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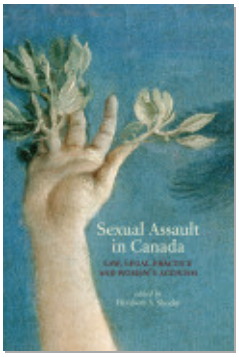


Published by

Sheehy, Elizabeth A.
Sexual Assault in Canada: Law, Legal Practice and Women's Activism.
University of Ottawa Press, 2012.
Project MUSE. https://dx.doi.org/10.1353/book.20786.

# 19.
# Zero Tolerance Some of the Time? Doctors and Sexual Abuse in Ontario

*Sanda Rodgers*

*Sanda Rodgers considers another form of resistance and backlash to sexual assault reforms — the disciplinary response of the College of Physicians and Surgeons to women's reports of sexual assault by doctors. While Susan Ehrlich discussed the subversion of sexual assault criminal law reforms through practices of trial discourse, Sanda's research shows how the disciplinary process, which is another avenue through which women can seek redress for sexual assault and which offers the potential to avoid the many aspects of the criminal process that complainants experience as punitive, has been captured by criminal law principles and practices. She highlights reliance on psychiatric "expertise" to pathologize women and to excuse perpetrators, echoing a theme introduced by Jane Doe and further problematized by Sunny Marriner. Sanda's analysis of "psychiatric therapy" imposed on doctors, usually as proposed by their own experts and supervised by their subordinates, illustrates the reification of psychiatric "expertise" over the safety of women patients.*

> [Confirming] the College's commitment to the safety of the public by affirming the philosophy of Zero Tolerance of sexual abuse, and in accordance with that philosophy, developing policies, procedures, practices, and education programmes that support it.
>
> — College of Physicians and Surgeons of Ontario, Council Motion, 27 May 1991

> 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.
>
> — *Regulated Health Professions Act,* Procedural Code 1993

In 1991, the College of Physicians and Surgeons of Ontario (CPSO) established a task force on the sexual exploitation of patients, and began

a systematic review of doctors' sexual abuse.[1] CPSO records revealed that the abuse of patients was well documented, and was not occasional or anomalous. However, little had been done by the CPSO to respond to the abuse and to offer protection to patients.

The 1991 task force found that the CPSO response to patient complaints of doctors' sexual abuse amounted to re-abuse of complainants. Penalties imposed on doctors were lenient. The doctors who staffed the discipline committees hearing the individual complaints over-identified with the accused physician. Minimal penalties were imposed and these were little more than a slap on the abuser's professional wrist. In those cases where the CPSO imposed significant penalties, Ontario courts regularly overturned these penalties, substituting lesser ones, and undermining the CPSO response to sexual abuse.[2]

In 1993, the Province of Ontario with the support of the CPSO, undertook major legislative reform, introducing changes to the *Regulated Health Professions Act*,[3] implementing zero tolerance of sexual abuse, and imposing mandatory license revocation as the penalty for the most serious cases of abuse.[4]

Prior legislation had defined professional misconduct to include sexual impropriety with a patient. However, the revised legislation included specific measures defining "sexual abuse," imposing a mandatory reporting obligation on all health care professionals to report

1 *The Final Report of the Task Force on Sexual Abuse of Patients* (Toronto: College of Physicians and Surgeons of Ontario, 1991).

2 *Ibid*. See also Paul Taylor, "4 Key Rulings Involving MDs Overruled Medical Body to Appeal Decision in Case Concerning Abuse of 3-year-old" *The Globe and Mail* (28 January 1991) A4.

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

4 For a more detailed review of the enactment of these provisions and their impact see: Sanda Rodgers, "Health Care Providers and Sexual Assault: Feminist Law Reform?" (1995) 8 CJWL 159; Sanda Rodgers, "Sexual Abuse by Health Care Professionals: The Failure of Reform in Ontario" (2004) 12 Health LJ 71. For a detailed study of the five-year assessment of the impact of the Ontario legislation and proposals for amendment, from which this article is drawn, see Sanda Rodgers, "Zero Tolerance Some of the Time? Doctors, Discipline and Sexual Abuse in Ontario" (2007) 15 Health LJ 353.

sexual abuse by other health care providers,[5] introducing specific penalties and restrictive licensing reinstatement provisions, and listing specific forms of sexual misconduct punishable by mandatory license revocation.

The most important reform was the mandatory revocation penalty imposed for sexual abuse of patients. License revocation was made mandatory for sexual intercourse; genital to genital, anal or oral contact; masturbation; or encouragement to masturbate in the presence of the professional. While *mandatory* revocation applied only to the listed acts, licence revocation could be imposed for other forms of sexual abuse. Under the new provisions, where a professional's license was revoked for sexual abuse of any kind, no application for reinstatement could be made for a minimum period of five years.

Fifteen years of experience with the zero tolerance provisions provides sufficient time to assess the impact of the 1993 reforms. How have the CPSO and the disciplinary processes responded to the objectives of the legislation? What has been the impact of the new provisions on disciplinary penalties? To determine the impact of the new provisions of the *Act* on CPSO proceedings, I have examined the decisions of the CPSO complaints and discipline committees concerning sexual abuse between 1994 and 2005. I have relied on two primary sources of information. The first is information provided by CPSO to PricewaterhouseCoopers as part of a statutorily mandated five-year review. The second is my own review of those post-1993 discipline decisions involving allegations of sexual abuse available on the CPSO website, whether in summary or complete form. In some cases, decisions that appeared in summary form are only available in full from other databases. Occasionally, I specifically refer to other sources. Where this is the case, the source of the information is noted here. While the information available from these sources is not coterminous, in each case it supported the same conclusions.

Regrettably, my review of the implementation of the 1993 zero tolerance provisions by the CPSO revealed widespread resistance, failure

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

to focus on public protection, and undermining of the zero tolerance provisions. This resistance primarily takes the form of a persistent and unacknowledged requirement that the complaint is independently corroborated, the disciplinary process gives advantage to the abusing doctor, and the defence relies on psychiatric "expertise" to pathologize the complainant and exculpate the offender. In addition, CPSO discipline decisions demonstrate narrow technical readings of the provisions of the *Act* and of CPSO guidelines, which undermine both the letter and the spirit of the legislative reforms.

Despite important legislative changes designed to ensure that sexual abuse is taken seriously and that those who transgress legislatively defined sexual boundaries are de-licensed, only 5.53 percent of cases involving allegations of sexual abuse between 1994 and 2005 ever reached the disciplinary stage. In those that did, there was an unacknowledged reliance on corroboration in the form of eye witnesses or multiple victims, replicating and reinforcing stereotypes of unreliable and retributive women complainants so often found in the response to male sexual violence.

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

Arguably, this resistance is neither deliberate nor intentional CPSO policy. Rather, it is the result of the very nature of the regulatory self-disciplinary process and of the fragmentation that occurs where each decision is understood to stand alone, rather than be considered as a part of a possible pattern. My purpose here is to identify those patterns. The CPSO must then take steps to address these patterns in order to return to its original commitment to the implementation of the 1993 reforms and the eradication of sexual abuse of patients.

## I. BARRIERS TO COMPLAINTS OF SEXUAL MISCONDUCT

The 1993 legislative reforms required that a complaint of sexual misconduct be received by the CPSO, investigated, and considered by the complaints committee and, should the complaints committee con-

sider it warranted, be forwarded to the discipline committee for a full adversarial hearing and the imposition of an appropriate penalty. Such penalties included both discretionary and mandatory license revocation.

There are two ways in which information concerning physician sexual misconduct can come to the attention of the CPSO. The first is through a mandatory report made by another health care professional. In fact, few members of the health professions comply with the mandatory reporting provisions. Between 1994 and 1998, there were 887 complaints by health care professionals of sexual misconduct by doctors.[6] As well, the CPSO admitted that it was unlikely that a mandatory report would be the basis for an investigation of a health care professional unless the name of the abused patient was provided. They also indicated that they did not use mandatory reports to track multiple complaints against a member, nor as similar fact evidence to trigger an investigation, nor to provide support for an existing complaint.[7]

The failure by the CPSO to use information obtained from mandatory reports is not the only barrier to effective implementation of the sexual misconduct provisions. The second source of sexual miscon-

6 PricewaterhouseCoopers, *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) [*PwC Report*]. The *PwC Report* was twenty-seven volumes in length, with a specific report on the performance of each of the health disciplines governed by the legislation. These numbers must be assessed taking into account under-reporting. See Table 2: Statistical Summary: Complaints and Mandatory Reports.

7 *PwC Report,* vol 6, *ibid* at 16. It should be noted that section 75 of the *Act* allows for an investigation where a mandatory report has been received. See also s 85.11 (2)(2)(1). See the recommendations of the Health Professions Regulatory Advisory Council, with regard to obtaining the patient's consent to disclose her identity and recommending that an investigation be undertaken where the registrar has reasonable and probable grounds to believe the member has abused a patient. Health Professions Regulatory Advisory Council, *Final Report to the Minister of Health and Long-term Care: Effectiveness of Colleges Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature* (Toronto: Ministry of Health, 2000), Health Professions Regulatory Advisory Council, online: <http://www.hprac.org/en/reports/resources/ComplaintsDiscipline_1996.pdf>, [*HPRAC Report*]. Contrast this to the recommendations of the Special task force on Sexual Abuse of Patients, *What About Accountability to the Patient?: Final Report of the Special task force on Sexual Abuse of Patients*, Chair: Marilou McPhredran (Toronto: College of Physicians and Surgeons of Ontario, 2000) [*2000 Report*] that mandatory reports should trigger an investigation where there is a reasonable suspicion that there is a risk of harm to patients *or upon two reports* [emphasis added] (at 39–40).

duct complaints are members of the public.[8] Between 1994 and 2001, the CPSO received 13,000 complaints of physician misconduct of all kinds, including sexual misconduct.[9] CPSO reported that 99 percent of these complaints were dismissed or were resolved internally without proceeding to a disciplinary hearing.[10]

Many obstacles impede an individual patient from personally filing a complaint of physician sexual misconduct. These include individual feelings of denial, complicity, shame, self-doubt, trauma, and loss, as well as a concern that the institution will favour its own members. These barriers suggest that those patients who do file complaints are only a small percentage of those who have been abused. The CPSO reported that between 1993 and 1998, 448 independent individual complaints of sexual abuse were filed with the college.[11] Of these, 213 were

8 It should be noted that those most likely to be abused may be the least likely to report abuse. "Immigrants, non-English speaking persons, the physically and mentally challenged, persons with life threatening illnesses, and persons in counselling and psychotherapeutic relationships are more likely to be reluctant or challenged in their ability to make a complaint against a health professional": *HPRAC Report, ibid* at 3. See also *2000 Report, ibid* at xii. The *Act* requires a formal complaint [s 25(4)]. A few of the colleges assist complainants by travelling to their homes, directing the complainant to resources for emotional support, or offering information in more than one language. Only the College of Nurses engages in outreach to the public or to at-risk or vulnerable groups. Three complainants indicated that the College of Physicians and Surgeons failed to support their special needs so that they could participate in the disciplinary process. These included a developmentally delayed complainant and two complainants who required financial assistance in order to attend the discipline committee hearing in Toronto: *2000 Report*, *ibid* at 17–18.

9 There are 28,000 members of the college in total.

10 Robert Cribb, Rita Daly & Laurie Monsebraaten, "How System Helps Shield Bad Doctors: College Admits Flaws in Process" *Toronto Star* (5 May 2001), online: <http://pqasb.pqarchiver.com/thestar/search.html>. Data calculated by the *Toronto Star* indicated that 111 doctors had been found guilty of incompetence or misconduct, including sexual misconduct, with only thirty-four losing their license to practice. Of the 141 that proceeded to a hearing between 1994 and 2001, seventy-seven concerned sexual misconduct, nineteen concerned patient death, and ten concerned psychological harm. It is difficult to reconcile this data with data generated by PwC. However, the years surveyed by PwC were 1994–1998. The *Star* data includes 1994–2001. Most recent data from the CPSO indicates that, in 2005, seventy-three of the complaints received by the complaints committee, including sexual abuse complaints, resulted in no action: CPSO, *Annual Report*, (Toronto: College of Physicians and Surgeons of Ontario, 2005) at 10 [*Annual Report*].

11 These are complaints against individual doctors. There may be multiple complainants. In 2005, there were 705 complaints on all matters of professional competence and conduct, 73 percent resulted in no action. Four percent were forwarded to discipline: *Annual Report*, *ibid*.

never referred by CPSO staff to the complaints committee because of the withdrawal of the complaint, the resignation of the member, or a formal or informal alternative dispute resolution process.[12] Two hundred and forty-three[13] complaints were forwarded to the complaints committee. Of these, ninety-nine received no action by the committee; eighty doctors received a written caution; and fifty-one doctors received an oral caution.[14] Only sixty-one doctors, or 14 percent (61/448), were referred to the discipline committee for a disciplinary hearing.[15] Of these, twenty-three doctors, or 38 percent (23/61), were found guilty by the discipline committee.[16] Twenty-nine (29/61) were found not guilty and thirty-one cases were withdrawn.[17] Overall, only 5 percent (23/448) of defendant doctors who were the subject of complaints of sexual abuse went on to be found guilty by the discipline committee.[18] On appeal to the courts, six were abandoned, ten were upheld, and one appeal was allowed.[19]

Thus, added to the failure of professionals to meet their mandatory reporting obligations, and the failure of the CPSO to follow up on those reports when received, is a significant drop-off rate between the filing

12 There were 181 pre-complaint dispositions and 108 ratifications of a resolution otherwise achieved between the parties — the college and the doctor: *PwC Report*, vol 22, *supra* note 6 at 29.

13 These numbers are discrepant with those above. The discrepancy arises in the numbers provided by the CPSO to PwC and relied on by PwC in its report. For the first set of numbers, see *PwC Report*, *ibid* vol 6: Summary of Key Findings. For the second set of numbers, see vol. 22: Report on the College of Physicians and Surgeons of Ontario: *PwC Report*, *ibid*.

14 Four were the subject of ratification of a resolution reached through ADR; one of legal ratification; three were referred to the quality assurance committee; four were referred to the executive committee, and two are indicated as "other": PwC Report vol 22, *ibid* at 30. The complainant may appeal to the Health Professions Appeal and Review Board.

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

16 *Ibid* at table 3: Statistical Summary of Referrals to Discipline. The college reported to PwC that the caseload of the discipline committee grew exponentially following the changes in the legislation and that successful prosecutions decreased by 50 percent by the end of 1996.

17 *Ibid* at 31.

18 *HPRAC Report, supra* note 7 at 16.

19 *PwC Report*, vol 22, *supra* note 6 at 10.

of a complaint by an individual and any resolution on the merits by the discipline committee.[20] Overall, the percentage of mandatory reports plus individual complaints of sexual abuse referred to discipline was 5.53 percent of all complaints that the CPSO received.[21]

This is a significant level of attrition.[22] It likely understates the real problem. The reluctance to file, high withdrawal rates, and the negative consequences of filing experienced by complainants, combined with the failure to pursue mandatory complaints, creates significant fall off. When combined with the informal screening and dismissal of complaints that are filed, these all combine to result in few complaints being subjected to the disciplinary process. Despite the zero tolerance legislation, this situation has not improved.

## II. BARRIERS TO GETTING HEARD BY THE DISCIPLINE COMMITTEE

What accounts for the 47.5 percent (213/448) of all complaints that never make it to the complaints committee, and for the 74.9 percent (182/243) of those that never make it from the complaints committee to the discipline committee? The non-founding of these complaints is the

20 The complaints committee may refer a doctor subject to a complaint to the executive committee for incapacity, or to the discipline committee for misconduct or incompetence, or require a member to appear before it to be cautioned or to take any action that it considers appropriate and consistent with the *Act*. It may not refer a doctor to the quality assurance committee for behaviour or remarks considered sexual, but it may refer a member to attend a continuing education or remediation program (Bill 171, *Health System Improvements Act, 2007*, 2d Sess, 38th Leg, Ontario, 2007, Sch M, assented to 4 June 2007, SO 2007, C 10) [*Bill 171*]. It may also dismiss the complaint if it is "frivolous, vexatious, made in bad faith or otherwise an abuse of process" [s 26(4)]. Among Colleges with ten or more patient complaints and mandatory reports, the proportion of complaints referred to the discipline committee ranges from 3.9 percent to 29.7 percent: *HPRAC Report, supra* note 7 at 9.

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

22 In one case, described in the *2000 Report*, the College of Physicians and Surgeons determined not to proceed to discipline. The committee made the decision without having consulted an expert to assess the practice methodology of a young doctor who engaged in psychotherapy with a previously abused patient, then further abused her. Under the *Act,* a complainant may appeal the decision not to proceed to the Health Professions Appeal and Review Board [HPARB]. The complainant appealed, and the board ordered the college to proceed: *supra* note 7 at 43.) The task force reported that those who did appeal to the HPARB generally considered that the delays and treatment that they experienced were disrespectful and insensitive. There is also a significant backlog: *supra* note 7 at 36).

result of a number of factors, each disturbing in its own right.[23] The imposition of any screening process diverts sexual abuse cases.

The language of the *Act* indicates that it is the statutory obligation of the complaints committee to investigate any complaint formally received. In fact, a preliminary investigation usually is carried out by staff of the CPSO and not by the committee.[24] The CPSO reported that complaints regularly were "resolved" without ever having been referred to the complaints committee for investigation.[25] In addition, some of the drop-off is attributable to the use of informal dispute resolution processes to respond to complaints not forwarded to the complaints committee for investigation.[26]

Whether the investigation formally is carried out by the complaints committee as required by the legislation, or is carried out informally, the scope of the investigation is key. The CPSO admitted that investigatory standards that it had implemented specifically to assist the complainant after the 1993 amendments were abandoned in 1997. The motive for discarding complainant-friendly strategies was the per-

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

24 HPRAC recommended that the investigatory role of the complaints committee be transferred to the registrar with oversight maintained by the complaints committee. This would separate the investigatory role from the adjudicative role of the complaints committee, although somewhat diminishing the public oversight role played by the public member of each complaints committee (recommendations 20, 21). PwC reports that thirteen of the colleges conducted some level of investigation prior to referral to the complaints committee. The College of Physicians and Surgeons is one of these: *supra* note 6 at 15. See also Richard A Steinecke, *A Complete Guide to the Regulated Health Professions Act* (looseleaf), (Aurora, ON: Canada Law Book, 1995).

25 The college claims that no serious complaint of a sexual nature is resolved but that "investigators may resolve issues that concern inappropriate comments or misunderstanding about proper physical examinations": *supra* note 6 at 17–18.

26 *Supra* note 6 at 17. The CPSO used Alternative Dispute Reolution [ADR] to respond to four complaints, of which only two were resolved. This occurred despite the position of Dr Bienstock, then president of the college, that ADR was inappropriate for *any* matters of sexual misbehaviour. This was recently formalized by amendments to the *Act* that now stipulate that ADR may not be recommended in cases of sexual abuse: *Bill 171*, *supra* note 20 at s 25(1).

ception that they were responsible for difficulties in concluding successful disciplinary prosecutions.[27] These supportive mechanisms included the provision by the CPSO of an investigatory team of women with experience and commitment to issues of sexual abuse. This team was dismantled. In addition, investigators were advised no longer to act as support persons for the complainant. Nor was the complainant any longer allowed significant control of the process. In addition, allegations of sexual abuse that could be re-characterized as clinical deficiencies were transferred by the CPSO for clinical investigation.[28] As well, the policy on collection of complainants' medical records changed, with those records being collected regardless of the possible prejudice to the complainant.[29] Furthermore, the CPSO determined formally that complaints could be resolved prior to referral to the complaints committee, despite the fact that the language of the *Act* contains no such authorization.

The 86 percent fall-off rate for those cases that do reach the complaints committee but do not get referred on to disciplinary adjudication is equally disturbing. The test used by the committee in deciding whether to send a complaint forward to the discipline committee is of critical importance to the profession's response to sexual misconduct. The decision to send to discipline is assessed on a number of factors: whether the alleged conduct constitutes professional misconduct, whether it warrants a discipline hearing, and whether the CPSO has clear and convincing proof of professional misconduct.[30] This is

27 This change is confirmed by the remarks of Susan Vella: "Particularly in the past four to five years, the proverbial pendulum has swung back in favour of a tangible bias against patients: so much so that many lawyers, including myself, cannot recommend that patients ever go to the college": *2000 Report*, *supra* note 7 at 43.

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

29 The *2000 Report* recommended the use of a specially designated sexual abuse investigator, following the model used by the Canadian and Ontario Human Rights Commission. The *HPRAC Report* rejects the recommendation but makes alternative recommendations designed to increase the support available to the complainant: *supra* note 7 at 11–12.

30 *Matheson v College of Nurses of Ontario* (1979), 27 OR (2d) 632 at 638, 107 DLR (3d) 430 (Ont H Ct Just). The College of Nurses uses a two-pronged test: is there *prima facie* evidence of sufficient quantity and quality that would meet the burden of proof for a finding of professional misconduct or incompetence; is it a very serious matter for the college. The sufficient standard of proof is clear and cogent evidence. The *HPRAC Report* draws an analogy between the role of the complaints committee under current legislation and that of a preliminary inquiry judge. This inappropriate evidentiary burden was noted by the task force in 1991, and again in 2000: *supra* note

tantamount to a requirement for *prima facie* evidence. It sets up multiple barriers before any complaint is referred for a disciplinary hearing, including assessment of the admissibility of evidence, determination of the credibility of the complainant and other witnesses, and the appropriate burden of proof in disciplinary matters. This amounts to the making of determinations of admissibility,[31] credibility, and probity at the informal stage, even though they must again be assessed at the formal investigatory stage.

It is clear that in considering complaints of any kind, multiple levels of screening create opportunities for systemic bias to operate. They allow for stereotypical myths about the credibility of women and children in sexual abuse matters to inform the decision whether or not to send a complaint to discipline. Yet this reliance on myth will be completely undocumented and therefore not subject to scrutiny. A better and more purposive approach that balances public interest in combating sexual abuse with fairness to the accused could be achieved by presuming that the facts as claimed are capable of proof for the purposes of deciding to forward a complaint to the discipline committee. At the disciplinary stage, full procedural fairness is available and the accused's interests are fully protected. In effect, by screening out complaints at this early stage of the process, the CPSO has created a form of preliminary hearing not authorized by statute.

7 at 37. See also Sydney L Robins, *Protecting Our Students: A Review to Identify and Prevent Sexual Misconduct in Ontario Schools* (Toronto: Ministry of the Attorney General, 2000) at 225: "There are obvious and important distinctions between criminal and administrative proceedings. It should be remembered that, in some areas, special and more relaxed evidentiary and procedural rules apply to administrative proceedings…."

31 The test for admissibility of hearsay evidence, for example, is relevant. Arguably, the threshold test in administrative matters is governed by more flexibility than in criminal matters. The *2000 Report*, in recommendation 13.0, suggested section 49 of the *Act* be repealed and that evidentiary rules be governed by the *Statutory Powers Procedure Act*: *supra* note 7 at 40. See also Robins, *ibid* at 231–32:

> It is appropriate to apply a lower threshold of reality and necessity in civil and, most particularly, in administrative proceedings. This accords with the interests at stake in those proceedings…. In the context of hearsay statements by student complainants or witnesses in sexual misconduct cases, it also accords with the position advanced throughout this chapter that, in striking the balance between competing interests, the rights of children or sexual complainants may acquire equal or greater prominence, particularly where the adverse party cannot lay claim to a right to make full answer and defence arising out of a potential deprivation of liberty.

A second barrier arises from the quasi-criminal evidentiary standards applied by the complaints committee in deciding whether to send the file on to discipline. Determinations of credibility of the complainant and the accused are properly the role of the discipline committee. The task of the complaints committee should be limited to screening out obviously frivolous complaints. Even where a case is forwarded to the discipline committee for a hearing, a full hearing may never occur. If the doctor pleads guilty, or there is an agreed statement of facts, a full hearing likely never will take place.[32] Screening out complaints so that they never reach a disciplinary hearing evades the public interest in de-licensing the offender and in educating practitioners and members of the public.

## III. DISCIPLINE COMMITTEE DECISIONS 1993–2005

The CPSO has published the outcomes of the disciplinary hearings against 120 doctors[33] in sex misconduct cases decided after 1993. These fall into two categories. One group involves acts of misconduct that occurred prior to the amendments, but where the hearing occurred after 1993. In these, the 1993 new definition of sexual abuse and the mandatory license revocation provisions did not apply. While revocation was not mandatory, it could be imposed for serious professional misconduct. The second group involves acts of misconduct that occurred after the 1993 amendments came into force. In these, mandatory licence revocation was required for certain categories of sexual abuse. Both the pre- and post-1993 cases include acts of sexual misconduct that fall short of requiring license revocation. Each case decided after 1993 was heard by the discipline committee in an environment in which it was clear that sexual abuse was being taken seriously by the CPSO and by the province. My review of the post-1993 decisions of the discipline committee revealed a number of striking features, and suggests that the disciplinary hearings fall short of the achievements promised by the 1993 legislation.

### Requiring Corroboration

In the criminal law context, male-centred assumptions about women's

32 Jenny Manzer, "Is *Health Professions Act* All Bark and No Bite?" *Med Post* (14 May 2000) 36.

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

sexuality and morality and about male sexual entitlement have informed the criminal law on sexual assault. This has resulted in evidentiary rules unique to sexual assault offences. These include definitions of rape that require penile penetration, non-consent demonstrated by violent resistance, and rules regarding the doctrine of recent complaint. Among these, the rules regarding the need for corroboration have been the most longstanding, pernicious, and intractable, rendering past sexual history relevant to present consent or refusal, and insisting on warnings concerning the danger of convicting on the otherwise uncorroborated evidence of a woman or child. All of these have been the subject of political, legislative, and judicial reform and of backlash to reform.[34] Legislatures and courts have found them, variously, to be irrational, discriminatory, and unconstitutional. Too often, despite explicit legislative repeal or judicial direction that such requirements are no longer valid, reliance on these legal markers of resistance resurfaces in slightly altered forms. It is not surprising, therefore, to find their resurgence in the context of physicians' sexual misconduct. This is despite the strong legislative message of the 1993 amendments that sexual abuse by professionals would not be tolerated.[35]

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

It is clear that many complaints never formally make it to the complaints committee and, of those that do, only a few are forwarded to the discipline committee. The most striking feature of those that *are* for-

34 Sheila McIntyre *et al*, "Tracking and Resisting Backlash Against Equality Gains in Sexual Offence Law" (2000) 20 Can Woman Stud 72.

35 This was noted by the task force prior to the amendments to the legislation: "It would seem that tribunals are most likely to render a finding of not guilty (a) where a physician denies the conduct and offers evidence as to good character in the community; and (b) where there is a lack of corroboration for the complaint": *supra* note 7 at 186. It is entirely discouraging to find that this has not changed.

warded is the presence of independent corroboration of the complaint. The corollary is, of course, that in the absence of corroboration the cases do not come forward at all — either because they never make it to the complaints committee or because the complaints committee fails to forward them to discipline committee. Furthermore, the relatively high failure rate of the few cases that do go forward without corroboration demonstrates the persistent resistance to finding sexual abuse on women's uncorroborated evidence.

In the cases heard by the discipline committee, corroboration takes a number of forms. The most decisive comes from a successful criminal conviction, or a disciplinary finding against the physician in another jurisdiction.[36] In such cases, the existence of a formal finding of criminal responsibility or disciplinary penalty constitutes the grounds for misconduct, without the need for a full investigation or full disciplinary hearing. The most striking form of corroboration is through the admission by an accused that the complaint of sexual abuse is true. This may take the form of a voluntary resignation, a guilty plea, or an admission that the abuse occurred by way of an agreed statement of facts or consent order. A second group of cases includes both the physician's guilty plea and additional independent corroboration. The third group demonstrates corroboration alone.

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

## Forms of Corroboration

Of the 120 cases of doctors[37] disciplined for sexual misbehaviour that were decided between 1993 and 2005, thirty-seven were resolved by

36 Previously, summaries of the tribunal decisions individually referred to below could be found on the CPSO website under the heading *Summary of discipline committee Decisions*. More recently, the CPSO revamped its website requiring that each doctor's name be searched individually. Only doctors holding current registration are indexed, online: <http://www.cpso.on.ca/docsearch/default.aspx?id=2054>. See eg *Campbell* (2007); *Singh* (1991); *Verma* (2001).

37 Some doctors were the subject of multiple complaints.

the guilty plea of the accused. Twenty-four of the cases involved both a guilty plea and additional corroborative evidence. The remaining cases involved a not-guilty plea by the doctor.[38] Despite the denial of guilt, at least thirty of these cases showed clear corroborative evidence in direct contradiction with the not-guilty plea. The corroboration took the form of multiple complainants, criminal convictions, similar-fact evidence, or tangible evidence such as photos, phone calls, and hotel receipts.[39] In only sixteen of the cases that were forwarded to the discipline committee by the complaints committee between 1993 and 2005, in which a not-guilty plea was entered, was there no clear evidence of corroboration.[40] Thus of the 120 doctors whose cases were forwarded to the discipline committee, all but sixteen[41] came forward either with clear corroborative proof: a guilty plea or its equivalent with or without additional corroborative evidence, or a claim of not guilty but clear evidence belying that claim. Few cases were forwarded in the complete absence of corroborative evidence. Of those that were, almost all resulted in findings of not guilty.

It is clear that the cases forwarded to the discipline committee were those where a successful prosecution could be most assuredly predicted, confirming the admission that the CPSO tightened the eviden-

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

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

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

41 *Alfred* (1994); *BVZ*, [1995] OCPSD No 4; *ERM*, [1995] OCPSD No 30; *ETM*, [1995] OCPSD No 8; *FLS*, [1998] OCPSD No 9; *FYF*, [2002] OCPDS No 17; *Henderson* (2004); *Jabouin* (1995); *Jagoo* (1998); *KIG*, [1998] OCPSD No 3; *LJL*, [1995] OCPSD No 33; *Longdon* (1995); *Lurie* (2004); *MYS*, [1996] OCPSD No 20; *O'Connor* (1997); OKS, [1995] OCPDS No 18; *Pilo* (1994); *PVM*, [1995] OCPSD No 2; *QLN*, [1996] OCPSD No 2; *RBA*, [1996] OCPSD No 27; *Ross* (2004); *SDE*, [1995] OCPSD No 14; *Sharma* (2003); *Singh* (1995); *Smith* (2003); *STO*, [1997] OCPSD No 3; *UUO*, [1996] OCPSD No 13; *Wyatt* (2001); *ZHJ*, [1994] OCPSD No 29.

tiary requirements at the screening stage and reduced its willingness to bring cases forward that represented the risk of unsuccessful prosecution. The cases that were brought forward make it clear that the CPSO took few risks. This resulted in a higher rate of prosecutorial success and avoided the possible political and financial costs associated with failure for members of the CPSO.

Despite the over-representation of corroborated complaints among the cases actually heard by the discipline committee, cases of sexual abuse where corroboration is present are anomalous. Sexual abuse occurs out of the sight of others,[42] making the easy availability of corroborative evidence unlikely and the over-representation of corroboration among the cases that are sent forward that much more notable. This is perhaps particularly true of the abuse that occurs between doctor and patient. Arguably, the CPSO is avoiding cases in which only the complainant's voice speaks authoritatively of the abuse. In so doing, it replicates both the unfounding of sexual assault complaints prevalent in the criminal law context[43] and the historical resistance to women's uncorroborated claims of assault. As a result, it leaves many cases of abuse unaddressed and abusers undeterred.

## Avoiding the Provisions of the Legislation

The mandatory revocation provisions apply only to the sexual abuse of "patients." The term "patient" is not defined by the legislation. In 1992, the CPSO issued guidelines with regard to doctor–patient "dating."[44] Policies also are in place that prescribe the steps to be taken when the doctor wishes to terminate the doctor–patient relationship.[45] Because these are guidelines, their content is advisory only.

The guidelines recommend that "dating" relationships be avoided during treatment and for a year following the termination of treatment.

42 See *1991 Report*, *supra* note 1 at 80: "Witnesses to such acts of sexual abuse are rare. The legal processes used to determine the veracity of complaints of sexual abuse must be responsive to the reality of this kind of abuse if abusers are to be found and stopped".

43 Scott Clark & Dorothy Hepworth, "Effects of Reform Legislation on the Processing of Sexual Assault Cases" in Julian V Roberts and Renate M Mohr, eds, *Confronting Sexual Assault: A Decade of Legal and Social Change* (Toronto: University of Toronto Press, 1994) 113.

44 See CPSO, "Physician–Patient Dating" (May 1992). See also CPSO, "Maintaining Boundaries with Patients" *Members' Dialogue* (Sept/Oct 2004).

45 See CPSO, "Ending the Physician–Patient Relationship" Policy #3–08 (Sept 2000, reviewed and updated 2008), online: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1592>.

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

The definition of "patient" is key to the rigorous enforcement of the legislation. The failure of the *Act* to define it forms the basis on which the requirements of the *Act* are avoided in certain cases. In a number of cases, the outcome of the discipline committee decision has foundered on the abrupt termination of the doctor–patient relationship, followed immediately by the doctor engaging in acts that otherwise would be sexual abuse.

The penalties imposed by the discipline committee where the doctor terminated the treatment relationship and immediately entered into a sexual relationship with the patient have been minimal. This is true even though the dynamics of the abuse are virtually identical and would require mandatory license revocation had they occurred within the doctor–patient relationship. Abrupt termination of the doctor–patient relationship specifically to evade the legislation has been sufficient to avoid license revocation, even where the relationship was one of psychotherapy.[46] Even when hasty termination of the doctor–patient relationship is for ulterior motives and violates CPSO directives and guidelines on doctor–patient termination, the penalties imposed are modest. The doctor has artfully fragmented the abusive and exploitative relationship. The grooming of the victim of abuse is implausibly di-

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

vided into notionally unrelated acts that occur prior to or after technical termination of the doctor–patient relationship. Acts that form part of a continuum of abuse are understood as separate acts. The arbitrary or manipulated timing of the acts as pre- or post-termination becomes key with regard to the imposition of the mandatory revocation penalty.

One example will suffice. Dr David Levy provided psychotherapy to patients with eating disorders. He began treating the complainant in 1993.[47] During treatment, Dr Levy disclosed information about his personal life, encouraged her to use his health club membership, conducted therapy sessions while jogging and skating with her, took her out for drinks and for meals, bought her flowers, and sent her personal cards and letters. In October of 1995, the doctor–patient relationship was terminated and Dr Levy advised her that she could contact him for further treatment if necessary. From that time on he contacted her continually, seeking a personal relationship. In March of 1996 they entered into a sexual relationship, which terminated in November of 1998. The discipline committee treated the abuse as occurring after the termination of the doctor–patient relationship and suspended Levy's license for one year. Four months of that period were lifted if he met a number of conditions, including completing a boundaries course and undergoing a psychiatric assessment. The decision of the discipline committee to treat the period prior to termination and the abuse that occurred after termination as unrelated, and the relationship as not triggering the mandatory revocation provisions because not technically occurring between a doctor and a patient, clearly circumvents the zero-tolerance spirit of the legislation.

CPSO committees stretch the provisions of the *Act* to avoid the imposition of penalties that otherwise would follow. It is impossible to be certain how many cases are deliberately diverted from the anticipated requirements of the *Act* at the inquiry stage or by the complaints committee. However, like the *Levy* case described above, there are several cases where the extent to which the discipline committee will go to avoid the imposition of mandatory penalties is visible on the face of the decision.

In particular, the discipline committee appears to have a soft spot for those (abusive) relationships with patients that are formalized by marriage or that show some measure of longevity.[48] *CPSO v Wyatt* is

47 *The College of Physicians and Surgeons of Ontario v Dr Lance David Levy*, online: <http://www.cpso.on.ca/uploadedFiles/Discipline_Decisions/K-M/LevyLD200302.pdf>.

48 See generally *AB v College of Physicians and Surgeons Prince Edward Island*, 2001 PESCTD 75, 205 Nfld. & PEIR 131, 204 DLR (4th) 750 (PEI S Ct); *N v College of Physi-*

one such case.[49] Dr Wyatt treated the complainant B from 1988–1994, providing general care as well as psychotherapy. She began treating B's partner, A, in 1992. She provided A with psychotherapy as she did B, and provided them both with couple counselling. Dr Wyatt began an intimate relationship with A in July of 1994, one month after terminating the doctor–patient relationship with A and in the same month in which she terminated the doctor–patient relationship with B. In August and September of 1995, Dr Wyatt disclosed her relationship with A to three therapists, two of whom also were her patients. All three therapists notified the CPSO.

In the view of the discipline committee, the termination of the doctor–patient relationship with A and with B removed Dr Wyatt from the provisions requiring mandatory revocation. This was despite the fact that the period between doctor–patient termination and the beginning of the personal relationship was merely a month, despite the psychotherapeutic nature of the relationship, and despite CPSO guidelines on terminating the psychotherapeutic doctor–patient relationship. Referring to the guidelines on physician–patient relationships following psychotherapy, the discipline committee concluded that a "severe" penalty was called for, but declined to impose revocation.

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

It is hard to believe that the CPSO takes sexual abuse of patients seriously when the technical and exploitative termination of a doctor–patient relationship, which included long-term psychotherapy, distin-

*cians and Surgeons British Columbia* (1997), 143 DLR (4th) 463, 86 BCAC 181 (BCCA); *Melunsky v College of Physiotherapists of Ontario* (1999), 85 ACWS (3d) 458 (Ont Ct Just (Gen Div)).

49 *CPSO v Wyatt*, [2000] OCPSD No 10.

guishes behaviour giving rise to a five-year mandatory revocation from that which results in the most minor of penalties. What is clear is that the discipline committee, despite lip service to the need for a severe penalty, fails to understand the fiduciary obligations of the doctor or the exploitative and abusive nature of physician sexual abuse, especially in a psychotherapeutic relationship.[50]

Similarly, in *CPSO v Abelsohn*[51] the committee again went to great lengths to avoid the mandatory revocation provisions. It also resisted imposing revocation as a discretionary matter. Dr Abelsohn, a general practitioner, provided psychotherapy over a two-and-a-half-year period to a "difficult" patient. In addition to inappropriate hugging and other physical behaviour during the therapy, on six occasions the patient masturbated in Dr Abelsohn's presence. Even after terminating the treatment relationship, Dr Abelsohn continued to meet his patient in public places.

The discipline committee concluded that sexual abuse as defined by the *Act* occurred on more than thirty occasions. In the view of the committee, this behaviour did not trigger mandatory revocation, although it did give rise to suspension of the doctor's license. The committee split on whether Dr Abelsohn had "encouraged the patient to masturbate in his presence," behaviour that would have required mandatory revocation.[52] Two committee members concluded that he did so. Two members concluded that he did not. It was the view of those members that because of the mandatory penalty, the "level of encouragement [required to trigger the mandatory revocation provisions] was high." In their view, mandatory revocation was required only for the worst type of predatory sexual behaviour motivated by the desire for sexual grati-

50 This pattern continues. For a very recent example, outside of the period of this study, see *Schogt* (2004), online: <http://www.cpso.on.ca/docsearch/details.aspx?view=6&ddid=397&id=%2052488> at 43. The psychotherapeutic relationship extended from 1992 to 2001, involving sessions several times a week. The doctor terminated the doctor–patient relationship and entered into a personal relationship. The CPSO withdrew the allegation of sexual abuse and the discipline committee imposed a nine-month suspension for misconduct, with three months lifted for participation in a boundaries and ethics course.

51 *CPSO v Abelsohn* (2004). This hearing was the subject of a series of newspaper columns supportive of Dr Abelsohn and highly critical of the complainant, online: <http://www/cpso.on.ca/uploadedfiles/Discipline_Decisions/A-B/AbelsohnAR200408.pdf?terms=abelsohn>.

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

fication. Encouragement required active "inducement, incitement, inspiring with courage, emboldening or energizing." They concluded that allowing the behaviour to occur did not necessarily mean that it was encouraged. This split precluded imposition of the mandatory penalty. Instead, the committee imposed a one-year suspension and a prohibition on practising psychotherapy in the future.

Wherever mandatory revocation can be construed as not strictly required by the terms of the *Act*, the penalties imposed by the discipline committee are minimal. This is demonstrated in cases that involve facts arising before the change in the *Act*; by complaints where exploitative and abusive conduct is artificially characterized as occurring after termination of the doctor–patient relationship; in cases where narrow interpretation of the mandatory provisions appears contrary to legislative intent; or in cases where the facts are simply described as extraordinary. More particularly, the discipline committee decisions demonstrate a romanticization of doctor–patient sexual abuse in some cases. In other cases, they reveal a misunderstanding of the nature of physician sexual abuse as perpetrated by demonized individualized predators seeking sexual gratification. They fail to understand physician sexual misconduct as an abuse of power in a relationship of heightened vulnerability.

## Criminalizing the Disciplinary Process: The Standard of Proof

In addition to the informal but persistent reliance on corroboration, the decisions of the Disciplinary Committee rely on an elevated standard of proof. The *Act* provides that the rules governing civil actions are applicable to the admissibility of evidence in disciplinary proceedings.[53] The burden of proof lies on the CPSO to establish that the case for professional discipline is made out. The civil standard of proof generally is described as requiring proof "on the balance of probabilities." However, because professional reputation and livelihood are at stake,

53 Readmissibility of evidence: "Despite the *Statutory Powers Procedure Act*, nothing is admissible at a hearing that would be inadmissible in a court in a civil action and the findings of a panel shall be based exclusively on evidence admitted before it" (1991, c 18, Sched 2, s 49). However, no evidence admitted in a disciplinary proceeding before the Complaints or discipline committee is admissible in a civil proceeding. See Steinecke, *supra* note 24 at 1170. See also *Re Gillen and the College of Physicians and Surgeons of Ontario* (1989), 68 OR (2d) 278 (H Ct Just, Div Ct); *Board of Opthamalic Dispensers v Toth*, [1990] OJ No 1802 (Ont CA): "The correct standard is that applicable in civil cases, ie proof on a balance of probabilities, with the qualification that before that standard can be said to have been met one must have regard for the proposition that the more serious the allegation to be proved, the more cogent must be the evidence" (1).

the language of the burden of proof to be met creeps toward the criminal, at the same time as the disciplinary tribunals regularly acknowledge that the criminal standard of "beyond a reasonable doubt" does not apply.[54]

The question of standard of proof in disciplinary matters was considered by the task force. While the preliminary report of the task force recommended a specific statutory provision confirming that the applicable standard should be the balance of probabilities,[55] the final report revealed a lack of confidence that even a specific legislative directive would be sufficient.[56] Instead, the final report abandoned its recommendation that the burden of proof be specifically identified as civil. It suggested instead that the absence of corroboration and the presence of good character evidence has the most dramatic effect on whether a guilt finding is likely. Addressing these issues specifically, the task force recommended that good character evidence expressly be countered by counsel for the CPSO in each case as having no bearing on propensity to abuse.[57] It also recommended that the legislation specifically provide that corroboration not be required in sexual abuse cases.[58] Neither of these recommendations was adopted in the 1993 revisions. Nor was clarification of the standard of proof made explicit.

## IV. THE USE OF PSYCHIATRIC EVIDENCE: PATHOLOGIZING THE COMPLAINANT, EXCULPATING THE PHYSICIAN

Discipline committee decisions reveal reliance by the accused physician on psychiatric expert evidence and on the complainant's personal records to pathologize and discredit the complainant.[59] At the same time, psychiatric expertise is used by counsel to exculpate and to rehab-

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

55 *CPSO v Boodoosingh* (1990), 73 OR (2d) 478 at 35 (H Ct Just, Div Ct).

56 *2000 Report*, *supra* note 7 at 186.

57 Recommendation 44, *ibid* at 51.

58 Recommendation 52, *ibid* at 52.

59 See eg Lise Gotell, "The Ideal Victim, the Hysterical Complainant and the Disclosure of Confidential Records: A Case Study of the Implications of the Charter for Sexual Assault Law" (2002) 40 Osgoode Hall LJ 251; Susan M Vella, "Credibility on Trial: Recovered Traumatic Memory Evidence in Sexual Abuse Cases" (1980) 32 UBC L Rev 91.

ilitate the accused physician.[60] The persistence of these arguments reiterates the continual focus on the professional's reputation and economic prospects rather than on public protection, on recognition and prohibition of abuse, and on fair and equitable consideration of the complainant's allegations.

Often it is the impact of prior abuse that brings the complainant into contact with the doctor in the first place. The patient's vulnerability — arising out of a history of abuse, addiction or alcoholism, youth, depression, disability, or family difficulties — positions her as a target of additional abuse at the hands of the physician to whom she turns for healing. A review of the disciplinary decisions reveals an over-representation of psychiatrists among those found to have abused their patients and an over-representation of women who are survivors of abuse as complainants.[61]

The accused doctor's records concerning the complainant are available to him in mounting his defence and are part of the disciplinary file. It is not possible to know how many discipline hearings specifically considered not only the complainant's records generated by the accused physician but also third-party health or counselling records. Discipline committee decisions that explicitly refer to an attempt to access the complainant's third-party records,[62] or to question the stability and credibility of the complainant without evidence of a formal request for records, reveal the accused's use of the complainant's emotional and mental health issues or prior history of abuse to undermine her credibility. In doing so, the accused re-abuses the complainant.[63] In *Jagoo*,

60 McIntyre *et al*, *supra* note 34.

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

62 See UUO, [1996] OCPSD No 13 (14 pages of psychiatric records released); MYS, [1996] OCPSD No 20 (upon motion for disclosure of the names of complainants seen at a counselling office or sexual assault centre, committee concluded probative value outweighed privacy interests); *Cameron* (1994) (psychiatric records); *Deitl* (1996); *Alfred* (1994) (committee reviewed complainants' psychiatric records); *Williams* (1996) (names and addresses of complainants); *Heath* (1995); *Bocking* (1995); *Gabrielle* (1995); *Deluco* (2005).

63 "When we listened to what patients told us, we felt that time had stood still during the nine years since we submitted our first report. Very little has improved and the kinds of difficulties that patients experience in trying to access self-regulation processes remain much the same": *2000 Report, supra* note 7 at xi; "The information indicates

the complainant was described as anxious and emotional, an ex-alcoholic, who had suffered sexual abuse as a child and was vulnerable to the influence of another complainant. In *QLN*, the complainant was described as suffering from an erotic and "eroticized transference" and "erotomania" in part resulting from her early unhappy family, obesity, low self-esteem, and failing marriage. In *Williams*, two defence experts testified on so-called "recovered memories" or "pseudo memories" claiming that "memory is an area fraught with pitfalls and requiring corroboration."[64] Experts for the CPSO countered with evidence relevant to sexual abuse and by rebutting the spurious claims of those relying on "false memory syndrome" as a factor in their defence. In *Deitel*, the committee denied the accused's motion to produce the complainant's third-party psychiatric records. The discipline committee commented that there was no evidence of collusion or false accusation. In *Heath*, the committee pointed out that the complainant had "no motive to fabricate … no history of psychiatric problems or substance abuse." In *Gabrielle,* the discipline committee again went to great lengths to counter evidence of "false memory syndrome" introduced on behalf of the accused physician, with findings that the *seven* complainants had no motive to fabricate the complaint.

The abusive and re-abusing impact of these tactics has been commented on by the discipline committee in several cases. One of the more egregious examples is found in *Deitel*, who earlier had been found guilty of professional misconduct involving sexual misconduct with a female patient. The case involved complaints by two women patients. A third patient served as a witness for the CPSO. The decision of the discipline committee revoking Deitel's license was appealed by the doctor on the issue of the admission of similar-fact evidence. Upholding the decision of the discipline committee, Mr Justice Corbett commented on the abusive conduct of counsel for the physician at the

that, despite the efforts of Colleges in striving to meet the requirements of the Act the complaints and discipline procedures of the RHPA implemented by Colleges fail to protect the public from sexual abuse by regulated health professionals and do not adequately deal with the special dynamics of sexual abuse cases that require people to be treated with sensitivity and respect": *HPRAC Report*, *supra* note 7 at 1; "Individuals who were interviewed and who had been abused by a member of a Regulated College found the complaint process was an amplification of an already traumatic experience": *PwC Report*, vol 6, *supra* note 6 at 3.

64 *Williams* (1996) at para 149.

discipline hearing and the impact of that conduct on the complainants and witness. He noted that "[t]he length and vigour of cross-examination was directly proportionate to the degree of psychological vulnerability of the patient" and that "the attack on the credibility of the complainants was unrelenting and, often was unnecessarily brutal."[65]

In stark contrast to the use of psychiatry to impugn, undermine, and belittle complainants, in numerous disciplinary proceedings, expert psychiatric evidence is relied on to explain, exonerate, and rehabilitate the abusing physician.[66] Thirty years of scholarship has debunked the myth that sexual abuse is committed only by deviant or disordered men. Yet the decisions of the discipline committee often reflect counsel's attempt to distinguish the accused from a mythic abuser in order to discredit the allegations against him. This takes two forms: those in which the accused is described as "normal" and thus not an abuser, and those in which he is described as "ill" and therefore not deserving of sanction. In some cases both strategies are utilized.

In the first group of cases, expert evidence is offered attesting to the fact that there is "no evidence that he is a predator,"[67] "no evidence of psychopathic traits or anti-social personality disorder,"[68] that he does not "meet the diagnostic criteria for a sexual disorder … for any paraphylia," that the "risk of professional misconduct is low if his practice is subject to conditions" and that he is "not currently professionally impaired."[69] In *Dobrowolski*, which involved four disciplinary hearings and seventeen complainants, the expert testified that Dobrowolski "is neither predatory nor anti-social," but rather had marital and financial difficulties and "inadequate training in the understanding of transfer-

65 *Deitel v College of Physicians and Surgeons of Ontario* (1997), 99 OAC 241 at para 224, 70 ACWS (3d) 1018 (Ct Just (Gen Div)). He notes that the transcript of the examination-in-chief of one of the complainants was 17 pages; the transcript of the cross-examination extended to 250 pages (para 224).

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

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

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

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

ence and counter-transference."[70] In *Nagahara*, where the physician pled guilty to professional misconduct and had a criminal conviction arising from the same abuse, testimony was offered that there was "no evidence of anti-social behaviour, psychopathy, impulsivity, sexual disorder or deviation, no personal or professional problems, no history of substance abuse, no features predictive of recidivism and that the re-offence potential was minimal." The penalty involved an order that Nagahara undergo treatment with the testifying expert as a condition of continuing to practice.

Evidence also often is offered of biochemical, phallometric, psychological, and physiological testing to support the claim that no "major mental illness or personality disorder" is present.[71] In one case, expert evidence was offered that because the accused physician had a "partner" (wife) who was a psychiatrist, it was unlikely he would have committed the abuse.[72] In another, the fact that the physician had been in a stable relationship for the last ten years was offered as exonerating evidence.[73]

There is no consistent evidence with regard to the length of treatment or evaluation that underlies these "expert" assessments, provided at the request and expense of the accused. In at least one case, the forensic psychiatrist interviewed the physician for only four hours, before concluding that he was "unable to detect any evidence of improper ethical behaviour, impulsive behaviour or indication of mental illness associated with aberrant behaviour."[74] In *Im*, the expert was "unable to detect evidence of conscious sexual intent in [the doctor's] actions" and concluded that the "factors usually seen in recidivism are not present," that there are no "antisocial feelings, impulsive behaviour or psychopathic tendencies … no evidence of sexual deviancy or psychosis." He reached these conclusions despite Im's criminal conviction for five sexual assaults.

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

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

72 *McRae* (1994).

73 *Irvine* (1996). But see *contra* GR Schoener *et al, Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention* (Minneapolis: Walk-In Counselling Center, 1989) at 71: "disintegration in the relationship may occur at any time, even years later. Thus, one must be careful in making judgments of post-therapy relationships that appear harmonious."

74 *Fernandez* (1997).

Exculpatory psychiatric expertise is also offered to explain and excuse the physician's sexual abuse of his patient. In *Re: Markman*,[75] Markman relied on both his treating psychiatrist and an "independent" expert psychiatrist to claim that "the stresses of his job environment led to a chemical abnormality of the brain, resulting in 'toucherism.'"[76] Markman was the subject of six complaints of sexual abuse, all heard together. All of the complainants worked at the hospital in which he practised. Markman had been found guilty of criminal sexual assault with regard to four of the incidents. In the last of the six assaults, against an intern in the teaching program at the hospital, Markman threatened he would kill her if she told anyone. He warned her that, as a mere intern, she would not be believed if she complained about his attack.[77] The discipline committee found him guilty of sexual abuse.

This reliance on psychiatric expertise to exonerate the physician is misplaced. In "Psychological Evaluation in Sexual Offence Cases,"[78] WL Marshall critically reviewed the literature on the reliability of the various psychiatric tests used to identify male sexual deviance and concluded that "[t]here is no justification for using interview or test data as a basis for determining the likelihood that an accused male did or did not commit a sexual offence."[79] He argued that the various tests used in such evaluations, including phallometric testing, although identified as objective and therefore scientific or respectable, are not so. He outlined their limited ability to reliably distinguish between those accused individuals who are dissimulating and those who are truthful about their involvement in deviant sexual behaviour.[80] He concluded that neither personal interviews nor file reviews are accurate. In his view the "evidence clearly indicates little can be said which is helpful" about

75 [1999] OCPSD No 6. See also *Beresford* (1994) where the sixty-eight-year-old doctor was allowed to continue practising where he identified a bipolar affective disorder as the cause of his sexual relationship with a psychiatric patient. His practice was restricted to male patients; *Bingham* (2003): committee took into consideration a psychiatric report on his physical and emotional health; *Seidman* (2003): medical issues — mood changes in high school, breakdown during fellowship and diagnosis with ADD.

76 *Ibid* at para 50.

77 See *R v Charalambous* (1997), 92 BCAC 1, 34 WCB (2d) 530 (BCCA). In *Charalambous*, the doctor arranged to have his former patient, Sian Simmonds, killed.

78 WL Marshall, "Psychological Evaluation in Sexual Offence Cases" (1995–96) 21 Queen's LJ 499 and see sources cited by Marshall.

79 *Ibid* at 500.

80 *Ibid* at 501, 505, 506.

propensity to abuse[81] and that experts are more likely to "mislead than to help the court."[82]

Many discipline committee penalties impose a requirement of psychiatric therapy on the abusing physician as a condition of returning to practice.[83] The theory is that therapy will ensure that he does not return to abusing his patients.[84] Such conditions overlook that the expert who proposed the rehabilitative plan is employed by the abusing physician himself and is not an independent assessor.[85]

In fact, many abusers may be untreatable and therapy unable to ensure that the physician returns safely to practice.[86] The literature reveals that such reliance on therapy as able to ensure rehabilitation is misplaced. Schoener et al, in their leading text *Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention*,[87] found the scholarly literature on therapist abuse both limited and lacking in methodology. They raised concerns both about the procedures for assessment of the physician and the lack of clear understanding of rehabilitation. They noted that in the US, a number of perpetrators are known to have reoffended.[88] They specified that in some such cases "far too much re-

81 *Ibid* at 509.

82 *Ibid* at 514.

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

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

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

86 Schoener: "many perpetrators may not be treatable, thus challenging the prevalent notion that a referral to long-term therapy will cure the problem and render the perpetrator a safe practitioner": *supra* note 73 at 399.

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

88 This is also the case in Canada, although it is impossible to be clear about the numbers who do so. In Ontario see eg *Genereux* (1994); *Deitl* (1996).

liance was placed on psychotherapy as a 'cure all' and on supervision of whatever sort as a safety net."[89]

They also noted many serious weaknesses in the imposition of supervisory structures on the doctor's practice as a condition of his returning to practice. In their view, meaningful supervision requires authority to review the physician's records, discuss cases, and have direct client contact. They noted the failure of supervisory models to prevent both continued sexual abuse and the incompetent health care that accompanies it. They pointed out that where supervisory orders are imposed, the person chosen to act as chaperone to the abusing doctor is most often a person who is in a subordinate relationship to the physician, such as a nurse or other assistant. As well, orders prohibiting the physician from seeing women patients ignore the possibility that the physician may engage in abusive behaviour with male patients and that sexually abusing seductive practices can occur in the treatment of couples. Supervisory orders of this kind are relatively common in discipline committee decisions, and all of these concerns are borne out by the reported cases.[90]

Even more prevalent than orders that require psychiatric treatment and/or supervision are those that require (re)education. Often all three conditions — therapy, third-party supervisory monitoring, and re-education — are imposed as part of the disciplinary penalty.[91] The

89 *Supra* note 73 at 419. They go so far as to say that licensing boards may be liable for the failure to obtain competent assessment and to develop sound rehabilitation plans. "It may be that the elimination of bogus rehabilitation efforts and the overly hasty granting of 'Rehabilitated' status … will be facilitated by malpractice suits filed against those who are less than adequate, professional, careful, thorough, and knowledgeable in assessing and rehabilitation offending therapists." See also *McClelland v Stewart*, [2006] BCSC 1948, 154 ACWS (3d) 1048 (S Ct).

90 See eg *Deluco* (2004); *Deitl* (1996); *Genereux* (1994); *Im* (2003); *Johnson* (1995).

91 See *Wesley* (2002) (psychiatric treatment and chaperone); *Davis* (1993) (psychiatric treatment, chaperone, and course); *Dobrowolski* (2004) (psychiatric treatment, chaperone, and course); *Carll* (2002) (boundaries course); *Comeau* (2001) (therapy); *Bergstrom* (2000) (course); *Crainford* (1998) (therapy); *Irvine* (2006) (therapy and course); *Nagahara* (1996) (therapy and chaperone); *Deitl* (1996) (therapy and monitoring imposed on earlier offences when last offence occurred); *Johnson* (1995) (therapy and chaperone); *Oosterholt* (1995) (therapy and chaperone); *Longdon* (1995) (course); *Turton* (1994) (therapy); *Genereux* (1994) (chaperone); *Bingham* (2003) (course); *Bothwell* (2003) (course and chaperone); *Deluco* (2005) (chaperone); *Dore* (1999) (course); *Dube* (2001) (course); *Henderson* (2004) (course); *Hurst* (1998) (course); *Im* (2003) (course and chaperone); *Ives* (2002) (course); *Jabouin* (1995) (course); *Kavouris* (2004) (course); *Koffman* (2003) (therapy and course); *Lambert* (2002) (therapy and course); *Levy* (2003) (psychiatric treatment, chaperone, and course); *Lurie* (2004) (course); *Miller* (2001, 2004) (chaperone); *Noreiga* (2003)

discipline committee often understands the abuse as a failure of education or training and orders re-education as a condition of continuing to practice. Generally referred to as a requirement that the physician obtain training in "appropriate boundaries," this device is used to lift a significant part of any license suspension imposed.[92]

Schoener et al also question the usefulness of ethics courses as rehabilitative measures.[93] Kenneth Pope found that "neither education nor psychotherapy has shown any evidence in published research studies of inhibiting sexual abuse of patients, and according to some studies, they actually appear to be positively associated with tendencies to abuse."[94] Nor is there any evidence that abuse by physicians is the result of insufficient training in either ethics or boundaries. In a number of cases, the physician subsequently was disciplined for sexual abuse despite the imposition of some or all of therapy, monitoring, or re-education. The reliance on therapy or on ethical re-education to excuse or to "heal" the sexual abuser of his misconduct is misplaced. It ignores exactly that understanding of sexual abuse that the revisions to the *Act* were meant to address — that sexual abuse is abuse of power and constitutes violence against women and children.[95]

(course and chaperone); *Rosen* (2002) (course and chaperone); *Ross* (2004) (therapy and chaperone); *Sharma* (2003) (course and chaperone); *Shiozaki* (2004) (course); *Silva-Ruette* (2003) (course); *Wong* (2003) (course and chaperone); *Wyatt* (2001) (therapy and course).

92 For an idea of what is meant by boundary training see, for example, Jill Hefley, "Strategies for Preventing Sexual Abuse" (1993), online: Member's Dialogue 8; Laurel Dempsey & Janet Ecker, "Understanding the Dating Guidelines" (1994), online: Member's Dialogue 9 (1994); Federation of State Medical Boards of the United States, Ad Hoc Committee on Physician Impairment, "Report on Sexual Boundary Issues" (1996), online: <http://www.fsmb.org/pdf/1996_grpol_sexual_boundary_issues.pdf>. This is an extraordinarily prevalent order in imposed penalties.

93 Scheoner, *supra* note 73 at 415; *JL* (1995); *M* (1995).

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

95 See also Schroener, *supra* note 73 at 422: "If sexual exploitation of clients by therapists is to be taken seriously by mental health professions and the public, it is important to establish that certain kinds of exploitation are regarded seriously, and they warrant a serious response, regardless of the motives or psychological status of the perpetrating therapist. This is the same attitude that is taken toward other serious transgressions against society, such as rape and incest".

## CONCLUSION

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

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

The complaints that do make it to adjudication by the discipline committee generally are those where independent corroboration of the complainant's accusation is available, although there is no such requirement in the legislation. In those few discipline committee hearings that do go ahead despite the absence of corroboration, a guilty determination is unlikely. Furthermore, discipline committee panels often demonstrate unwillingness to apply the *Act* vigorously and appropriately, avoiding the provisions of the legislation, ignoring CPSO policies, and criminalizing the disciplinary process in ways that protect the accused doctor. Criminalization of the process occurs particularly by raising the burden of proof on the CPSO from a civil towards a criminal standard, paying undue attention to the impact of disciplinary proceedings on the doctor's reputation and economic situation, and ignoring their obligations to the public, to the profession, and to the injured complainant. Expert witnesses, acting on behalf of the accused doctor, are allowed to pathologize the complainant and to exculpate and rehabilitate the accused. Where penalties are imposed, discipline committee panels are much too eager to assume that the imposition of ethics or boundary training, of therapy, and of third-party supervision will provide the public with protection from re-abuse by the doctor, and to reduce already short license suspensions even further.

A renewed allegiance by the CPSO to their original commitment to zero tolerance of sexual misconduct is required. The CPSO must ensure

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