member has resigned and agreed never to practise again in Ontario, a notation of the resignation and agreement.

14. Information that is required to be kept in the register in accordance with the by-laws. 2007, c. 10, Sched. M, s. 28.

Publication ban

(3) No action shall be taken under this section which violates a publication ban, and nothing in this section requires or authorizes the violation of a publication ban. 2007, c. 10, Sched. M, s. 28.

Access to information by the public

(5) All of the information required by paragraphs 1 to 13 of subsection (2) and all information designated as public in the by-laws shall, subject to subsections (6), (7), (8), (9) and (11), be made available to an individual during normal business hours, and shall be posted on the College's website in a manner that is accessible to the public or in any other manner and form specified by the Minister. 2007, c. 10, Sched. M, s. 28.

Other cases when information may be withheld

(11) The Registrar shall refuse to disclose to an individual or to post on the College's website information required by paragraph 7 of subsection (2) if,

(a) a finding of professional misconduct was made against the member and the order made was only a reprimand or only a fine, or a finding of incapacity was made against the member;

(b) more than six years have passed since the information was prepared or last updated;

(c) the member has made an application to the relevant committee for the removal of the information from public access because the information is no longer relevant to the member's suitability to practise, and if,

(i) the relevant committee believes that a refusal to disclose the information outweighs the desirability of public access to the information in the interest of any person affected or the public interest, and

(ii) the relevant committee has directed the Registrar to remove the information from public access; and

(d) the information does not relate to disciplinary proceedings concerning sexual abuse as defined in clause (a) or (b) of the definition of "sexual abuse" in subsection 1 (3). 2007, c. 10, Sched. M, s. 28.

25. Panel for investigation or consideration

(1) A panel shall be selected by the chair of the Inquiries, Complaints and Reports Committee from among the members of the Committee to investigate a complaint filed with the Registrar regarding the conduct or actions of a member or to consider a report that is made by the Registrar under clause 79 (a). 2007, c. 10, Sched. M, s. 30.

Composition

(2) A panel shall be composed of at least three persons, at least one of whom shall be a person appointed to the Council by the Lieutenant Governor in Council. 2007, c. 10, Sched. M, s. 30.

Quorum

(3) Three members of a panel constitute a quorum. 2007, c. 10, Sched. M, s. 30.

Complaint must be recorded

(4) A panel shall not be selected to investigate a complaint unless the complaint is in writing or is recorded on a tape, film, disk or other medium. 2007, c. 10, Sched. M, s. 30.

Complainant to be informed

(5) The Registrar shall give a complainant notice of receipt of his or her complaint and a general explanation of the processes of the College, including the jurisdiction and role of the Inquiries, Complaints and Reports Committee, together with a copy of the provisions of sections 28 to 29. 2007, c. 10, Sched. M, s. 30.

Notice to member

(6) The Registrar shall give the member, within 14 days of receipt of the complaint or the report,

- (a) notice of the complaint, together with a copy of the provisions of sections 28 to 29, or notice of the receipt of the report;
- (b) a copy of the provisions of section 25.2; and
- (c) a copy of all available prior decisions involving the member unless the decision was to take no further action under subsection 26 (5). 2007, c. 10, Sched. M, s. 30.

25.1. Alternative dispute resolution with respect to a complaint

(1) The Registrar may, with the consent of both the complainant and the member, refer the complainant and the member to an alternative dispute resolution process,

- (a) if the matter has not yet been referred to the Discipline Committee under section 26; and
- (b) if the matter does not involve an allegation of sexual abuse. 2007, c. 10, Sched. M, s. 30.

26. What a panel may do

(1) A panel, after investigating a complaint or considering a report, considering the submissions of the member and making reasonable efforts to consider all records and documents it considers relevant to the complaint or the report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or the report.
2. Refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings.

3. Require the member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned.

4. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws. 2007, c. 10, Sched. M, s. 30.

27 Notice of decision

(1) A panel shall give the complainant and the member who is the subject of the complaint,

(a) a copy of its decision;

(b) a copy of its reasons, if the panel acted under paragraph 3 or 4 of subsection 26 (1); and

(c) a notice advising the member and the complainant of any right to request a review they may have under subsection 29 (2). 2007, c. 10, Sched. M, s. 30.

Timely disposal

28. (1) A panel shall dispose of a complaint within 150 days after the filing of the complaint. 2007, c. 10, Sched. M, s. 30.

Not affected by ADR

(2) A referral to an alternative dispute resolution process under section 25.1 does not affect the time requirements under this section. 2007, c. 10, Sched. M, s. 30.

If complaint not disposed of

(3) If a panel has not disposed of a complaint within 150 days after the complaint was filed, the Registrar shall provide the complainant with written notice of that fact and an expected date of disposition which shall be no more than 60 days from the date of the written notice. 2007, c. 10, Sched. M, s. 30.

If further delay

(4) If a panel has not disposed of the complaint by the expected date of disposition described in subsection (3), the Registrar shall,

(a) provide the member and complainant with written notice and reasons for the delay and the new expected date of disposition which shall be no more than 30 days from the date of the revised notice or from the expected date of disposition described in subsection (3), whichever is sooner; and

(b) provide the Board with written notice of and reasons for the delay as were provided to the member and complainant. 2007, c. 10, Sched. M, s. 30.

Powers of the Board

(5) The Board, on application of the member or the complainant, shall consider the written reasons for the delay and shall do any one of the following:

1. Direct the Inquiries, Complaints and Reports Committee to continue the investigation.

2. Make recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.

3. Investigate the complaint and make an order under subsection (9) within 120 days of the decision to investigate the complaint. 2007, c. 10, Sched. M, s. 30.

Board's investigatory powers

(6) In investigating a complaint under paragraph 3 of subsection (5), the Board has all the powers of a panel of the Inquiries, Complaints and Reports Committee and of the Registrar with respect to the investigation of the matter and may appoint an investigator under clause 75 (1) (c). 2007, c. 10, Sched. M, s. 30.

Continuing power of Inquiries, Complaints and Reports Committee

(7) The Inquiries, Complaints and Reports Committee may take action under section 26 at any time before the Board completes its investigation. 2007, c. 10, Sched. M, s. 30.

Same

(8) For greater certainty, if the Inquiries, Complaints and Reports Committee takes action as provided for in subsection (7), the Board no longer has jurisdiction to take action under section 26. 2007, c. 10, Sched. M, s. 30.

Powers of Board re an investigation

(9) After an investigation, the Board may do any one or more of the following:

1. Refer the matter to the Inquiries, Complaints and Reports Committee.
2. Make recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.
3. Require the Inquiries, Complaints and Reports Committee or a panel to do anything the Committee or a panel may do under the health profession Act and this Code except to request the Registrar to conduct an investigation. 2007, c. 10, Sched. M, s. 30.

Powers of Board re time limits

28.1 If the Board is satisfied that no person will be unduly prejudiced, it may, on reasonable grounds, extend any time limit with respect to,

- (a) a requirement, under subsection 21 (1), for a review or hearing by the Board;
- (b) a request, under subsection 29 (2), for a review by the Board; or
- (c) the Registrar's obligation to give to the Board, under subsection 32 (1), a record of an investigation of a complaint against a member and all relevant documents and things. 2007, c. 10, Sched. M, s. 30.

29 Review by Board

(1) Subject to section 30, the Board shall review a decision of a panel of the Inquiries, Complaints and Reports Committee if the Board receives a request under subsection (2). 2007, c. 10, Sched. M, s. 30.

(b) pending clarification

Request for Review

(2) The complainant or the member who is the subject of the complaint may request the Board to review a decision of a panel of the Inquiries, Complaints and Reports Committee unless the decision was,

- (a) to refer an allegation of professional misconduct or incompetence to the Discipline Committee; or
- (b) to refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings. 2007, c. 10, Sched. M, s. 30.

31 Personal representative as complainant

A complainant's personal representative may act as the complainant for the purposes of a review of the decision by the Board if the complainant dies or becomes incapacitated. 1991, c. 18, Sched. 2, s. 31.

33 Procedure

- (2) In conducting a review, the Board,
 - (a) shall give the party requesting the review an opportunity to comment on the matters set out in clauses (1) (a) and (b) and the other party an opportunity to respond to those comments;
 - (b) may require the College to send a representative;
 - (c) may question the parties and the representative of the College;
 - (d) may permit the parties to make representations with respect to issues raised by any questions asked under clause (c); and
 - (e) shall not allow the parties or the representative of the College to question each other. 1991, c. 18, Sched. 2, s. 33.

35 Powers of Board

- (1) After conducting a review of a decision, the Board may do any one or more of the following:
 1. Confirm all or part of the decision.
 2. Make recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.
 3. Require the Inquiries, Complaints and Reports Committee to do anything the Committee or a panel may do under the health profession Act and this Code except to request the Registrar to conduct an investigation. 1991, c. 18, Sched. 2, s. 35 (1); 2007, c. 10, Sched. M, s. 32 (1, 2).

36 Inquiries, Complaints and Reports Committee referral

- (1) The Inquiries, Complaints and Reports Committee may refer a specified allegation of a member's professional misconduct or incompetence to the Discipline Committee. 2007, c. 10, Sched. M, s. 33 (1).

Allegations of Sexual abuse

- (2) In deciding whether or not to refer an allegation of the sexual abuse of a patient to the Discipline Committee, the Inquiries, Complaints and Reports Committee shall take into account any opinion, required under subsection 85.3 (5), as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future. 1993, c. 37, s. 9; 2007, c. 10, Sched. M, s. 33 (2).

37 Interim suspension

(1) The Inquiries, Complaints and Reports Committee may, subject to subsection (5), make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

- (a) an allegation is referred to the Discipline Committee; and
- (b) it is of the opinion that the conduct of the member exposes or is likely to expose his or her patients to harm or injury. 1991, c. 18, Sched. 2, s. 37 (1); 2007, c. 10, Sched. M, s. 34 (1).

38 Panel for discipline hearing

(1) The chair of the Discipline Committee shall select a panel from among the members of the Committee to hold a hearing of allegations of a member's professional misconduct or incompetence referred to the Committee by the Inquiries, Complaints and Reports Committee. 1991, c. 18, Sched. 2, s. 38 (1); 2007, c. 10, Sched. M, s. 35.

Composition

(2) A panel shall be composed of at least three and no more than five persons, at least two of whom shall be persons appointed to the Council by the Lieutenant Governor in Council. 1991, c. 18, Sched. 2, s. 38 (2).

41 Parties

The College and the member against whom allegations have been made are parties to a hearing. 1991, c. 18, Sched. 2, s. 41.

41.1 Non-party participation in hearings

(1) A panel, on application by a person who is not a party, may allow the person to participate in a hearing if,

- (a) the good character, propriety of conduct or competence of the person is an issue at the hearing; or
- (b) the participation of the person, would, in the opinion of the panel, be of assistance to the panel. 1993, c. 37, s. 10; 2007, c. 10, Sched. M, s. 36.

42 Disclosure of Evidence

(1) Evidence against a member is not admissible at a hearing of allegations against the member unless the member is given, at least ten days before the hearing,

- (a) in the case of written or documentary evidence, an opportunity to examine the evidence;
- (b) in the case of evidence of an expert, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence; or
- (c) in the case of evidence of a witness, the identity of the witness. 1991, c. 18, Sched. 2, s. 42 (1); 1993, c. 37, s. 11.

45 Hearings public

(1) A hearing shall, subject to subsection (2), be open to the public. 1991, c. 18, Sched. 2, s. 45 (1).

Exclusion of public

- (2) The panel may make an order that the public be excluded from a hearing or any part of it if the panel is satisfied that,
- (a) matters involving public security may be disclosed;
 - (b) financial or personal or other matters may be disclosed at the hearing of such a nature that the harm created by disclosure would outweigh the desirability of adhering to the principle that hearings be open to the public;
 - (c) a person involved in a criminal proceeding or in a civil suit or proceeding may be prejudiced; or
 - (d) the safety of a person may be jeopardized. 1991, c. 18, Sched. 2, s. 45 (2); 2007, c. 10, Sched. M, s. 37.

Orders preventing public disclosure

- (3) In situations in which the panel may make an order that the public be excluded from a hearing, it may make orders it considers necessary to prevent the public disclosure of matters disclosed at the hearing, including orders banning the publication or broadcasting of those matters. 1991, c. 18, Sched. 2, s. 45 (3).

Public information may be disclosed

- (4) No order shall be made under subsection (3) that prevents the publication of anything that is contained in the register and available to the public. 1991, c. 18, Sched. 2, s. 45 (4).

47 Sexual misconduct witnesses

- (1) A panel shall, on the request of a witness whose testimony is in relation to allegations of a member's misconduct of a sexual nature involving the witness, make an order that no person shall publish the identity of the witness or any information that could disclose the identity of the witness. 1991, c. 18, Sched. 2, s. 47.

Interpretation

- (2) In subsection (1), "allegations of a member's misconduct of a sexual nature" include, but are not limited to, allegations that the member sexually abused the witness when the witness was a patient of the member. 1993, c. 37, s. 13.

49 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.

51 Professional misconduct

- (1) A panel shall find that a member has committed an act of professional misconduct if,

- (a) the member has been found guilty of an offence that is relevant to the member's suitability to practise;
- (b) the governing body of a health profession in a jurisdiction other than Ontario has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct as defined in the regulations;
- (b.0.1) the member has failed to co-operate with the Quality Assurance Committee or any assessor appointed by that committee;
- (b.1) the member has sexually abused a patient; or
- (c) the member has committed an act of professional misconduct as defined in the regulations. 1991, c. 18, Sched. 2, s. 51 (1); 1993, c. 37, s. 14 (1); 2007, c. 10, Sched. M, s. 39 (1).

Orders

- (2) If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:
1. Directing the Registrar to revoke the member's certificate of registration.
 2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time.
 3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.
 4. Requiring the member to appear before the panel to be reprimanded.
 5. Requiring the member to pay a fine of not more than \$35,000 to the Minister of Finance.
 - 5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.
 - 5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1. 1991, c. 18, Sched. 2, s. 51 (2); 1993, c. 37, s. 14 (2).

Orders relating to sexual abuse

- (5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):
1. Reprimand the member.
 2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
 - i. sexual intercourse,
 - ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
 - iii. masturbation of the member by, or in the presence of, the patient,
 - iv. masturbation of the patient by the member,
 - v. encouragement of the patient by the member to masturbate in the presence of the member. 1993, c. 37, s. 14 (3).

Statement re impact of sexual abuse

(6) Before making an order under subsection (5), the panel shall consider any written statement that has been filed, and any oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient. 1993, c. 37, s. 14 (3).

Same

(7) The statement may be made by the patient or by his or her representative. 1993, c. 37, s. 14 (3).

Same

(8) The panel shall not consider the statement unless a finding of professional misconduct has been made. 1993, c. 37, s. 14 (3).

Notice to member

(9) When a written statement is filed, the panel shall, as soon as possible, have copies of it provided to the member, to his or her counsel and to the College. 1993, c. 37, s. 14 (3).

Incompetence

52. (1) A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted. 1991, c. 18, Sched. 2, s. 52 (1); 2007, c. 10, Sched. M, s. 40 (1).

Decision to complainant

54. A panel shall give its decision and reasons in writing to the parties and, if the matter had been referred to the Discipline Committee by the Inquiries, Complaints and Reports Committee, to the complainant in the matter. 1991, c. 18, Sched. 2, s. 54; 2007, c. 10, Sched. M, s. 41.

Release of evidence

55. The Discipline Committee shall release documents and things put into evidence at a hearing to the person who produced them, on request, within a reasonable time after the matter in issue has been finally determined. 1991, c. 18, Sched. 2, s. 55.

56 Publication of decisions

(1) The College shall publish a panel's decision and its reasons, or a summary of its reasons, in its annual report and may publish the decision and reasons or summary in any other publication of the College.

Publication of member's name

- (2) In publishing a decision and reasons or summary under subsection (1), the College shall publish the name of the member who was the subject of the proceeding if,
- (a) the results of the proceeding may be obtained by a person from the register; or
 - (b) the member requests the publication of his or her name.

Withholding of member's name

- (3) The College shall not publish the member's name unless it is required to do so under subsection (2). 1991, c. 18, Sched. 2, s. 56.

70 Appeals from decisions

- (1) A party to proceedings before the Board concerning a registration hearing or review or to proceedings before a panel of the Discipline or Fitness to Practise Committee, other than a hearing of an application under subsection 72 (1), may appeal from the decision of the Board or panel to the Divisional Court.

Basis of appeal

- (2) An appeal under subsection (1) may be made on questions of law or fact or both.

Court's powers

- (3) In an appeal under subsection (1), the Court has all the powers of the panel that dealt with the matter and, in an appeal from the Board, the Court also has all the powers of the Board. 1991, c. 18, Sched. 2, s. 70.

71.2 Order where public at risk

If the conduct of the member exposes or is likely to expose his or her patients to harm or injury and urgent intervention is needed, the College may apply to a judge of the Superior Court of Justice for an order declaring that an order that was made by a panel of the Discipline Committee on the grounds of professional misconduct and that directs the Registrar to revoke, suspend or impose terms, conditions or limitations on a member's certificate shall take effect immediately despite any appeal and any other Act. 2007, c. 10, Sched. M, s. 51.

72 Applications for reinstatement

- (1) A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed. 1991, c. 18, Sched. 2, s. 72 (1).

Time of application, sexual abuse cases

- (3) An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,
- (a) five years after the date on which the certificate of registration was revoked; or

(b) six months after a decision has been made in a previous application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Notice where complainant

(4) The Registrar shall give the complainant in the original proceeding notice of an application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Reasons for reinstatement

(5) The person making the application under subsection (1) shall provide reasons why the certificate should be issued or the suspension be removed. 2007, c. 10, Sched. M, s. 52.

Referral to Committee

73. (1) The Registrar shall refer the application, if the revocation or suspension was on the grounds of,

- (a) professional misconduct or incompetence, to the Discipline Committee; or
- (b) incapacity, to the Fitness to Practise Committee.

Hearings

(2) The chair of a committee to which an application is referred shall select a panel from among the members of the committee to hold a hearing of the application.

Order

(5) A panel may, after a hearing, make an order doing any one or more of the following:

1. Directing the Registrar to issue a certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration. 1991, c. 18, Sched. 2, s. 73 (1-5).

Limitation for sexual abuse cases

(5.1) A panel may not make an order directing that the Registrar issue a new certificate of registration to an applicant whose certificate had been revoked for sexual abuse of a patient unless the prescribed conditions are met. 1993, c. 37, s. 19.

Decision

(6) A panel that held a hearing of an application shall give its decision and reasons in writing to the applicant and the Registrar. 1991, c. 18, Sched. 2, s. 73 (6).

74 Orders without hearing

(1) The Council or Executive Committee may, without a hearing, with respect to a person whose certificate of registration has been revoked or suspended as a result of

disciplinary or incapacity proceedings, make an order doing any one or more of the following:

1. Directing the Registrar to issue a new certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration if an order is made under paragraph 1 or 2. 1991, c. 18, Sched. 2, s. 74.

Limitation

(2) This section does not apply with respect to a revocation for sexual abuse of a patient. 1993, c. 37, s. 20.

Emergencies

75 (2) The Registrar may appoint an investigator if,

- (a) the Registrar believes on reasonable and probable grounds that the conduct of the member exposes or is likely to expose his or her patients to harm or injury, and that the investigator should be appointed immediately; and
- (b) there is not time to seek approval from the Inquiries, Complaints and Reports Committee. 2007, c. 10, Sched. M, s. 53.

Report

(3) Where an investigator has been appointed under subsection (2), the Registrar shall report the appointment of the investigator to the Inquiries, Complaints and Reports Committee within five days. 2007, c. 10, Sched. M, s. 53.

Entries and searches

77. (1) A justice of the peace may, on the application of the investigator made without notice, issue a warrant authorizing an investigator to enter and search a place and examine any document or thing specified in the warrant if the justice of the peace is satisfied that the investigator has been properly appointed and that there are reasonable and probable grounds established upon oath for believing that,

- (a) the member being investigated has committed an act of professional misconduct or is incompetent; and
- (b) there is something relevant to the investigation at the place. 2007, c. 10, Sched. M, s. 55.

Minimum requirements for quality assurance program

80.1 A quality assurance program prescribed under section 80 shall include,

- (a) continuing education or professional development designed to,
 - (i) promote continuing competence and continuing quality improvement among the members,

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (a) is amended by adding the following subclause:

- (i.1) promote interprofessional collaboration,
- See: 2009, c. 26, ss. 24 (14), 27 (2).

- (ii) address changes in practice environments, and
- (iii) incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council;
- (b) self, peer and practice assessments; and
- (c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program. 2007, c. 10, Sched. M, s. 58.

84 Patients relations program

- (1) The College shall have a patient relations program. 1991, c. 18, Sched. 2, s. 84 (1).

Measures for sexual abuse of patients

- (2) The patient relations program must include measures for preventing and dealing with sexual abuse of patients. 1993, c. 37, s. 22 (1); 2007, c. 10, Sched. M, s. 60 (1).

Same

- (3) The measures for preventing and dealing with sexual abuse of patients must include,
 - (a) educational requirements for members;
 - (b) guidelines for the conduct of members with their patients;
 - (c) training for the College's staff; and
 - (d) the provision of information to the public. 1991, c. 18, Sched. 2, s. 84 (3); 1993, c. 37, s. 22 (2); 2007, c. 10, Sched. M, s. 60 (2).

Report on program

- (4) The Council shall give the Health Professions Regulatory Advisory Council a written report describing the patient relation program and, when changes are made to the program, a written report describing the changes. 1991, c. 18, Sched. 2, s. 84 (4).

85.1 Reporting by members

- (1) A member shall file a report in accordance with section 85.3 if the member 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.

If name not known

- (2) A member is not required to file a report if the member does not know the name of the member who would be the subject of the report.

If information from a patient

- (3) If a member is required to file a report because of reasonable grounds obtained from one of the member's patients, the member shall use his or her best efforts to advise the patient of the requirement to file the report before doing so. 1993, c. 37, s. 23.

85.2 Reporting by facilities

(1) A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility is incompetent, incapacitated, or has sexually abused a patient. 1993, c. 37, s. 23; 2007, c. 10, Sched. M, s. 61.

When non-individuals have reasonable grounds

(2) For the purposes of subsection (1), a person who operates a facility but who is not an individual shall be deemed to have reasonable grounds if the individual who is responsible for the operation of the facility has reasonable grounds. 1993, c. 37, s. 23.

If name not known

(3) A person who operates a facility is not required to file a report if the person does not know the name of the member who would be the subject of the report. 1993, c. 37, s. 23.

85.3 Requirements if required reports

(1) A report required under section 85.1 or 85.2 must be filed in writing with the Registrar of the College of the member who is the subject of the report. 1993, c. 37, s. 23.

Timing of report

(2) The report must be filed within 30 days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, or that the incompetence or the incapacity of the member is likely to expose a patient to harm or injury and there is urgent need for intervention, in which case the report must be filed forthwith. 2007, c. 10, Sched. M, s. 62 (1).

Contents of report

(3) The report must contain,
(a) the name of the person filing the report;
(b) the name of the member who is the subject of the report;
(c) an explanation of the alleged sexual abuse, incompetence or incapacity;
(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4). 1993, c. 37, s. 23; 2007, c. 10, Sched. M, s. 62 (2).

Patients not named without consent

(4) The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name. 1993, c. 37, s. 23.

If reporter providing psychotherapy

(5) If a member who is required to file a report under section 85.1 is providing psychotherapy to the member who would be the subject of the report, the report must also contain the opinion of the member filing the report, if he or she is able to form one, as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future. 1993, c. 37, s. 23.

85.6 Immunity for reports

No action or other proceeding shall be instituted against a person for filing a report in good faith under section 85.1, 85.2, 85.4 or 85.5. 1993, c. 37, s. 23.

85.7 Funding provided by College

(1) There shall be a program, established by the College, to provide funding for therapy and counselling for persons who, while patients, were sexually abused by members. 1993, c. 37, s. 23.

Funding governed by regulations

(2) The funding shall be provided in accordance with the regulations made under the *Regulated Health Professions Act, 1991*. 1993, c. 37, s. 23.

Administration

(3) The Patient Relations Committee shall administer the program. 1993, c. 37, s. 23.

Eligibility

(4) A person is eligible for funding only if,
(a) there is a finding by a panel of the Discipline Committee that the person, while a patient, was sexually abused by a member; or
(b) the alternative requirements prescribed in the regulations made by the Council are satisfied. 1993, c. 37, s. 23.

Effect of appeal

(5) A person's eligibility for funding under clause (4) (a) is not affected by an appeal from the panel's finding. 1993, c. 37, s. 23.

No assessment

(6) A person is not required to undergo a psychological or other assessment before receiving funding. 1993, c. 37, s. 23.

Choice of therapist or counsellor

(7) A person who is eligible for funding is entitled to choose any therapist or counsellor, subject to the following restrictions:
1. The therapist or counsellor must not be a person to whom the eligible person has any family relationship.
2. The therapist or counsellor must not be a person who, to the College's knowledge, has at any time or in any jurisdiction been found guilty of professional misconduct

of a sexual nature or been found civilly or criminally liable for an act of a similar nature.

3. If the therapist or counsellor is not a member of a regulated health profession, the College may require the person to sign a document indicating that he or she understands that the therapist or counsellor is not subject to professional discipline. 1993, c. 37, s. 23.

Payment

(8) Funding shall be paid only to the therapist or counsellor chosen by the person. 1993, c. 37, s. 23.

Use of funding

(9) Funding shall be used only to pay for therapy or counselling and shall not be applied directly or indirectly for any other purpose. 1993, c. 37, s. 23.

Same

(10) Funding may be used to pay for therapy or counselling that was provided at any time after the sexual abuse took place. 2007, c. 10, Sched. M, s. 64.

Other coverage

(11) The funding that is provided to a person shall be reduced by the amount that the Ontario Health Insurance Plan or a private insurer is required to pay for therapy or counselling for the person during the period of time during which funding may be provided for him or her under the program. 1993, c. 37, s. 23.

Right of recovery

(12) The College is entitled to recover from the member, in a proceeding brought in a court of competent jurisdiction, money paid in accordance with this section for therapy or counselling for an eligible person referred to in clause (4) (a). 1993, c. 37, s. 23.

Person not required to testify

(13) The eligible person shall not be required to appear or testify in the proceeding. 1993, c. 37, s. 23.

Professional, fiduciary and ethical obligations to patients

85.11 (1) The professional, fiduciary and ethical obligations of a member to a person on whose behalf the member is practising a health profession,
(a) are not diminished by the fact that the member is practising through a health profession corporation; and
(b) apply equally to the corporation and to its directors, officers, shareholders, agents and employees. 2000, c. 42, Sched., s. 37; 2001, c. 8, s. 221 (1).

87 Court Orders

The College may apply to the Superior Court of Justice for an order directing a person to comply with a provision of the health profession Act, this Code, the

Regulated Health Professions Act, 1991, the regulations under those Acts or the by-laws made under clause 94 (1) (l.2), (l.3) (s), (t), (t.1), (t.2), (v), (w) or (y). 1991, c. 18, Sched. 2, s. 87; 1998, c. 18, Sched. G, s. 20; 2000, c. 42, Sched., s. 38; 2001, c. 8, s. 224; 2006, c. 19, Sched. C, s. 1 (1).

93 Offences

(1) Every person who contravenes an order made under subsection 7 (3) or section 45 or 47, or who contravenes subsection 76 (3), 82 (2) or (3), 85.2 (1), 85.5 (1) or (2) or 85.14 (2) or section 92.1 is guilty of an offence and on conviction is liable,
(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or
(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence. 2007, c. 10, Sched. M, s. 72; 2009, c. 26, s. 24 (17).

95 Regulations

(1) Subject to the approval of the Lieutenant Governor in Council and with prior review of the Minister, the Council may make regulations,
(0.a) providing that the spousal exception in subsection 1 (5) applies in respect of the College;

Appendix G:

Re-Vision: Zero Tolerance Implemented

Rationale

There are numerous related sections of the RHPA that articulate components of the Ontario policy for zero tolerance of sexual abuse of patients. However, the RHPA still allows for broad areas of discretion to colleges in their interpretation of applying the law in sexual abuse cases. In May and June of 2015, the task force hosted two roundtables with invited legal experts who have represented organizations and individuals involved in a wide range of cases and a wide range of perspectives on policy issues related to the sexual abuse provisions of the RHPA. For a list of the distinguished individuals, to whom we are grateful, and who participated in these roundtables on the law, please see Appendix E.

The task force appreciates that we need to be clear as to why we recommend major changes to the RHPA that, if accepted, will result in Ontario patients no longer taking complaints of sexual abuse to the individual regulatory health colleges, depending on the professional affiliation of the regulated health professional facing sexual abuse allegations. In the democratic process, law and policy reviews often utilize freedom of expression to welcome thoughtful critiques and peer-reviewed analysis by legal scholars, with the reasonable expectation that examples be given to support conclusions that differ from conclusions reached in the cases under review, be they decisions made by judges on the Supreme Court of Canada or members of a quasi-judicial tribunal. The task force undertook to explain, by way of a recent college decision, the significance of decisions where a college panel accepted facts of sexualized acts that can be found in s. 51 of the RHPA *Code*, but diverted their decision away from the mandatory revocation required by s.51, in certain specific circumstances. For greater clarity, relevant excerpts of s. 51 state:

Professional misconduct

(1) A panel shall find that a member has committed an act of professional misconduct if, ...

b.1) the member has sexually abused a patient;

....

(5) If a panel finds a member has committed an act of professional misconduct by **sexually abusing a patient**, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. **Revoke** the member's certificate of registration **if the sexual abuse consisted of, or included, any of the following**,
 - i. sexual intercourse,
 - ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
 - iii. masturbation of the member by, or in the presence of, the patient,
 - iv. masturbation of the patient by the member,
 - v. encouragement of the patient by the member to masturbate in the presence of the member. 1993, c. 37, s. 14 (3). [emphasis added]

With the assistance of our legal counsel, the task force invited a panel of experts from the academy (professors of law or medicine) and from the Bar of Ontario (including practitioners who have represented regulated health professionals as well as patients and regulatory colleges in individual cases and related policy issues) to review a number of actual decisions in which we saw a gap between the wording in the RHPA and the interpretation and application of that wording by the colleges in some sexual abuse complaints by patients. Of several such cases, the roundtable participants chose to review the decision below. The critical analysis in this Appendix to the task force report is based on acceptance of the agreed upon facts in the case. This 'Re-Vision' demonstrates what could have been possible within the current RHPA, linking relevant sections of the RHPA that could have been applied to uphold the zero tolerance of sexual abuse standard, and pointing out how the college panel in this case chose to interpret the RHPA in ways that did not result in mandatory revocation and therefore did not uphold Ontario's zero tolerance standard.

A review of the discipline decisions issued by various regulated health colleges over the past ten years or so revealed that some health professionals found to have committed sexualized acts that could be interpreted to come within the RHPA definition of sexual abuse, have not had their licences to practice revoked. In fact, in some cases, the ICRC exercised its discretion and

declined to send complaints under s. 51(1)(b.1) (sexual abuse of a patient) of the *Health Professions Procedural Code* (the “Code”), instead directing the complaint to be heard on the basis of the allegations constituting disgraceful, dishonourable or unprofessional conduct. In the latter situation, section 51(5)2, which mandates revocation of a health professional’s licence to practice where sexual abuse of a patient as described by that provision has been proven, cannot be applied by the discipline committee. Even in cases where the committee’s findings of fact indicate that acts of the respondent health professional come within the list detailed in section 51(5)2, the ICRC direction has the effect of diverting the case from mandatory revocation.

The task force is gravely concerned that discretion is being exercised in college processes that result in diversion from mandatory revocation in cases where that acts of sexual exploitation are clearly identified in the RHPA and its *Code*. Consistent with the public policy objective of zero tolerance, an actual case will be explored in which a physician’s certificate was suspended, rather than revoked, notwithstanding the finding that he engaged in serious sexual abuse of a person he had recently assessed for mental health issues in a hospital context.¹

The analysis of this case, here in Appendix G, helps to demonstrate the gaps in the *Code* which have, at least in part, hampered the fulfillment of the public policy objective of zero tolerance under Ontario’s current regulated health system.

Although substantially different applications of the RHPA result, for the purpose of this illustration, the findings of fact made by the Discipline Panel have been adopted in full.

Findings Of The Discipline Committee Of The CPSO

The material findings for purposes of this illustration, as made by the Discipline Committee (Committee) of the CPSO in *College of Physicians and Surgeons of Ontario v Redhead*, 2013 ONCPSD 18 (CanLII) (written reasons released on May 15, 2013), were as follows:

1. The Complainant lived in the same town as Dr. Redhead all of her life.
- 2.

3. Her family doctor, who was in the same medical office as Dr. Redhead, was sexually abusing her. (This misconduct was the subject of a separate discipline proceeding resulting in the family physician losing his license pursuant to section 51(5) of the *Health Professions Procedural Code*.)²
4. This same family doctor facilitated an introduction of the Complainant to Dr. Redhead for potential sexual contact, to the knowledge of Dr. Redhead.
5. Dr. Redhead admitted that he treated the Complainant on several occasions in November and December 2006 when he was on call for the emergency department of the local hospital.
6. November 11, 2006 was the first time that Dr. Redhead had professional contact with the Complainant. This contact was by telephone when the Complainant was admitted to the emergency department . As a result of this telephone consultation, Dr. Redhead ordered medication for the Complainant

. The Complainant was then discharged from the emergency department on the same date.

7. The second time Dr. Redhead had professional contact with the Complainant was on November 12, 2006 again in the emergency department. Dr. Redhead asked the Complainant and her aunt to pick up Chinese food for him, which they did. He then conducted an assessment of the complainant

. The Complainant was then discharged from the hospital.

8. The third professional contact occurred later in the evening of November 12, 2006. Dr. Redhead admitted the Complainant to the care of her family doctor. Dr. Redhead assessed the Complainant

. On this occasion, Dr. Redhead spent 30 minutes assessing the Complainant.

9. The complainant remained in the hospital until November 27, 2006. The medical records indicated that Dr. Redhead was officially charged with the complainant's care on November 24 in the absence of her family doctor, though he did not see her again during the course of this hospital admission.

10. The fourth professional contact with the Complainant was in person on December 27, 2006. The Complainant was admitted

. Dr. Redhead assessed the Complainant in the evening. Following the assessment, Dr. Redhead ordered medication for the Complainant and she was discharged home later that evening.

11. The fifth professional contact with the Complainant was on December 28, 2006. The Complainant was admitted to hospital after being seen by Dr. Redhead in the emergency department. Dr. Redhead sent her home to get her things and then she was admitted as an in-patient approximately 2 hours later to the hospital. The emergency department record for this admission indicates that Dr. Redhead dictated notes of the history which the Complainant provided, as well as of her physical examination of her at that time.

12. The sixth professional contact with the Complainant was on December 29, 2006, at the hospital. Dr. Redhead made a note of the complainant's behaviour in the hospital chart.

13. On December 30, 2006, Dr. Redhead wrote an order for the Complainant's medication to be decreased in the hospital. Specifically, he made a note to decrease the complainant's

14. Dr. Redhead was in a doctor-patient relationship with the Complainant during the course of her hospital admissions between November and December 2006.

15. A finding of credibility was made against Dr. Redhead on the issue of his claim that he did not realize he had treated the complainant, when he committed the impugned sexual acts.

16. Dr. Redhead saw the Complainant in January 2007, approximately 2 weeks after providing a assessment of her and having engaged in "significant therapeutic interventions" with her in the hospital, and recognized her as having been the patient from the hospital.

17. Dr. Redhead had assessed the complainant at the hospital for, amongst other things, .
18. The sexualized conduct by Dr. Redhead ended about 3 months after it started, as a result of Dr. Redhead's wife learning of it. Implicit in this finding was the fact that Dr. Redhead unilaterally ended the sexual relationship.
19. The Committee found that the Complainant was easily manipulated and that Dr. Redhead attempted to deflect blame from himself onto the Complainant after his wife discovered the impugned sexual acts.
20. The family doctor coerced the Complainant to writing a letter to the College drafted by the family doctor, falsely denying that she and he had been in a sexual relationship. The Committee relied on this event as evidence of the Complainant's vulnerability to her doctor.
21. Dr. Redhead may have engaged in sexual intercourse with the Complainant during the same period as he provided, free of charge, medication, , and money. In any event, the Committee found it was immaterial whether the was provided during the same time as the sex acts or two weeks after the sex acts stopped. [p. 27]
22. The Committee found that Dr. Redhead was aware of the Complainant's vulnerabilities and was having problems emotionally coping with her life at the outset of the impugned sex acts.
23. The Committee found that Dr. Redhead's relationship with the Complainant "was not a relationship between peers. The giving of gifts by Dr. Redhead to someone who he knew had such problems, served only to deepen her dependence on him and thus exploited her vulnerability and augmented the power imbalance between them."
24. In its Decision and Reasons on Penalty, the Discipline Committee found that the Complainant was treated by Dr. Redhead

Dr. Redhead's five attendances on [the Complainant] within a short period of time included **significant exploration of her** circumstances. Dr. Redhead twice admitted her to hospital, attended her there, and repeatedly assessed her . Although his care for her was not continuous and other physicians were involved in it, **Dr.**

Redhead engaged in significant therapeutic interventions with [the Complainant].” [emphasis added]

25. The Committee ordered Dr. Redhead to appear before the panel to be reprimanded, directed the registrar to suspend his certificate of registration for a period of 5 months, required Dr. Redhead, at his own expense to successfully complete College facilitated instruction in professionalism/ethics and ordered Dr. Redhead to pay reduced costs to the College in the sum of \$25,000 reflecting what the Committee characterized as divided success as the College was unsuccessful in proving “sexual abuse”. The Committee found instead that Dr. Redhead committed conduct which was disgraceful, dishonourable and unprofessional, which, accordingly, did not attract mandatory revocation of his licence in light of its finding that the Complainant was not a “patient” at the time of the serious sex acts committed by Dr. Redhead against her.

Analysis: Zero Tolerance Not Implemented

1. The starting point of the Committee’s analysis was its observation that, as there is no definition of “patient” in the *Health Professions Procedural Code*, “it is up to the Committee to apply its expertise in considering all the facts and circumstances in order to determine whether a complainant who was having a sexual “relationship” was also a patient of the health care professional.”
2. The Committee found that the Complainant was not Dr. Redhead’s patient at the time of the impugned sexual acts because Dr. Redhead had ostensibly not provided any medical treatment at a time concurrent with the sexual acts. The provision of _____, following the hospital admissions, were considered by the Committee to be in the nature of incidental treatment whether or not they were provided during the time Dr. Redhead was having sex with the Complainant, ostensibly as that term was used by the Court of Appeal in *Leering*,³ since the provision of this medication was deemed by the Committee to be “minor in nature or casual” within the context of the impugned sexual acts.
3. However, the Committee adopted a narrow interpretation of “incidental”. The Court of Appeal, in *Leering*, was examining the concept of minor or isolated emergency medical treatment of a spouse in the context of a pre-existing spousal relationship. In the

Redhead case, the provision of an _____ flowed from a clear doctor/patient treatment relationship which commenced at the hospital. In fact, it was Dr. Redhead who prescribed Efflexor to the Complainant while treating her at the hospital. In any event, the Complainant was not Dr. Redhead's spouse. Indeed, there was no pre-existing (personal) relationship between Dr. Redhead and the Complainant prior to her admissions to the hospital.

4. Furthermore, by providing medication to the Complainant, which medication was a necessary component of her medical treatment arising from the hospitalizations, Dr. Redhead extended his doctor-patient treating relationship with the Complainant concurrent with the impugned sexual acts. This fact alone was enough to bring the case squarely within the scope of section 51(5) of the *Code*, attracting mandatory revocation of his licence to practice medicine. The fact that Dr. Redhead provided the medication free of charge, during the same time as his sexualized behaviours with the Complainant makes the doctor/patient relationship even more insidious and reminiscent of the Supreme Court of Canada's landmark doctor/patient (exchange of drugs for sex) sexual abuse case of *Norberg v. Wynrib* [[1992] 2 SCR 226] in which the Supreme Court of Canada found that a patient could not consent to sex with her doctor where that sex was in exchange for drugs to feed her addiction.
5. In addition, the Committee did not take into consideration the nature of the pre-existing doctor-patient relationship but rather focused, apparently exclusively, on the duration Dr. Redhead's ostensible formal medical treatment of the Complainant. In doing so, the Committee failed to
 - a) address the nature of the power and authority that a doctor has over his patient, as is implicit in the status-based fiduciary relationship which exists between doctors and their patients (imposing a strict duty of loyalty on the physician to not engage in activity which will harm the patient, in favour of his own sexual gratification interests),
 - b) acknowledge the importance of the impact of such sex acts by doctors on the public trust and integrity of the health care profession, and
 - c) recognize the ongoing coercive influence a doctor can have on a vulnerable patient, even after the formal "termination" of the doctor/patient relationship.

6. The Committee also apparently placed little weight on the College of Physician and Surgeon's own policy, entitled *Physician-Patient "Dating"* (1992) (the "Policy") which was in place at the time of the impugned sex acts. This policy stipulates that, in general, physicians should not have any sexualized form of contact with a former patient for a period of one year following the date of the last professional contact with the patient, even if the physician has formally terminated the professional relationship. The Policy further stipulates that in some instances, it may *never* be appropriate for a post termination sexual relationship to develop, but that, on the other hand, it may sometimes be unnecessary to wait for one year before a sexual relationship can develop, for example, in the case of an emergency room physician who has treated a patient on one occasion. Implicit in this Policy is the recognition by the College of Physicians and Surgeons of Ontario that a doctor can have a coercive influence and ongoing effective authority over a former patient. The Committee reasoned that the Policy was only a guideline and its application would depend on the particular circumstances of the physician/patient relationship. The Committee did not provide any analysis on the likely ongoing authority and influence Dr. Redhead exercised over the Complainant by virtue of his position as not only a doctor, but as the Complainant's doctor over the course of her various hospitalizations for assessment and treatment.
7. The Committee failed to recognize that the "significant therapeutic intervention" by Dr. Redhead was a hospital/institutionalized setting in which the Complainant was particularly vulnerable and emotionally fragile and dependent upon for her emergency psychiatric in-patient care. By analogy to the Committee's decision, would sexual acts committed by a health professional within weeks following the release of a patient from a short term admission in a residential health care facility (like an addictions centre) also fall short of sexual abuse of a patient thereby attracting a lesser penalty than mandatory revocation under the Code? Is this consistent with the zero tolerance public policy objective enshrined by the Legislature in the *Code*? The answer is an emphatic "no".
8. Various courts and tribunals, along with the medical profession, have recognized that the power and authority held by a health professional over a patient, particularly one engaged in psychotherapeutic treatment, continues to survive past the formal termination of a patient relationship. This is consistent with the fiduciary nature of

the health professional/patient relationship. For example, in *Re Seitz*, 2002 CanLII 49662 (Manitoba College of Physicians and Surgeons), the Committee found as follows:

“The physician/patient relationship is a fiduciary relationship. It is based on trust. The patient reposes trust and confidence in the physician and the physician assumes responsibility for the relationship because the physician holds the more powerful position in the relationship. The physician is obligated to act in the best interests of the patient and to use the therapeutic relationship to further those interests. Not be used to further the physician’s own interests.

It is not acceptable to terminate a physician/patient relationship with the intent of engaging in a sexual relationship. The physician’s ethical obligation not to exploit the physician/patient relationship for the physician’s personal advantage applies whenever a physician considers a termination of the physician/patient relationship to pursue a personal relationship. Where a physician/patient relationship is terminated with the intent of entering a personal relationship, the physician is accountable for any exploitation.”

9. The Ontario Court of Appeal in *R v. Matheson* (1999 CanLII 3719) upheld the criminal conviction of a psychologist who had sexual intercourse with 2 patients. In the context of that decision, the Court of Appeal cited various passages from the Supreme Court of Canada’s landmark decision in *Norberg v Wynrib* including the following passage (from McLachlin J., as she then was):

“I think it readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship — trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests.”

10. The Court of Appeal in *R v. Matheson* also cited *R. v Audet*⁴ [1996] 2 SCR 171, 1996 CanLII 198 (SCC) by analogy. In *Audet*, a teacher sexually assaulted a former student. In setting aside the acquittal and entering a conviction, the Supreme Court of Canada recognized that the accused’s position of authority as a teacher survived the termination of the teacher/student relationship, and thus any ostensible consent was vitiated/negated by virtue of the finding

that the teacher coerced consent through the improper exercise of his authority as the student's former teacher. In *Audet* the Supreme Court of Canada found that in the vast majority of cases a teacher has authority over students because of the important role which society has entrusted in them to discharge. This finding easily applies, by analogy, to the important societal role vested in its health professionals over patients, and therefore, by analogy, over former patients.

11. In *Mussani v. College of Physicians and Surgeons of Ontario* 2004 CanLII 48653, the Ontario Court of Appeal, relying on the Final Report of the Task Force on Sexual Abuse of Patients, commissioned by The College of Physicians and Surgeons of Ontario (1991 Task Force Report) and the subsequent adoption of the zero tolerance policy reflected in the RHPA and the Code, stated the following:

“The Task Force found ample evidence that sexual abuse by physicians was a serious societal problem....Its recommendations for zero tolerance and mandatory revocation were founded upon a number of important findings and factors. Principal among these were the following:

- a) the general vulnerability of patients in such relationships;
- b) the power imbalance that almost invariably exists in favor of the practitioner, thus facilitating easy invasion of the patient's sexual boundaries;
- c) the privileged position of doctors in society, based on their education, status and access to resources;
- d) the breach of trust entailed in such conduct by physicians;
- e) the serious, long-term injury to the victim, both physical and emotional, that results from the sexual abuse, including the harmful effects on future care caused by the victim's inability to place her trust in other doctors and caregivers;
- f) that sexual abuse tarnishes public trust in the entire profession;
- g) the results of an historical review by the Task Force of sanctioning decisions by the College's discipline committee and the Divisional Court, which demonstrated a leniency that reflected “a profound non-appreciation of the harm done to victims”; and,
- h) the significant risk of recidivism by abusers, enhanced effectiveness of rehabilitation measures and previous

restrictions on doctor's practices in providing protection against the re-occurrence of abuse." [para 20-22]

12. In *Norberg v Wynrib*, [1992] McLachlin J. (as she then was), recognized that the hallmarks of a fiduciary relationship exist in doctor/patient relationships, and that a doctor's fiduciary duty to act in the best health related interests of his patient, and to avoid preferring his own sexual gratification interests over the interests of his patient, is paramount. McLachlin J. also cited with approval extensively from the 1991 Task Force Report in the course of her analysis. McLachlin J. found:

Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires. [p. 272]⁵

13. In short, the discipline committee failed to recognize the inherently fiduciary character of Dr. Redhead arising presumptively by virtue of his status as a doctor in relation to the Complainant. The discipline committee thereby failed to recognize the ongoing authority and influence which Dr. Redhead exercised over the Complainant, subsequent to the technical termination of the doctor/patient relationship, continuing to give medication to the Complainant enhanced his influence as a doctor beyond the Complainant's hospitalization.

14. The findings of fact of the discipline committee, when applied to the existing jurisprudence, and the significant body of clinical literature including the well-known phenomenon of transference, supported a conclusion that the significant power, authority, influence and trust vested in a physician/patient relationship persists beyond the formal termination of medical treatment. The admitted sexual abuse of the Complainant constituted an abuse of the power and authority over the Complainant which Dr. Redhead gained when the Complainant was in the hospital and under his medical care. Dr. Redhead used his knowledge of the Complainant's vulnerabilities to his advantage in procuring sexual acts for his personal pleasure which were not in the Complainant's best health related interests.

15. In this review, it is the opinion of the task force that, based on the accepted findings of fact in this case by the CPSO discipline committee, the acts of sexual exploitation to which the doctor admitted can be found in the mandatory revocation section of the

RHPA *Code* and it was open to the committee to use its discretion to find that a sufficient patient/physician relationship existed as to bring this case within the mandatory revocation provisions of the law. A finding that Dr. Redhead committed sexual abuse against his former patient, resulting in the mandatory revocation of his certificate (rather than a 5 month suspension), would have upheld the zero tolerance policy reflected by the *Regulated Health Professions Act* and the *Code*, carried out the College's mandate of protection of the public, and enhanced patient safety from sexual abuse by physicians and other health professionals. It would also have preserved the integrity of the health profession and the public trust inherent in the privilege of self-regulation.

Endnotes

1. See *Ontario (College of Physicians and Surgeons of Ontario) v. Redhead, C. A.*, 2013 ONCPSD 18 (CanLII).
- 2.
3. *Leering v. College of Chiropractors of Ontario*, 2010 ONCA 87, 98 O.R. (3d) 561.
4. *R. v Audet* [1996] 2 SCR 171, 1996 CanLII 198 (SCC).
5. *Norberg v. Wynrib*, [1992] 2 SCR 226, 1992 CanLII 65 (SCC), retrieved from <https://www.canlii.org/en/ca/scc/doc/1992/1992canlii65/1992canlii65.html>.

Appendix H: Samples of Media Coverage, December 2014–December 2015

Date	Title	Publication	Author	Link
December 16, 2014	Protecting the Safety and Well-Being of Ontario Patients: Province to Conduct Review of Regulated Health Professions Act, 1991	Ontario Newsroom	Ministry of Health and Long-Term Care	http://news.ontario.ca/mohltc/en/2014/12/protecting-the-safety-and-well-being-of-ontario-patients.html
December 16, 2014	New Minister's Task Force to Review Legislation to Prevent Sexual Abuse of Patients	Ontario Newsroom	Ministry of Health and Long-Term Care	http://news.ontario.ca/mohltc/en/2014/12/new-ministers-task-force-to-review-legislation-to-prevent-sexual-abuse-of-patients.html
January 14, 2015	Ontario Is Re-examining the Law that Allows Doctors to Practice After Sexually Assaulting Their Patients	Vice	Emma Paling	http://www.vice.com/en_ca/read/ontario-is-re-examining-the-law-that-allows-doctors-to-practice-after-sexually-assaulting-their-patients-273
January 22, 2015	Ex-Sick Kids doc loses licence over misconduct including sexual impropriety	Toronto Sun	Michele Mandel	http://www.torontosun.com/2015/01/22/ex-sick-kids-doc-loses-licence-over-misconduct-including-sexual-impropriety
January 26, 2015	Allegations of sexual assault dropped against Hamilton psychiatrist	Toronto Star	Laura Armstrong	http://www.thestar.com/life/health_wellness/2015/01/26/allegations-of-sexual-assault-dropped-against-hamilton-psychiatrist.html
February 2, 2015	College of Physicians spreads word about doctor misconduct—just not to police	Toronto Star	Laura Armstrong	http://www.thestar.com/life/health_wellness/2015/02/02/college-of-physicians-spreads-word-about-doctor-misconduct-just-not-to-police.html

Date	Title	Publication	Author	Link
February 19, 2015	Dr. Mohamed Salih Izzeldin faces five sex assault counts	London Free Press	Randy Richmond	http://www.lfpress.com/2015/02/19/dr-mohamed-salih-izzeldin-faces-five-sex-assault-counts
February 27, 2015	Windsor doctor charged with sexual assault	Windsor Star	Trevor Wilhelm	http://blogs.windsorstar.com/news/windsor-doctor-charged-with-sexual-assault
February 28, 2015	'Backroom deals' keep problem MDs out of the public eye	Toronto Star	Theresa Boyle	http://www.thestar.com/news/gta/2015/02/28/backroom-deals-keep-problem-mds-out-of-the-public-eye.html
March 30, 2015	Anger of doctor's sex-assault victim shows through at latest hearing: Porter	Toronto Star	Catherine Porter	http://www.thestar.com/news/world/2015/03/30/anger-of-doctors-sex-assault-victim-shows-through-at-latest-hearing-porter.html
April 9, 2015	Plastic surgeon invokes Charter in appealing sexual abuse ruling	OurWindsor.ca	Jacques Gallant	http://www.ourwindsor.ca/news-story/5548819-plastic-surgeon-invokes-charter-in-appealing-sexual-abuse-ruling/
April 13, 2015	College of Physicians slow to censure silent bystanders: Porter	Toronto Star	Catherine Porter	http://www.thestar.com/news/world/2015/04/13/college-of-physicians-slow-to-censure-silent-bystanders-porter.html
April 14, 2015	MD gets revoked license back after court ruling on sex-assault case	Toronto Star	Laura Armstrong	http://www.thestar.com/news/gta/2015/04/14/md-gets-revoked-licence-back-after-court-ruling-on-sex-assault-case.html
April 15, 2015	Cobourg chiropractor loses licence	Northumberland Today	Cecilia Nasmith	http://www.northumberlandtoday.com/2015/04/15/cobourg-chiropractor-loses-licence
April 17, 2015	No legal representation for victims of assault by Ontario doctors	Toronto Star	Catherine Porter	http://www.thestar.com/news/insight/2015/04/17/no-legal-representation-for-victims-of-assault-by-ontario-doctors.html
May 4, 2015	Burlington doctor admits to sexual abuse	Toronto Star	Marco Chown Oved	http://www.thestar.com/news/gta/2015/05/04/burlington-doctor-admits-to-sexual-abuse.html

Date	Title	Publication	Author	Link
May 7, 2015	Doctor's license revoked for sleeping with 3 patients	Toronto Star	Marco Chown Oved	http://www.thestar.com/news/gta/2015/05/07/doctors-licence-revoked-for-sleeping-with-3-patients.html
May 11, 2015	Windsor psychiatrist Ravi Shenava faces more patient allegations of sexual assault	Windsor Star	Sarah Sacheli	http://blogs.windsorstar.com/news/windsor-psychiatrist-ravi-shenava-faces-more-patient-allegations-of-sexual-assault
May 12, 2015	Consent merits more talk	London Free Press	Jonathan Sher	http://www.lfpress.com/2015/05/12/consent-merits-more-talk
May 28, 2015	Western University doctor abused sex assault victim, says Ontario College of Physicians and Surgeons	London Free Press	Jonathan Sher	http://www.lfpress.com/2015/05/28/md-abused-sex-assault-victim-says-regulator
June 2, 2015	Physicians' watchdog loosens reins on secrecy	Toronto Star	Theresa Boyle	http://www.pressreader.com/canada/toronto-star/20150602/281479275022003/TextView
June 2, 2015	Sex assault hearings a surreal merry-go-round: Porter	Toronto Star	Catherine Porter	http://www.thestar.com/life/health_wellness/2015/06/02/sex-assault-hearings-a-surreal-merry-go-round-porter.html
June 3, 2015	The Spectator's View: College of physicians opts for transparency	Hamilton Spectator	Howard Elliott	http://www.thespec.com/opinion-story/5657003-the-spectator-s-view-college-of-physicians-opts-for-transparency/
June 3, 2015	Complaint of sexual nature against doctor revived—again	Toronto Star	Jacques Gallant	http://www.thestar.com/news/gta/2015/06/03/complaint-of-sexual-nature-against-doctor-revived-again.html
June 4, 2015	College of Physicians and Surgeons of Ontario charges Dr. Douglas Brooks of professional misconduct	Sault Star	Jeffrey Ougler	http://www.saultstar.com/2015/06/04/college-of-physician-and-surgeons-of-ontario-charges-dr-douglas-brooks-of-professional-misconduct
July 16, 2015	Doctors group will pay unlimited funds to fight sex abuse claims	CBC News	Robert Jones	http://www.cbc.ca/news/canada/new-brunswick/doctors-group-will-pay-unlimited-funds-to-fight-sex-abuse-claims-1.3154324

Date	Title	Publication	Author	Link
July 20, 2015	Toronto doctor found guilty of sex abuse of four patients	Toronto Star	Jacques Gallant	http://www.thestar.com/news/gta/2015/07/20/toronto-doctor-found-guilty-of-sex-abuse-of-four-patients.html
July 23, 2015	Patients come first	Toronto Star		
September 22, 2015	Barrie dermatologist being investigated by college	The Barrie Examiner	Cheryl Browne	http://www.thebarrieexaminer.com/2015/09/22/barrie-dermatologist-being-investigated-by-college
October 4, 2015	Sex consensual but pharmacist's licence loss ruled constitutional	The Hamilton Spectator	Colin Perkel	http://www.thespec.com/news-story/5930031-sex-consensual-but-pharmacist-s-licence-loss-ruled-constitutional/
October 5, 2015	Area doctor sexually abused four female patient, College of Physicians and Surgeons finds	Ottawa Citizen	Don Butler	http://ottawacitizen.com/news/local-news/area-doctor-sexually-abused-four-female-patients-college-of-physicians-and-surgeons-finds
October 6, 2015	College of physicians and surgeons shares information with police about MDs' alleged criminal acts	Ottawa Citizen	Don Butler	http://ottawacitizen.com/news/local-news/college-of-physicians-and-surgeons-forwarding-discipline-decisions-to-police
October 6, 2015	Doc fondled me at Sick Kids in '60s, woman tells trial	Toronto Sun	Sam Pazzano	http://www.torontosun.com/2015/10/06/doc-fondled-me-at-sick-kids-woman-tells-trial
October 21, 2015	Ottawa doctor who sexually abused patients barred from seeing female clients alone: College	National Post	Don Butler	http://news.nationalpost.com/news/canada/ottawa-doctor-who-sexually-abused-patients-barrd-from-seeing-female-clients-alone-college
October 21, 2015	Government body revokes licence of area doctor who sexually abused four patients	Ottawa Citizen	Don Butler	http://ottawacitizen.com/news/local-news/government-body-revokes-licence-of-doctors-who-sexually-abused-patients
October 29, 2015	Eye doctor receives public reprimand	The Kingston Whig-Standard	Steph Crosier	http://www.thewhig.com/2015/10/29/eye-doctor-receives-public-reprimand

Date	Title	Publication	Author	Link
November 12, 2015	Health practitioner faces sex rap	The Toronto Sun		
November 18, 2015	Doc denies allegations dermatologist faces lose of licence and sexual assault charges	The Barrie Examiner		
November 25, 2015	Disciplinary hearing on hold for doctor	The Barrie Examiner		
November 28, 2015	The high cost of OB/GYN mistakes in Ontario	Toronto Star	Robert Cribb, Theresa Boyle, Emma Jarratt Harriet	http://www.thestar.com/news/canada/2015/11/28/the-high-cost-of-obgyn-mistakes-in-ontario.html
November 30, 2015	Psychiatrist's decades of sex transgressions over	Toronto Star	Tara Deschamps	http://www.thestar.com/news/gta/2015/11/30/psychiatrists-decades-of-sex-transgressions-over.html
December 2, 2015	London doc finally loses licence	London Free Press	Jane Sims	http://www.lfpress.com/2015/12/02/london-doc-finally-loses-licence
December 9, 2015	Unlicensed therapist found guilty	Daily Observer (Pembroke)		

Appendix I:

Acronyms

ACE: Advocacy Centre for the Elderly

CLEO: Community Legal Education Ontario

CMPA: Canadian Medical Protective Association

CNO: College of Nurses of Ontario

COFM: Council of Ontario Faculties of Medicine

CPO: College of Psychologists of Ontario

CPSO: College of Physicians and Surgeons of Ontario

CSO: Civil society organizations

COU: Council of Ontario Universities

ECFAA: *Excellent Care for All Act*

ED: Emergency department

EFPO: Education of Future Physicians of Ontario

HCP: Health care professional

HPARB: Health Professions Appeal and Review Board

HPLR: Health Professions Legislation Review (Ontario)

HPRAC: Health Professions Regulatory Advisory Council

ICRC: Inquiries, Complaints and Reports Committee

LAO: Legal Aid Ontario

LEAF: Women's Legal Education and Action Fund

METRAC: Metropolitan Action Committee on Violence Against Women and Children

MLPRP: Medical Liability Protection Reimbursement Program

MOHLTC: Ministry of Health and Long-Term Care

MOU: Memorandum of understanding

MTCU: Ministry of Training, Colleges and Universities

NGO: Non-governmental organization

OHIP: Ontario Health Insurance Plan

OCRCC: Ontario Coalition of Rape Crisis Centres

OHA: Ontario Hospital Association

OHIP: Ontario Health Insurance Plan

OMA: Ontario Medical Association

ONA: Ontario Nurses Association

OSAPPA: Ontario Safety and Patient Protection Authority

PAC: Public access centre

PGME: Post-graduate medical education

PRC: Patient relations committee

QIP: Quality Improvement Plan

QPSP: Quality and Patient Safety Plan

RCDSO: Royal College of Dental Surgeons of Ontario

RHPA: *Regulated Health Professions Act, 1991*

ROP: Required Organizational Practices

SA/DVTC: Sexual Assault/Domestic Violence Care and Treatment Centres

SANE: Sexual Assault Nurse Examiner

TDD: Telecommunications device for the deaf

UK: United Kingdom

UN: United Nations

WHO: World Health Organization

YWCA: Young Women's Christian Association

Appendix J: Table of Cases

Court Cases	
Case Citation	Chapter
<i>C (DC) v. Starzecki</i> , [1996] 2 W.W.R. 317 (Man. Q.B.)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>D.M.M. v. Pilo</i> , [1996] O.J. No. 938 (Gen. Div.)(Q.L.)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>Huet v. Lynch</i> , 184 DLR (4th) 658, 2000 ABCA 97 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>J.G. v. Tyhurst</i> (2003), 226 DLR (4th) 447, 2003 BCCA 224 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>JK v. Alfred</i> , [1996] O.J. No. 2461 (Gen. Div.)(Q.L.)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>Leering v. College of Chiropractors of Ontario</i> , 2010 ONCA 87, 98 O.R. (3d) 561	Appendix G: Re-Vision: Zero Tolerance Applied
<i>McInerney v MacDonald</i> , [1992] 2 SCR 138, 1992 CanLII 57 (SCC)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>Mussani v. College of Physicians & Surgeons (Ontario)</i> [2004] 74 OR (3d); 248 DLR (4th) 632 (Ontario Court of Appeal)	Chapter 1: Introduction and Recommendations
<i>Norberg v. Wynrib</i> , [1992] 2 SCR 226, [1991] SCJ No 107 (QL)	Chapter 1: Introduction and Recommendations
<i>Norberg v. Wynrib</i> , [1992] 2 SCR 226, 1991 CanLII 7424 (SCC).	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>R v. Audet</i> , [1996] 2 SCR 171, 1996 CanLII 198 (SCC)	Appendix G: Re-Vision: Zero Tolerance Applied
<i>R v. Doodnaught</i> , 2013 ONSC 8022 (CanLII)	Chapter 3: A Systemic Betrayal of Trust: Survivors Speak
<i>R v. Doodnaught</i> , 2014 ONSC 1196 (CanLII)	Chapter 3: A Systemic Betrayal of Trust: Survivors Speak
<i>R v. Litchfield</i> , [1993] 4 SCR 333, 1993 CanLII 44 (SCC)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>R v. Matheson</i> (1999), 44 OR (3d) 557, 1999 CanLII 3719 (ON CA).	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>Re Axelrod (In Bankruptcy)</i> (1994), 20 OR (3d) 133, 1994 CanLII 3446 (ON CA)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>Taylor v. McGillivray</i> (1993), 143 NBR (2d) 241, 1993 CanLII 6916 (NB QB)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>W (B) v. Mellor</i> , [1989] B.C.J. 1393 (S.C.)(Q.L.)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity

College Cases	
Case Citation	Chapter
College Cases	
<i>College of Nurses of Ontario v. Klein</i> , 2009 CanLII 92091 (ON CNO)	Chapter 1: Introduction and Recommendations
<i>College of Physicians & Surgeons (Ontario) v. Mussani</i> , 1999 ONCPSD 3 (CanLII);	Chapter 1: Introduction and Recommendations
<i>College of Physicians & Surgeons (Ontario) v. Mussani</i> , 2000 ONCPSD 22 (CanLII)	Chapter 1: Introduction and Recommendations
<i>College of Physicians and Surgeons of Ontario v. Carter</i> , 2012 ONCPSD 14 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons v. Gorman</i> , 2007 ONCPSD 6 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons of Ontario v. Gorman, R.</i> , 2013 ONCPSD 33 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons of Ontario v. Minnes, B. G.</i> , 2014 ONCPSD 27 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons of Ontario v. Mussani</i> (2004), 74 OR (3d) 1, 2004 CanLII 48653 (Ont CA)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons of Ontario v. Powell, G. W.</i> , 2014 ONCPSD 8 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons of Ontario v. Redhead</i> , 2013 CanLII 96591 (ON CPSD).	Chapter 4: The Why and How of Ontario's Zero Tolerance Standard; Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity; Appendix G: Re-Vision: Zero Tolerance Applied
<i>College of Physicians and Surgeons of Ontario v. Maharajh</i> 2013 ONCPSD 37 (ON CPSD)	Chapter 4: The Why and How of Ontario's Zero Tolerance Standard; Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons v. Peirovy</i> , 2015 ONCPSD 30 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons v. Redhead</i> , 2013 ONCPSD 18 (CanLII).	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons v. Schogt</i> , 2004 ONCPSD 16 (CanLII)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity
<i>College of Physicians and Surgeons of Ontario v. Tadros</i> , 2015 ONCPSD 27 (CanLii)	Chapter 5: Modernization of the <i>Regulated Health Professions Act, 1991</i> , for Health and Dignity

“ Prevention of sexual abuse is about education, education, education in all the regulated professions, for students and postgraduate students, plus continuous professional education, and — equally important — education to the public about what’s not acceptable, and where patients can go for help. ”

– Dr. Gail Robinson, medical advisor to the task force

“ Ontario’s faculties of medicine recognize the significant importance of the prevention of sexual abuse of patients and are fully engaged in delivering curricula that teaches and enforces professionalism. ”

– Ontario medical school deans to the Honourable Dr. Eric Hoskins, June 8, 2015

“ I have searched through my lecture notes and am unable to find the precise lecture during which we talked about sexual abuse, which I think speaks to how superficial and not memorable the discussion was. ”

– Ontario medical student

“ Aboriginal people are reporting a significant lack of trust in health care providers and the Ontario health care system. The increased negative health status and surrounding political and historical factors have led Aboriginal people to be especially vulnerable in their encounters with the system. ”

– Ontario Federation of Indigenous Friendship Centres

“ The LGBTQ community, especially immigrant and refugee and transgender community members, face further barriers of homophobia and lack of hospital staff trained in gender identity issues. They may fear reporting for being “outed” or fear other repercussions from family, community and legal systems. ”

– Advocate

Independent Report of the Minister’s Task Force on the Prevention of Sexual Abuse of Patients and the *Regulated Health Professions Act, 1991*

Marilou McPhedran (Chair), Sheila Macdonald (Member)