



Health Professions Regulatory Advisory Council

The Spousal Patient

Advice to the Minister of Health and Long-Term Care for Alternatives
to the Mandatory Revocation Provisions and the Delivery of Treatment to Spouses
under the *Regulated Health Professions Act, 1991*

JUNE 2012



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June 1, 2012

The Honourable Deb Matthews
Minister of Health and Long-Term Care
10th Floor Hepburn Block
80 Grosvenor Street
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Dear Minister,

We are pleased to present our report to you on the issue of mandatory revocation provisions related to the treatment of spouses by health care professionals under the *Regulated Health Professions Act, 1991* (RHPA). The recommendation in this report upholds the government's position on zero tolerance for sexual abuse by regulated health professions. Our recommendation also recognizes the unintended consequences of this legislation for many of the regulated health professions.

Through broad based consultation, we heard from a broad range of stakeholders – including spouses of health professionals – expressing concern about the negative impact on the quality of, and access to, their personal health care.

It is understood that treating any family member is an unacceptable practice for many health professions with the matter enshrined in their codes of professional conduct. However, a major theme from the HPRAC consultations was that a violation of a college standard for treating a spouse should focus on the rationale of compromised care rather than the automatic assumption of sexual abuse.

In our deliberation, we concluded that a narrow focus on alternatives to the mandatory revocation provisions would not adequately address the issue referred to HPRAC. Consideration should be given to alternatives to the sexual abuse offence, strictly as it relates to the treatment of a spouse. Therefore, our recommendation is to amend the definition of sexual abuse in the RHPA to exclude consensual sexual relations within a spousal relationship. Colleges, who wish to continue to prohibit their members from treating their spouse, should make profession specific changes to professional misconduct regulations and/or standards of practice to enforce such practice.

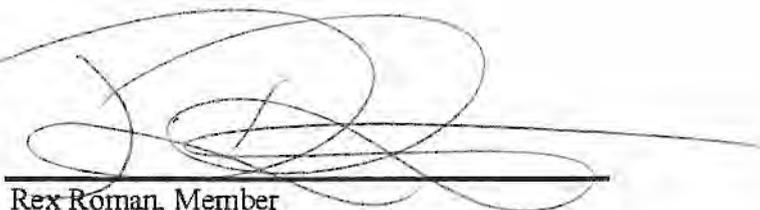
This recommendation upholds the government's commitment to a zero tolerance policy related to sexual abuse while respecting the governance and authority of the professional Colleges.

We look forward to meeting with you to discuss the findings in this report and our recommendations.

Sincerely,



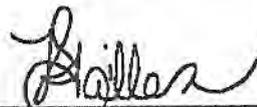
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The Spousal Patient

Advice to the Minister of Health and Long-Term Care for Alternatives to the Mandatory Revocation Provisions and the Delivery of Treatment to Spouses under the *Regulated Health Professions Act, 1991*

Executive Summary

In response to expressions of concern from segments of the regulated health professions community, the Minister of Health and Long-Term Care asked the Health Professions Regulatory Advisory Council (HPRAC) to review elements of the *Regulated Health Professions Act, 1991* (RHPA). Specifically, HPRAC was asked to review those elements that require mandatory revocation of the health professional's certificate of registration for providing treatment to a spouse.

The RHPA was proclaimed in 1991 and included provisions for mandatory five-year revocation of the health professional's certificate of registration if found guilty of sexual abuse. The sexual abuse provisions came from an increased awareness at the time of sexual abuse of patients by regulated health professionals. Evidence reported by the Sexual Abuse Task Forces in 1991 and 2000 supported the need for the zero tolerance approach to sexual abuse by regulated health professionals.

The issue raised with the Minister results from the RHPA definition of sexual abuse that describes relationships and acts that would be considered part of a normal spousal relationship and, yet, spouses are not exempted from the RHPA.

Concerns about the sexual abuse provisions in the RHPA have been brought to public attention as a result of a recent court decision. In *Leering vs. College of Chiropractors of Ontario*,¹ the court upheld the College of Chiropractors of Ontario's decision that the chiropractor was guilty of sexual abuse because he treated a woman with whom he was not married but was intimately involved. The courts deemed the treatment constituted sexual abuse under the RHPA regardless of the nature of the pre-existing personal relationship.

In response, members of the public have expressed concerns about the sexual abuse provisions in the RHPA. This court decision was problematic for many health professionals who see treating family members, including spouses, as part of their professional culture.

Attention has focused on perceived unfairness to spouses of some regulated health professionals, where spouses of health professionals are prohibited from receiving treatment from their preferred health professional. The zero tolerance provisions have also been criticized as being ineffective, citing lengthy delays in the resolution of complaints and low numbers of cases reaching the disciplinary hearing stage.

¹ *Leering v. College of Chiropractors of Ontario*, [2010] ONCA 87.

In response to the referral question, HPRAC conducted extensive research and public consultation to determine if alternatives to the mandatory revocation provisions could exist. A number of documents, including summaries of a literature review, a jurisdictional review, and a jurisprudence review, were developed and made publicly available to support the consultation process.

From HPRAC's research and consultation, four alternatives emerged:

- Change the definition of the sexual abuse offence in the RHPA.
- Maintain the sexual abuse offence and permit an exemption to penalty.
- Maintain the sexual abuse offence and permit proportional penalties.
- Maintain the status quo.

During its research and consultation, HPRAC learned that current provisions have negatively impacted access to care for the spouses of health professionals. These negative impacts included limited or no access to health care in remote areas, infringement on one's right to choose a health provider and the inability to have health services provided by a trusted provider (especially important in cases of health phobia).

HPRAC was further advised that maintaining the offence and simply allowing alternatives to the revocation penalty may weaken the zero tolerance provisions and create confusion on how sexual abuse complaints should be handled. Ninety-seven percent of participating stakeholders indicated dissatisfaction with the current definition of sexual abuse when applied to treatment of spouses by health professionals.

In assessing the results of research and consultation, HPRAC applied the tests of risk of public harm and public interest while always ensuring the government's commitment to zero tolerance on sexual abuse was maintained. A critical consideration in the analysis was whether a pre-existing spousal/conjugal relationship had an impact on the health care provider-patient relationship. On this matter, HPRAC concluded that spousal, health care provider-patient relationships are different from non-spousal, health care provider-patient relationships. Further, HPRAC recognized that merely focusing on alternatives to the mandatory revocation provisions would be insufficient to address the issue.

After due consideration and analysis, HPRAC recommends that the treatment of spouses by health care professionals should be expressly exempted in the sexual abuse provisions of the RHPA. Specifically, the language of the RHPA should be amended to exempt spouses from the definition of sexual abuse, as the treatment of a spouse by a health care professional is not regarded as sexual abuse.

In keeping with the zero tolerance on sexual abuse, colleges that wish to prohibit members from treating their spouses should make changes to professional misconduct regulations and/or standards of practice to enforce such practice – as many do already.

1. The Minister's Request

On June 24th, 2011, the Honourable Deb Matthews, Minister of Health and Long-Term Care, asked the Health Professions Regulatory Advisory Council (HPRAC) to provide advice on the issue of mandatory revocation provisions and delivery of treatment to spouses by health care professionals under the *Regulated Health Professions Act, 1991* (RHPA).² The Minister requested that HPRAC focus solely on one issue: whether or not alternatives to the mandatory revocation provisions should exist in the RHPA with respect to the treatment of a spouse by a regulated health professional. The Minister also requested that HPRAC examine the risk of harm and public interest implications that any such alternatives pose. The Minister confirmed the government's commitment to zero tolerance for sexual abuse.

A spouse, within the context of the referral letter, was defined as a person with whom the regulated health professional was married, or with whom the regulated health professional was living in a conjugal relationship outside of marriage.

This document is HPRAC's advisory report in response to the Minister's request.

About HPRAC

HPRAC was established under the RHPA, with a statutory duty to advise the Minister of Health and Long-Term Care on matters related to the regulation of health professions in Ontario. This includes providing advice to the Minister on:

- Whether unregulated health professions should be regulated;
- Whether regulated health professions should no longer be regulated;
- Amendments to the RHPA;
- Amendments to a health profession's Act or a regulation under any of those Acts;
- Matters concerning the quality assurance programs and patient relations programs undertaken by health colleges;
- Any matter the Minister refers to HPRAC relating to the regulation of the health professions.

The Minister relies on recommendations from HPRAC as a source of evidence-informed advice in the formulation of policy in relation to health professional regulation in Ontario. In providing

² The RHPA is an umbrella legislation governing 23 regulated health professions in Ontario. It provides a framework for regulating health care providers and protects patients and the public by ensuring that health care providers meet standards of practice and competencies.

its advice and preparing its recommendations, HPRAC is independent of the Minister of Health and Long-Term Care, the Ministry of Health and Long-Term Care, the regulated health colleges, regulated health professional and provider associations, and stakeholders who have an interest in issues on which it provides advice. This ensures that HPRAC is free from constraining alliances and conflict of interest, and is able to carry out its activities in a fair and unbiased manner.

HPRAC presents its recommendations in a report to the Minister for consideration. HPRAC recommendations are advisory only and the Minister is not bound to accept HPRAC's advice. The report is confidential. However, the Minister may choose to publicly release an HPRAC report. Any follow-up action is at the discretion of the Minister. Should the Minister choose to accept HPRAC's advice, the Ministry of Health and Long-Term Care is responsible for implementation based on the direction of the government.

In developing its advice to the Minister, HPRAC strives to ensure that its processes are thorough, timely and efficient; and built on a foundation of fairness, transparency and evidence-based decision making. HPRAC undertakes research to secure evidence for its conclusions, drawing on organizations and individuals with relevant expertise, both in Ontario and elsewhere. HPRAC adjusts its consultation process to the matter under consideration.

2. Background

Zero Tolerance for Sexual Abuse

The zero tolerance provisions on sexual abuse were included in the introduction of the RHPA in the early 1990's when there was an increased awareness of sexual abuse of patients by regulated health professionals. The Act was supported by stakeholders, regulatory colleges, subject matter experts and all political parties.

Chronology

- 1991: The College of Physicians and Surgeons of Ontario (CPSO) identified sexual abuse of patients as a real problem and established a Task Force on Sexual Abuse to examine the issue. The Task Force recommended, among other things, a policy of zero tolerance towards sexual abuse, which included a mandatory five-year registration revocation and placement of an obligation on all regulated health professionals to report abuse by other regulated health professionals.³ The Task Force was successful in bringing patient abuse into the public eye and ultimately initiating ways for patients to voice abuse complaints.⁴
- 1993: Bill 100 was passed in the legislature to amend the RHPA to require the reporting of sexual abuse as defined in the Act and to include in some cases, a mandatory five-year revocation of the member's certificate of registration. The goal of the amendments was to eradicate the sexual abuse of patients by members of regulated health professions.⁵ The amendments defined sexual abuse of patients for the first time and established new procedures and standards.⁶ It also required HPRAC to report to the Minister on each college's complaints and discipline procedures five years after the amended RHPA had been in force.
- 1999-2000: As part of the five-year review of the RHPA, HPRAC contracted PricewaterhouseCoopers to report on the health regulatory colleges' self-evaluations of the complaints and discipline processes. The Minister of Health and Long-Term Care and HPRAC commissioned a follow-up task force to report on patient experiences with colleges' complaints and discipline procedures for sexual abuse.⁷ Findings from both of these reports were incorporated in HPRAC's report to the Minister about the

³ Marilou McPhedran et al., *The Final Report of the Task Force on Sexual Abuse of Patients*, Commissioned by the College of Physicians and Surgeons of Ontario, (November 25, 1991).

⁴ Ontario Women's Justice Network, "Doctor-Patient Sexual Assault and Abuse," (2008).

⁵ Ibid 4.

⁶ Ibid 4.

⁷ Marilou McPhedran et al., "What about accountability to the patient?," *Final report of the Special Task Force on Sexual Abuse of Patients*, (2000).

Effectiveness of Colleges' Complaints and Discipline Procedures for Professional Misconduct of a Sexual Nature. The findings from this report indicated the colleges' complaints and discipline procedures were ineffective in protecting the public from sexual abuse by regulated health professionals.⁸ The report identified concerns about clarity of process; and the complexity of the complaints process being a major deterrent for patients/clients to file and follow through with a complaint.⁹ At the time, it appeared that the colleges' actions did not go far enough to prevent sexual abuse by health professionals.¹⁰

- 2006: HPRAC submitted to the Minister its report *Regulation of Health Professions in Ontario: New Directions*. Part of this report advised the Minister to amend the legislative framework of the RHPA to improve accountability and transparency.
- 2007: *Health System Improvements Act, 2007* was introduced to improve the legislative framework governing health professions in Ontario. One of the major changes was a realignment of the colleges' complaints and discipline committees.¹¹ Colleges were also required to have more informative websites to enhance communications with their members, other colleges, key stakeholders and the public.¹² In addition, many colleges updated their patient relations programs to educate their members and the public about sexual abuse prevention.¹³

The Ministry of Health and Long-Term Care recognized that health regulatory colleges have a central role to play in the eradication of sexual abuse of patients by regulated health professionals and, over time, colleges have evolved practices and approaches to address the sexual abuse of patients in Ontario. All these changes have helped to improve the regulatory system's transparency and accountability to the public.

Sexual Abuse Provisions in the RHPA

As a result of the Government of Ontario's approach to sexual abuse in the early 1990's and the incorporation of the zero tolerance provisions in the RHPA, the legislation includes specific provisions related to the sexual abuse of patients by regulated health professionals. In essence, health professionals are prohibited from engaging in a sexual relationship with their patients. A co-existing sexual and patient relationship is considered to be professional misconduct, which is

⁸ 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, ON,2000).

⁹ Ibid 8.

¹⁰ Ibid 8.

¹¹ Ministry of Health and Long-Term Care, *Compendium: Health System Improvements Act, 2006*. Schedule M.

¹² Health Professions Regulatory Advisory Council, *A report to the Minister of Health and Long-Term Care on the Health Profession Regulatory Colleges' Patient Relations Programs*, (Toronto, ON, 2008).

¹³ Ibid 12.

further defined as “sexual abuse”. The legislation further states that certain acts of sexual abuse committed by a regulated health professional are grounds for mandatory revocation of the health professional’s certificate of registration for a minimum of five years.

Ethical Issues Supporting a Zero Tolerance Approach

The concepts and principles related to the ethics of health professional/patient sexual relationships are well documented.¹⁴ The most evident ethical principles that emerge are: power imbalance, transference, trust and consent.¹⁵

Power Imbalance

There are a number of aspects in a health professional-patient relationship that help foster a power imbalance. A patient allows a health professional to conduct intimate physical examinations, and relies on the professional to provide care based upon their training and knowledge. A patient also provides sensitive information about themselves and often comes to see a physician when they are unwell or in pain. In some cases, the patient does not speak the language of the health professional. These factors are one-sided, putting the patient in a vulnerable position and creating an imbalance of power the health professional has over the patient.

It is argued that relationships with power imbalance have the potential for sexual abuse and abuse of power built into it. As a result of this power imbalance, a professional has the ability to manipulate the patient by putting their interests, such as sexual desire, ahead of the patient’s best interest.¹⁶

Transference

Power imbalance may also lead to transference which occurs when a patient has preconceived notions of respect and reverence for the health care provider that were shaped by long standing role models and stereotypes. Transference can lead patients to idealize the health professional and to experience the feeling of submissiveness. This idealization places the patient in a vulnerable and dependant position that may be exploited by the health professional. As a result,

¹⁴ Karen Zelas, “Sex and doctor-patient relationship,” *New Zealand Medical Journal* 110 (1997): 60-62; Katherine H. Hall, “Sexualization of the doctor-patient relationship: is it ever ethically permissible?” *Family Practice* 18, no. 5 (2001): 511-515; Fiona Subotsky, Susan Bewley, and Michael Crowe, eds., *Abuse of the Doctor-Patient Relationship* (London: The Royal College of Psychiatrists, 2010).

¹⁵ Karen Zelas, “Sex and doctor-patient relationship,” *New Zealand Medical Journal* 110 (1997): 60-62; R. Gillon, *Philosophical medical ethics*, (Chichester: John Wiley and Sons, 1985).

¹⁶ Marilou McPhedran et al., *The Final Report of the Task Force on Sexual Abuse of Patients*, Commissioned by the College of Physicians and Surgeons of Ontario (November 25, 1991); Howard Brody, *The Healer’s Power* (New Haven: Yale University Press, 1992).

it is the professional's responsibility to identify and maintain the boundaries of the therapeutic relationship.¹⁷

Trust

Trust is required for patients to divulge intimate details, to take potentially harmful medications, and to undergo procedures when unconscious. Three key features describe the circumstances in which a trusting relationship occurs: there is an expectation of trustworthiness, a power differential exists, and the interaction occurs under conditions of privacy.¹⁸

Trust is an underlying principle of the concept of boundaries and it has been argued that it is a health professional's breach of trust, not patient consent, which is the crucial issue regarding sexual impropriety.¹⁹

Consent

The concepts of power imbalance, transference and trust have serious ethical implications on another concept in the health professional-patient relationship: consent. As a result of the power imbalance and idealization present in the health professional-patient relationship, a patient is no longer considered capable to consent to a sexual relationship with a health professional: "even if consent can be given, exploitation can be nevertheless be argued if the fiduciary has acquired information about the client's vulnerabilities that otherwise would remain concealed".²⁰ Thus, patient consent is never considered an acceptable rationalization for a health professional to engage in sexual relations with a patient.²¹

To illustrate the impact of these concepts further, one judge outlined the dynamics of sexual abuse by health professions in a 1998 decision as included in the final report of the Task Force on Sexual Abuse of Patients issued in 2000 titled "*What about Accountability to the Patient?*".²²

¹⁷ College of Physicians and Surgeons of Nova Scotia, "Sexual misconduct in the physician-patient relationship," (December 2010); Katherine H. Hall, "Sexualization of the doctor-patient relationship: is it ever ethically permissible?" *Family Practice* 18, no.5 (2001): 511-515; R.I. Simon, "Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1," *Psychiatric Annals* 24, no. 11 (1994): 509-515.

¹⁸ Shirley Feldman-Summers, "Sexual contact in fiduciary relationships," in *Sexual exploitation in professional relationships*, edited by G.O. Gabbard (Washington D.C.: American Psychiatric Press, 1989), 193-209.

¹⁹ R.I. Simon, "Therapist-patient sex. From boundary violations to sexual misconduct," *Psychiatry Clinics of North America* 22, no1 (1999): 31-47; R.I. Simon, "Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1," *Psychiatric Annals* 24, no.11 (1994): 509-515; Joel Friedman, and Marcia Mobila Boumil, *Betrayal of trust: sex and power in professional relationships* (Westport, CT: Praeger Publishers, 1995).

²⁰ Shirley Feldman-Summers, "Sexual contact in fiduciary relationships," in *Sexual exploitation in professional relationships*, edited by G.O. Gabbard (Washington D.C.: American Psychiatric Press, 1989), 208.

²¹ R.I. Simon, "Therapist-patient sex. From boundary violations to sexual misconduct," *Psychiatry Clinics of North America* 22, no1 (1999): 31-47; R.I. Simon, "Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1," *Psychiatric Annals* 24, no.11 (1994): 509-515; Joel Friedman, and Marcia Mobila Boumil, *Betrayal of trust: sex and power in professional relationships*. (Westport, CT: Praeger Publishers, 1995).

²² Marilou McPhedran et al., "*What about accountability to the patient?*" *Final report of the Special Task Force on Sexual Abuse of Patients*, (2000).

Sexual Abuse Provisions in the RHPA and Treatment of Spouses

A recent court decision and subsequent debate in the media and among regulated health professionals have revealed some concerns regarding the sexual abuse provisions in the RHPA. A 2010 appellate court decision (*Leering v. College of Chiropractors of Ontario*²³) upheld the College of Chiropractors of Ontario's disciplinary panel decision, ruling that, where a health professional/client relationship has been established and sexual intercourse has occurred, sexual abuse will be the resulting finding regardless of the nature of the relationship, including a pre-existing spousal or conjugal relationship between the health professional and patient. In other words, if a health professional is found to be treating their spouse (with whom they have an established sexual relationship) they would be subject to the mandatory revocation provision of the RHPA. (See Legislative Summary section for further discussion on this topic.)

Media coverage on the zero tolerance provisions has criticized its effectiveness, citing lengthy delays in the resolution of complaints and low numbers of cases reaching the disciplinary hearing stage.²⁴ Media coverage has also focused on aspects of the sexual abuse provisions perceived to be unfair to spouses of some regulated health professionals.²⁵ Some regulated health professionals were operating under the assumption that the sexual abuse provisions did not apply to spouses.²⁶

Treatment of a Spouse (or related person)

Many of the regulatory colleges actively discourage the treatment of spouses (or related persons). Some colleges grant exceptions for emergency, episodic care or the provision of care in remote regions where finding an alternate health care provider is not possible or practical.

A review of health profession-specific legislation and college documents showed wide variation in colleges' position for treating a spouse (or related person).

²³ *Leering v. College of Chiropractors of Ontario*, [2010] ONCA 87.

²⁴ Judy Steed, "Less than zero tolerance on patient abuse," *Toronto Star*, April 8, 2011.

²⁵ Theresa Boyle, "Dentists flout 'stupid' law that treats them as sex abusers," *Toronto Star*, April 20, 2011.

²⁶ Royal College of Dental Surgeons of Ontario, "Ontario Court of Appeal decision says Zero Tolerance Rule bans health providers from treating spouses or partners," *Dispatch*, May/June 2010.

Of the twenty-one health regulatory colleges:

- Six prohibit the treatment of spouses (or related persons) through standards of practice - except for episodic care, emergency care, when no alternate provider can be found or when no payment is received.²⁷
- Nine provide guidelines/comments to their members against treating a spouse (or related person).
- Three communicate that it is permissible to treat related persons. Some of these colleges state it is inherent to the profession's culture to include family and or related persons in their practice. For example, the College of Midwives of Ontario has stated that "Midwives...provide primary health care during a period of a woman's life that is often considered to be a family event. This context of care provision may influence a midwife's decision to provide care to family members, friends or colleagues, as midwives may want to be involved in the care of their loved ones during this important time".²⁸
- Two do not have an official position on treating spouses (or related persons).²⁹
- Four have no documentation on their websites pertaining to spousal treatment. However, communication documents were found on the websites advising their members about the Leering court case and the potential to be charged with sexual abuse for treating one's spouse.³⁰

Where a college explicitly discourages treatment of a spouse (or a related person) the reasons are:

- Concerns about lack of objectivity when treating a related person. Several of the colleges speak of dual relationships³¹ where the member's professional objectivity may be compromised.
- Concerns that the related person may not feel free to disclose personal information that may have an impact on the therapeutic relationship.
- Concerns about the member's ability to maintain full patient confidentiality when treating a related person.
- Risk of billing fraud.

²⁷ All 21 health profession-specific Acts have professional misconduct regulations which state that not upholding the college's standards of practice is considered to be professional misconduct. Therefore, if a college has a standard which prohibits their members from treating a related person, members who violate this standard may be reviewed by the discipline committee for professional misconduct.

²⁸ College of Midwives of Ontario, *Guidelines for Midwives caring for related person* (September 2010).

²⁹ College of Denturists of Ontario and College of Medical Radiation Technologists of Ontario both indicated in their submissions they do not have an official position on treatment of spouses.

³⁰ Royal College of Dental Surgeons of Ontario, "Ontario Court of Appeal decision says Zero Tolerance Rule bans health providers from treating spouses or partners," *Dispatch*, May/June 2010; College of Denturists of Ontario, "Ontario health practitioners can no longer treat their spouses," *Contact Update*, July 2010; College of Opticians of Ontario, "Ontario Court of Appeal Confirms Treatment of Spouses by Health Professionals - "Zero Tolerance" Reminder," *Viewpoint*, Sept 2010.

³¹ A dual relationship is defined by some colleges as having any type of relationship with a patient/client outside of the therapeutic relationship. Having dual relationships may be a potential for conflict of interest where patient-centered care is jeopardized.

With the most recent court ruling on *Leering vs. College of Chiropractors of Ontario*, members of some regulated health colleges have been informed that treating a spouse may be viewed as sexual abuse as defined in the RHPA.

3. HPRAC's Approach

When a referral is received from the Minister, HPRAC determines relevant public interest concerns and questions. HPRAC attempts to understand all perspectives on an issue including those of key health professionals, other affected health professionals, clients and patients, advocates and regulators. Each issue proceeds through a multi-stage process where information and responses are requested from and shared with stakeholders. HPRAC conducts literature, jurisdictional and jurisprudence reviews, and engages in key informant interviews. Its analysis of the issues leads to a determination of additional information required, and the appropriate processes to be used.

Overview of Consultation Process

Stakeholder input informs HPRAC in developing its recommendations to the Minister. As noted previously, as part of its consultation process, HPRAC notifies and consults with stakeholders whom, in HPRAC's opinion, could potentially be affected. The various stakeholders and interested parties include regulatory health colleges, health profession associations, health care providers and the public. In general, the following key principles are used in developing the consultation program:

- Inclusion of interested stakeholders and members of the public at a level of involvement suitable to their needs and interests.
- Flexibility to respond to unanticipated issues and stakeholder input throughout the referral period.
- An expectation that the consultation process would crystallize broad themes as well as highlighting unanticipated "outlier" issues. The numerical results were never expected to indicate support for, or opposition to, a particular topic. By definition, respondents self select to participate in the consultation process and, in so doing, present their own particular biased views on the subject matter.
- Incorporation of issues, concerns, comments and perspectives brought forward into the recommendation-making process.
- Ensuring that all consultation material was available in both official languages and, on request, providing information on accessible formats.

Within its mandate, HPRAC may consult with selected individuals and organizations to obtain information it deems necessary to complete the review of the Minister's referral. Persons or organizations with identified expertise or stake in the issue may be invited, at HPRAC's discretion, to make presentations, reports or submissions to HPRAC. These individuals and

groups may include hard-to-reach groups as well as those individuals and groups who may not have adequate resources to participate in standard processes and methods.

In this particular referral, town hall sessions were conducted across Ontario. These consultation meetings allowed stakeholders and the public to identify any concerns or issues that should be addressed in the referral.

Risk of Harm and Public Interest

The Minister's referral letter requested that HPRAC include an evaluation of the risk of harm the alternatives, if any, may pose and the public interest implications. Risk of harm, as a concept, is fundamental to the protection of the public and this principle is woven into the fabric of the RHPA. Section 30 (1) of the RHPA references risk of harm as, "serious bodily harm [which] may result from the treatment or advice or from an omission..."

The Supreme Court of Canada, in the leading case concerning the interpretation of the phrase, defined "serious bodily harm" to mean, "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the physical or psychological integrity, health or well-being of a complainant."³²

Therefore, in the context of this referral HPRAC adopted the following definition of risk of harm in its evaluation of whether alternatives should exist to the mandatory revocation provisions in the RHPA in relation to the treatment of a spouse:³³

The term risk of harm refers to actions where a substantial risk of physical or mental harm may result from the practice of the profession. This criterion is intended to provide a clear articulation of the degree of harm posed by the profession to the health and safety of the public. In addressing the risk of harm in this context, the applicant is asked to identify the risks associated with the practice of the profession concerned, as distinct from risks inherent in the area of health care within which the profession operates.

³² *R.v.McCraw*, [1991] 3 S.C.R. 72.

³³ Health Professions Regulatory Advisory Council, *Regulation of a New Health Profession under the Regulated Health Professions Act (RHPA), 1991, Criteria and Process*.

Public Interest

Again, as part of the RHPA, public interest is stated within the Minister's duty to ensure, "...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."³⁴

Within the context of this definition of public interest, HPRAC used the following principles to evaluate whether alternatives should exist to the mandatory revocation provisions in the RHPA in relation to the treatment of a spouse:³⁵

- Protect the public from unqualified, incompetent and unfit health care providers to the extent possible.
- Establish mechanisms to encourage the provision of high quality care.
- Provide the public with freedom of choice within a range of safe health care options.
- Establish scope of evolution in the roles played by individual professions and flexibility in how individual professionals can be utilized, to ensure maximum system efficiency.
- Ensure regulation is proportionate to risk to patients and public.
- Ensure regulation is efficient by minimizing duplication and avoiding delays in taking action to protect the public.

³⁴ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, s. 3.

³⁵ Health Professions Legislation Review, *Striking a New Balance: a Blueprint for the Regulation of Ontario's Health Professions*, (1989): 6; Department of Health, *Extending Professional and Occupational Regulation* (Leeds: Author, 2009).

4. Literature Review

HPRAC commissioned a literature review in September 2011 to understand the risks and merits of allowing sexual relations between health care providers and their patients. The initial focus of the review was spousal treatment by health professionals; however, few studies addressed treatment of patients who were sexual partners before treatment occurred. Therefore, the scope was expanded to include sexual relationships between patients and providers, generally. This information was posted publicly on the HPRAC website³⁶ for consideration during public consultations.

The literature review centered on the following parameters:

1. Ethical concerns around sexual relationships between health care providers and spouses or sexual partners.
2. Prevalence of sexual boundary violations.
3. Risk factors leading to such boundary violations.
4. Impact of sexual relationships with health care providers on patients.
5. Recidivism and effectiveness of disciplinary mechanisms in other jurisdictions.

Five professions were of particular interest: physicians, dentists, psychologists, chiropractors, and massage therapists.

Analysis

The literature review identified only one article that specifically mentions spousal treatment by health professionals. Authors of this one article identified the treatment of spouses could reasonably be excluded from definitions of sexual boundary violations.³⁷ All other articles and studies focused on other issues associated with the broader subject of health care provider-patient relationships.³⁸

In regards to other aspects of sexual boundary violations, the review found there were disagreements about how to define boundaries for acceptable sexual contact between patients and providers. Some experts argued that zero tolerance for an infinite period of time following

³⁶ http://www.hprac.org/en/projects/resources/LiteratureReview_SexualRelationshipsbetweenPatientsandHealthProfessionals.pdf

³⁷ G.E. White, J.A. Coverdale, A.N. Thomson, "Can one be a good doctor and have a sexual relationship with one's patient?" *Family Practice* 11, no. 4 (1994).

³⁸ *Ibid* 37.

termination of the professional relationship, especially with respect to psychotherapeutic relationships is an appropriate standard.³⁹ Other experts have advised more flexibility in defining what is an appropriate relationship following treatment.⁴⁰ Flexibility was given based on factors such as the nature of the professional relationship (e.g., therapeutic or not), the length of time since treatment ended, and whether or not the patient had a condition that could affect their ability to make decisions.⁴¹

Although the review did not find any articles on the effectiveness of disciplinary mechanisms, the review noted one article which argued different standards should apply to different disciplines.⁴²

³⁹ Marilou McPhedran et al., The Final Report of the Task Force on Sexual Abuse of Patients, Commissioned by the College of Physicians and Surgeons of Ontario, (November 25, 1991); P.S. Appelbaum, L.M. Jorgenson, and P.K. Sutherland, "Sexual Relationships between Physicians and Patients," *Archives of Internal Medicine* 154 (1994): 2561-2565.

⁴⁰ J. Coverdale, T. Bayer, E. Chiang, J.Thornby, M. Bangs, "National survey on physicians' attitudes toward social and sexual contact with patients," *Southern Medical Journal* 87, no. 11 (1994).

⁴¹ N. Jousset, A. Gaudin, M.Penneau, C. Rouge-Maillart, "Practitioner sex abuse: occurrence, prevention and disciplinary sanction," *Medicine, Science and the Law* 48, no. 3, (2008).

⁴² S.W. Gorman, "Sex outside of the therapy hour: Practical and constitutional limits on therapist sexual misconduct regulations," *UCLA Law Review* 56 (2009):983-1038.

5. Jurisdictions Review

HPRAC completed a jurisdictional review in July 2011 on the issue of mandatory revocation provisions and treatment of spouses by regulated health professionals. The purpose of the review was to determine how other jurisdictions address sexual misconduct⁴³ in legislation and whether legislation specifically addresses the treatment of a spouse by regulated health professionals.⁴⁴

The review included the legislation, regulations, codes and standards relating to seven professions across ten Canadian provinces, six U.S. jurisdictions, as well as the U.K., Australia, South Africa and New Zealand. The websites for each jurisdiction's regulatory body and professional association were also examined for supporting documentation. Where adequate information was not available online, key informant interviews were held by telephone with representatives of regulatory bodies and government. Email correspondence served to gather further documentation.

Seven professions were chosen for this review based on a combination of the number of sexual misconduct complaints their Ontario colleges receive annually (as stated in annual reports) and the professions' exposure to the patient. They are: physician, chiropractor, dentist, dental hygienist, massage therapist, nurse and psychologist.

The summary of the jurisdictional review was posted publicly on the HPRAC website⁴⁵ for consideration during public consultations.

Analysis

In the jurisdictions examined, Ontario's sexual abuse provisions and mandatory penalty as described in the RHPA is unique. There is a wide variation in how regulatory bodies deal with sexual misconduct by health professionals and different mechanisms are utilized depending on the profession and province. Sexual misconduct can be addressed directly in legislation (i.e. omnibus legislation or health profession-specific Acts or regulations), or it can be addressed in the professions' ethical codes or standards of practice. Sexual misconduct can also be addressed indirectly under the concepts of "unprofessional conduct," "professional conduct," "dishonourable conduct" and the like, which can be found explicitly in the legislation.

⁴³ During the jurisdictional review many jurisdictions used the terms sexual "misconduct", "abuse", "impropriety", "contact", and "relations" interchangeably, with sexual misconduct being the most common; therefore, sexual misconduct was chosen to be the consistent concept for jurisdictional analysis.

⁴⁴ Based on the Minister's referral letter to HPRAC, the term spouse will include "common-law" partners.

⁴⁵ http://www.hprac.org/en/projects/resources/JurisdictionalReview_MandatoryRevocationProvisionsTreatmentofSpousesbyRegulatedHealthProfessionals.pdf

Of the ten Canadian provinces reviewed only three provinces, Ontario, Quebec and Prince Edward Island (PEI) have explicit references to penalties for sexual misconduct in their legislation; only Ontario has a five-year mandatory revocation.

Among the Canadian provinces with an omnibus legislation to govern the regulation of health professions, none explicitly address the issue of spousal treatment in their law. The issue of spousal treatment is addressed through other mechanisms. For example, Alberta by way of standards of practice, permits chiropractors to treat their spouse, but prohibits psychologists from doing the same.

Among the international jurisdictions reviewed, California exempts a regulated health professional from being charged with sexual misconduct if found to be treating his/her spouse. Other jurisdictions address spousal treatment through different mechanisms depending on the profession.

In general, the review found four basic models used with respect to the treatment of a spouse by a regulated health professional.

- **Model 1** – Sexual abuse provision in legislation with explicit spousal exemption clause (except in the case of psychotherapeutic treatment).
- **Model 2** – Each regulatory body has the discretion to determine the sexual abuse provision in their respective legislation and determine if a spousal exemption should exist.
- **Model 3** – Sexual abuse provision exists within an omnibus legislation and the penalty for the provision is determined case-by-case by the regulatory body.
- **Model 4** – Sexual abuse provision exists within an omnibus legislation with mandatory penalty associated with it.

In those models permitting a discretionary approach, there is a wide variation in how regulatory bodies deal with sexual misconduct by health professionals. Where a mandatory penalty is required, no information was found that identified alternative punishments for sexual abuse for health professionals that treat their spouse.

Definitions of Spouse

The review found few definitions of spouse in legislation. For example, in Alberta the standards of practice applicable to chiropractors define spouse to include a common-law partner. In California, the term is not specifically defined but the legislation includes a “person in an equivalent domestic relationship” as permissible for a health professional to treat.⁴⁶

In addition to the jurisdictional review, Ontario and Canadian laws were searched for a definition of spouse. Most definitions of spouse encompass the idea of marriage⁴⁷ or some form of cohabitation.^{48, 49} For example, some definitions considered subjects like marriage/cohabitation, the length of the relationship and even the presence of children. Many of the Ontario laws reviewed simply referred to the definition of spouse in another Act – the definition offered in Ontario’s *Family Law Act, 1990* was often referenced. Overall the majority of definitions had only slight variations from each other.

⁴⁶ *California Business and Professions Code §726.*

⁴⁷ *Family Law Act, R.S.O. 1990, c. F.3, s. 1(1).*

⁴⁸ *Health Care Consent Act, 1996, S.O. 1996, c.2, Sched.A, s. 20(7).*

⁴⁹ *R.R.O. 1990, Reg. 636, s. 1.*

6. Legislative Summary & Jurisprudence Review

RHPA - General

In Ontario, the 23 regulated health professions are governed under the RHPA and each profession's complimentary profession-specific Act. Health regulatory colleges are responsible for regulating their respective professions including, among other things, establishing rules, policies and standards of practice for their respective professions, within the overall structure of the legislation.

The RHPA includes provisions related to the sexual abuse of patients by regulated health professionals based on the zero tolerance policy adopted by the Ontario government in the early 1990's. Under the RHPA, health care professionals are prohibited from engaging in a sexual relationship with a patient and a co-existing sexual and health professional-patient relationship is considered under the legislation to be professional misconduct, and further defined as sexual abuse.

Subsection 1(3) in the Health Professions Procedural Code of the RHPA (the Code) defines "sexual abuse" of a patient by a member as:⁵⁰

- 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.

Subsection 51 (5) in the Code further states that certain acts of sexual abuse committed by a regulated health professional are grounds for mandatory revocation of the individual's certificate of registration for a minimum of five years. These acts include:⁵¹

- sexual intercourse,
- genital to genital, genital to anal, oral to genital, or oral to anal contact,
- masturbation of the member by, or in the presence of, the patient,

⁵⁰ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 1(3).

⁵¹ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 51(5).

- masturbation of the patient by the member,
- encouragement of the patient by the member to masturbate in the presence of the member.

When there is an alleged violation of this sexual abuse provision and the college is notified of this violation by a complainant, a complaints and disciplinary process ensues.

Regulatory College Committees

As part of the colleges' duty to regulate the profession in the public interest, all health regulatory colleges carry out a complaints and disciplinary process. Under the RHPA, patients (or anyone else) have a way to engage the colleges' oversight functions through the complaints process.

Under the RHPA, each college is obligated to establish an Inquiries, Complaints and Reports Committee (ICRC) and a Discipline Committee (DC) (See Appendix A for a comparison of the ICRC and DC). The ICRC is an investigative body established to review formal complaints⁵² and Registrar's reports, including those related to professional misconduct.⁵³ An ICRC investigation is initiated when a complaint is made to the college. The ICRC has discretionary powers to determine whether there is sufficient evidence to refer the matter to the DC.⁵⁴ Based on the evidence, the ICRC has the power to dismiss complaints if they believe the complaint is frivolous or vexatious in nature.⁵⁵ The ICRC is not an adjudicator of complaints and is not required to hold public hearings or publish its decisions.

Once the ICRC refers a complaint (e.g. sexual abuse) to the DC for investigation, the DC's decision is made public and the member's name is associated with the discipline committee's decision on the college's public registry until the issue has been resolved.⁵⁶ Hearings conducted by the DC are open to the public unless there is a compelling reason for privacy. Decisions from a DC hearing about a member would also be published in the college's annual report or any other publication of the college. Other information available to the public includes notations about every finding of professional negligence or malpractice against a regulated health care provider (unless it is reversed on appeal);⁵⁷ and notations where a member resigned or agreed never again to practice in Ontario as a result of a proceeding under the ICRC.⁵⁸

⁵² Section 25(4) of Health Professions Procedural Code states, "A panel shall not selected to investigate a complaint unless the complaint is in writing or is recorded on a tape, film, disk or other medium."

⁵³ Complaints do not have to come from the patient or person affected by the conduct. The Registrar could be notified of a member's professional misconduct through a third party and initiate an investigation through the appointment of an investigator, with the approval of the ICRC.

⁵⁴ Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act* (Canada: Canada Law Book, 2011).

⁵⁵ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s 26(4).

⁵⁶ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s 23(2)7.

⁵⁷ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s 23(2)6.

⁵⁸ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s 23(2)13.

If the DC finds that a member has committed an act of professional misconduct by sexually abusing a patient, the committee is required by legislation to do the following (in addition to anything else the panel may do).⁵⁹

From section 51(5)

1. Reprimand the member.
2. Revoke the member's certificate of registration if the sexual abuse consisted of acts under paragraph 2 of section 51. (5).

Other Ontario Statutes

Within Ontario's health care context, two other statutes specifically address the issue of service exchange with a spouse. The *Long-Term Care Homes Act, 2007* and the *Retirement Homes Act, 2010* have clear prohibition of sexual abuse. Both statutes also have exemptions to the sexual abuse offence for consensual sexual relationships between a licensee/staff member and resident if that relationship has predated the resident's admittance to the facility and/or the staff member's date of employment. This is unlike the RHPA which does not provide explicit exemptions to zero tolerance for spousal relationships. A summary of the relevant portions of the legislation is found in Appendix B.

Jurisprudence Review

In August 2011, HPRAC commissioned a jurisprudence review of cases in which a regulated health professional's certificate of registration was sought to be revoked as a result of a sexual relationship with a patient. The review focused on treatment provided by regulated health professionals to people with whom they were in a spousal relationship or with whom they were living in a conjugal relationship outside of marriage. This information was posted publicly on HPRAC website⁶⁰ for consideration during public consultations.

The jurisprudence review examined several unique, Canadian cases. In addition, two relevant American sexual abuse cases were also examined. One case involved mandatory revocation of a health professional's licence and the other involved a one-year suspension followed by a year of probation. The scope of the jurisprudence review was limited to physicians, chiropractors and psychologists; however, other relevant cases involving other regulated health professions have also been reviewed by HPRAC in the course of researching this referral.

⁵⁹ Refer to subsection 51 (2) of the Code.

⁶⁰ http://www.hprac.org/en/projects/resources/JurisprudenceReview_TreatmentofSpousesbyRegulatedHealthProfessionals.pdf

College of Chiropractors of Ontario

The appellate court decision for *Leering v. College of Chiropractors of Ontario*⁶¹ has generated some public interest in the sexual abuse provisions of the RHPA. The Leering decision represented the third time that the zero tolerance sexual abuse provisions had been challenged in the Court of Appeal. The Courts upheld the disciplinary panel decision, ruling that, where a health professional/client relationship has been established and sexual intercourse has occurred sexual abuse will be the resulting finding regardless of the nature of the relationship or when the relationship began. In other words, if a health professional treats his/her sexual partner; they would be subject to the mandatory revocation provisions of the RHPA.

College of Nurses of Ontario

Cases heard by a health regulatory college's discipline committee are not always appealed in court. For example, in their submission to HPRAC, the College of Nurses of Ontario (CNO) reported one sexual abuse case involving a spousal relationship that resulted in a mandatory revocation.⁶²

In this case, CNO's discipline committee learned of sexual activity that took place between a nurse and her long-term client, including relationship evidence such as cohabitation; the establishment of joint bank accounts; and the changing-of-hands of large sums of money. When the relationship ended, the client reported the member to the CNO. The member pleaded guilty to committing acts of professional misconduct that included engaging in physical sexual relations or touching of a sexual nature with the client. As a result, regardless of the circumstances surrounding the relationship, the discipline committee panel was bound by the sexual abuse provisions of the RHPA to order an oral reprimand and revoke the member's certificate of registration. In its decision, the panel indicated "since the Member admitted to the allegations of sexual abuse, no mitigating or extenuating circumstances would change the penalty decision."⁶³ The panel concluded the proposed penalty is reasonable and in the public interest, and this decision was never appealed to the courts.⁶⁴

College of Dental Hygienists of Ontario

The College of Dental Hygienists of Ontario (CDHO) also reported one sexual abuse case involving spousal relationship that resulted in a mandatory revocation.⁶⁵ In this particular case, the CDHO received a complaint about one of its members who developed a personal and sexual relationship with a client; a relationship that eventually ended in marriage. The complaint was filed by the member's spouse some years later after the marriage had dissolved. CDHO concluded that although the member's conduct was not predatory in nature the law was clear: upon the finding that the member's conduct met the definition of sexual abuse in the RHPA, the

⁶¹ *Leering v. College of Chiropractors of Ontario*, [2010] ONCA 87.

⁶² College of Nurses of Ontario (CNO) submission to HPRAC, January 2012.

⁶³ College of Nurses of Ontario, Discipline Decision for Ms. D. Leahey. November 19, 2007.

⁶⁴ *Ibid* 63.

⁶⁵ College of Dental Hygienists of Ontario (CDHO) submission to HPRAC, January 2012.

mandatory revocation provisions needed to be invoked.⁶⁶ Again, this decision was never appealed to the courts.

Analysis

The sexual abuse provisions in the RHPA have been challenged in the Ontario Court of Appeal, and the court has upheld the decisions of disciplinary panels when the panel has invoked the mandatory revocation penalty for sexual abuse.⁶⁷ In coming to its decision, the Court has examined and confirmed the importance of the zero tolerance provisions including the ethical considerations, such as power imbalance, transference, trust and consent. However, the Court has also acknowledged the difficulty of its decisions in situations where there is truly a consensual relationship unrelated to the doctor-patient (or provider-patient) relationship.⁶⁸

In determining whether sexual abuse occurred, the current legislation does not allow the nature of the sexual relationship to be considered, such as the expected and assumed sexual relationship between spouses. A guilty sexual abuse finding by a discipline committee or higher court is determined by the presence of a concurrent sexual and a health professional-patient relationship. Once this factual determination has been made, no further inquiry is required.⁶⁹ The result of this factual determination for the discipline committee is the application of the mandatory revocation punishment.

Some legal scholars have also considered the challenges associated with mandatory orders, specifically about the unfairness that can result from mandatory orders.⁷⁰ This was made in reference to the Leering case as well as other non-health care related court decisions.⁷¹

Canadian Charter of Rights and Freedoms Challenge

The jurisprudence review referenced three cases that dealt with Charter challenges.⁷² With respect to the Mussani decision, the claim was made that the mandatory revocation provisions for sexual abuse in the RHPA violated sections 7 and 12 of the *Canadian Charter of Rights and Freedoms*.⁷³ The court dismissed both claims and found no constitutional right to practise a profession unfettered by the applicable rules and standards. The courts further found the

⁶⁶ College of Dental Hygienists of Ontario, Discipline Decision for Ms. Mizzau, March 4, 2005.

⁶⁷ *Mussani v. College of Physicians and Surgeons of Ontario*, [2004] OJ No. 5176; *Rosenberg v. College of Physicians and Surgeons of Ontario*, [2006] D.L.R. (4th) 275; *Leering v. College of Chiropractors of Ontario*, [2010] ONCA 87.

⁶⁸ *Leering v. College of Chiropractors of Ontario*, [2010] ONCA 87.

⁶⁹ *Ibid* 68.

⁷⁰ *R v. Smickle*, [2012] ONSC 602 – case of mandatory order with illegal firearms.

⁷¹ *Ibid* 70.

⁷² *Mussani v. College of Physicians and Surgeons of Ontario* [2004], 74 O.R. (3d); *AB v. College of Physicians and Surgeons of Prince Edward Island*, [2001] PESCTD 75,204 DLR (4th) 750; *Rosenberg v. College of Physicians and Surgeons of Ontario*, [2006] D.L.R. (4th) 275.

⁷³ Section 7 states: Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. Section 12 states: Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

requirement to choose between terminating a professional relationship with a patient or entering into what can be a consensual, non-exploitive sexual relationship with that patient entails no loss of life, liberty or security under the Charter, thus upholding the sexual abuse provisions of the RHPA.

At the time of writing this report an additional Notice of Constitutional challenge has been filed related to the sexual abuse provisions in the RHPA; the case is outstanding.⁷⁴

⁷⁴ *Hanif v. Ministry of the Attorney General of Ontario and Ontario College of Pharmacists*, 2012 to be heard by The Ontario Superior Court of Justice.

7. Consultation Program

As part of this referral from the Minister, HPRAC conducted an extensive consultation program to develop its recommendations. These consultations occurred from October 2011- January 2012. To ensure the broadest possible consultation process, HPRAC included, in addition to written submissions (paper and on-line), a series of eight town hall sessions at major centres in the province.

Identification of Stakeholders

To ensure that the broader community of interest had the opportunity to participate in this referral, a number of groups/organizations and individuals were identified. They were included in the consultation notifications, invitations to on-line surveys, focus groups and other consultation activities. HPRAC made every effort to reach relevant stakeholder groups and individuals across the province. The following are the stakeholder groups HPRAC consulted to gather feedback (for a detailed list of stakeholders, refer to Appendix C):

- Regulatory Health Colleges;
- Regulated Health Profession Associations;
- Regulated Health Care Professionals;
- Academics/Experts with interest/expertise in regulation, sexual abuse, women's issues, ethics, and law;
- Organizations/Groups with an interest in regulation, sexual abuse, women's issues, and Lesbian Gay Bisexual and Transgender issues;
- Local Health Integration Networks; and
- Public.

HPRAC Website

HPRAC's website was the primary communication mechanism for this referral. Information was posted on the referral specific webpage on the site to provide broad access to information about the referral.

On a weekly basis, submissions received were posted for review along with meeting summary notes from the town hall sessions.⁷⁵

Background Material for Consultations

HPRAC's literature, jurisdictional and jurisprudence reviews on the issue of mandatory revocation provisions and treatment of spouses by health professionals were made available to all stakeholders via the HPRAC website and included as background information to the consultation process. In addition to these three research documents, HPRAC also prepared a background paper to summarize key issues presented in its research.

Methods of Consultation

Key Informant Consultations

A number of key informant interviews were conducted. The purpose of the interviews was to identify stakeholders' interests and concerns early in the consultation process. Interviews were requested with representatives of key stakeholder groups and individuals with expertise in the area of sexual abuse. These groups and individuals were chosen for their involvement in activities related to sexual abuse issues.

Key informant interviews included:

- Joint Centre for Bioethics – University of Toronto.
- Ethno-cultural consultations with medical practitioners from the Middle East and health representatives and health centers servicing Aboriginal communities.
- Sanda Rodgers, retired Professor of Law, University of Ottawa, sexual abuse and legislative academic expert on women's issues and health law.
- Echo: Improving Women's Health in Ontario.

Stakeholder Consultations

HPRAC used three mechanisms to obtain broad stakeholder input:

1. written submissions through on-line web-based survey,
2. feedback form submitted by fax or mail, and
3. town hall sessions across Ontario.

⁷⁵ <http://www.hprac.org/en/projects/spousaltreatment.asp>.

A series of eight town hall sessions were conducted in seven cities across Ontario to compliment feedback provided through the on-line and paper submission format. The town hall sessions provided the opportunity for stakeholders and the public to identify any concerns or issues that should be addressed in the referral. It was not necessary to attend a consultation meeting if the stakeholder was able to convey his/her comments through other available feedback mechanisms. Locations were selected to obtain a broad range of input from across Ontario.

Each location held two consultation sessions (one for the public/public interest organizations and one for the health professionals/professional organizations). The consultation meetings were advertised via the HPRAC website, electronic media, regulatory colleges and regulated health professions associations.

The questions asked in each of these mechanisms were identical and can be found in Appendix D.

Analysis approach

Submissions were reviewed to determine key recommendation themes and to highlight issues with regard to the current legislation. A number of submissions included multiple recommendations. Therefore, percentages referenced in the following analysis reflect the number of times an item was mentioned in the consultation and not the number of respondents who made the recommendation. The recommendations and issues were then deliberated to determine how they impact risk of harm and public interest.

Important Note

It should be emphasized that HPRAC's expectation of the consultation process was that it would crystallize broad themes as well as unanticipated issues and would not be viewed as a quantitative indication of stakeholder interests or concerns.

Findings

A total of 972 submissions were received, with 917 submitted by individuals and 55 from organizations. Of the individual submissions, 43% were from dental professions (dentists, dental hygienists or spouses of either profession) and 11% were submitted from other regulated health professionals or spouses of health professionals. The remaining 46% did not identify a specific profession affiliation.

Of the 55 organization submissions, 18 were from regulated health colleges, 24 from health professional associations, while the remaining 13 were from other associations or joint submissions.

When asked if alternatives should exist for the mandatory revocation provisions in the RHPA, majority of the responses said “yes” (see Appendix E– Figure 1 for summary of responses). When asked what these alternatives should be, the options proposed reflected three themes:

- Change the definition of the sexual abuse offence in the RHPA.
- Maintain the sexual abuse offence and permit an exemption to penalty.
- Maintain the sexual abuse offence and permit proportional penalties.

The first three options were further broken down to sub-alternatives. A detailed explanation can be found in Appendix F.

Table 1. Suggested alternatives to the mandatory revocation provisions

Option	Sub-Alternatives
Change the definition of sexual abuse in the RHPA	<ul style="list-style-type: none"> • Define terms and/or nature of relationship. • Exempt treatment of spouses from the offence (all cases). • Exempt treatment of spouses from the offence (some cases). • Exemption to offence for circumstantial treatment of a spouse. • Remove sexual abuse offence from the RHPA.
Maintain the sexual abuse offence and permit an exemption to penalty	<ul style="list-style-type: none"> • Spousal exemption for <u>all</u> regulated health professionals. • Spousal exemption for <u>some</u> regulated health professionals. • Spousal exemption where explicit consent exists for treatment. • Remove sexual abuse penalty from the RHPA.
Maintain the sexual abuse offence and permit proportional penalties	<ul style="list-style-type: none"> • Review individual complaints on a case-by-case basis. • Change the length / severity of punishment. • Abolish the punishment.

Where general comments were provided, many of the submissions and feedback from the town hall sessions identified unintended consequences from the current mandatory revocation provisions in the RHPA. They were:

- Loss of patient’s choice of health provider;
- Access to care, particularly for remote, northern communities;
- Trust, particularly as it relates to those with health provider phobias;
- Deviation from the intent of the legislation;
- Malicious misuse of the legislation;
- Financial hardship;
- Damage to reputation; and
- Undermining effective reporting of true sexual abuse cases.

Many of these considerations affect risk of harm and public interest concerns with the status quo.

What HPRAC Heard

The spousal treatment consultation program resulted in more responses than any prior HPRAC referral. The 972 respondents represented a wide range of interests from individuals, spouses, and patients to regulatory colleges and associations. While there was a broad range of respondents, a large volume of responses came from the dental community (dentists, spouses of dentists and dental hygienists). This section of the report will highlight some of the key themes, opinions and outlier issues provided to HPRAC during the consultations.

At each town hall session, a member of the HPRAC council heard respondents and acted as moderator. All responses were documented for sharing on the HPRAC website. HPRAC heard first hand the sensitivity of the issue as well as the impact the current mandatory revocation provisions have on individuals and families.

Many submissions voiced continued strong support for zero tolerance towards sexual abuse committed by regulated health professionals. However, there were also very strong opinions registered with respect to the fairness of the current mandatory revocation provisions for sexual abuse in relation to the treatment of a spouse. These submissions supported a variety of policy options regarding alternatives to the mandatory revocation provisions for the treatment of spouses by health care professionals.

No Changes to Definition or Revocation Provisions

A limited number of submissions supported the status quo; that is, no change to the current legislative provisions regarding mandatory revocation for sexual abuse when treating a spouse. Two colleges indicated their preference to be excluded from any exemptions to the current sexual provisions in the legislation, if provided.⁷⁶

The respondents supporting the status quo reported that the existing provisions can be applied fairly, and are not overly broad.⁷⁷ They report there is enough capacity within the RHPA to deal with allegations of sexual abuse through the investigative process of ICRC.⁷⁸

These respondents were concerned that any alternatives to the current legislative status may create a double standard in how sexual abuse is handled by the colleges, leading to uncertainty and confusion.⁷⁹ They were also concerned that by allowing exemptions to treat a spouse, the definition of “spouse” could be open to challenge as being under-inclusive, with a risk that disciplinary hearings may focus on whether a spousal relationship existed and not whether simultaneous doctor-patient relationship and sexual relationship existed.⁸⁰

It was also suggested that the power imbalance operating in a health care provider-patient relationship is present regardless of whether the patient is a spouse or not, and that there is no reason that a spouse is more able than a non-spouse to consent to treatment by a sexual partner.⁸¹ Finally, respondents expressed the fear that any exemption implemented may erode the zero tolerance mechanism aimed at eradicating sexual abuse.⁸²

Alternatives to Mandatory Revocation provisions - No Change to Definition

Many respondents supported some form of alternative to the mandatory revocation provisions. The alternatives varied by the approach to implementation. One alternative would be to give

⁷⁶ College of Physicians and Surgeons of Ontario (CPSO) submission to HPRAC, January 2012; College of Psychologists of Ontario submission to HPRAC, January 2012.

⁷⁷ CPSO submission to HPRAC, January 2012.

⁷⁸ College of Denturists of Ontario submission to HPRAC, January 2012; College of Medical Laboratory Technologists of Ontario (CMLTO) submission to HPRAC, January 2012; College of Medical Radiation Technologists of Ontario (CMRTO) submission to HPRAC, January 2012; CNO submission to HPRAC, January 2012.

⁷⁹ CMRTO submission to HPRAC, January 2012.

⁸⁰ CPSO submission to HPRAC, January 2012.

⁸¹ CPSO submission to HPRAC, January 2012.

⁸² CNO submission to HPRAC, January 2012; CPSO submission to HPRAC, January 2012; Individual# 280 submission to HPRAC, January 2012.

regulatory colleges the discretion to both determine if their members should be permitted to treat a spouse and also the punishment that should be applied in circumstances where the college has determined that sexual abuse occurred.⁸³ However, the manner in which such discretion would be applied varied.

Some respondents suggested that the penalty provisions be removed from legislation leaving colleges' discipline committee the freedom to exercise their judgment in determining appropriate penalties on a case-by-case basis.⁸⁴ Other respondents suggested that ICRC's be given greater discretion to decide on proceeding with an allegation of sexual abuse against a member where the patient satisfies a clear definition of spouse.⁸⁵

Another alternative presented was to maintain the current mandatory revocation provisions, but allow individual regulatory colleges to apply for exemption through regulations.⁸⁶ The onus would be placed on each college seeking exemption to demonstrate why this prohibition need not apply to their members based on public interest and risk of harm.⁸⁷ Where a spousal exemption would be granted, the college regulation could specify the conditions or circumstance under which a member of that college would be permitted to treat his or her spouse, with a focus on avoiding spousal treatment when other alternatives might be available.⁸⁸ Ministry review and approval of the regulation was seen as sufficient to ensure that appropriate interprofessional consistency and public protection is maintained.⁸⁹ It was suggested that where statutory prohibition for health professionals treating their spouses might be required, a profession-by-profession based approach with "spousal exemptions" could be included in the profession-specific acts.

Some respondents pointed out that having an exemption only for the penalty could run a risk of discipline hearings becoming an inquiry into whether a spousal relationship existed and when it became spousal, thus diverting attention away from central issue of whether there was a concurrent sexual and patient relationship.⁹⁰

⁸³ College of Physiotherapists of Ontario submission to HPRAC, January 2012; Association of Ontario Midwives (AOM) submission to HPRAC, January 2012; Ontario Society of Occupational Therapist (OSOT) submission to HPRAC, January 2012; Ontario Association of Optometrists submission to HPRAC, January 2012; Ontario Association of Prosthetists & Orthotists (OAPO) submission to HPRAC, January 2012.

⁸⁴ College of Dental Hygienists of Ontario (CDHO) submission to HPRAC, January 2012; Royal College of Dental Surgeons of Ontario (RCDSO) submission to HPRAC, January 2012; College of Opticians of Ontario submission to HPRAC, January 2012; College of Occupational Therapists of Ontario (COTO) submission to HPRAC, January 2012; Ontario Association of Speech Language Pathologists and Audiologists (OSLA) submission to HPRAC, January 2012; Ontario Dental Hygienists Association (ODHA) submission to HPRAC, January 2012; Ontario Association of MRT submission to HPRAC, January 2012; Board of Directors of Drugless Therapy Naturopathy(BDDT-N) submission to HPRAC, January 2012.; Ontario Dental Association (ODA) submission to HPRAC, January 2012.

⁸⁵ College of Chiropractors of Ontario submission to HPRAC, January 2012; Ontario College of Pharmacists (OCP) submission to HPRAC, January 2012.

⁸⁶ Ontario Physiotherapy Association submission to HPRAC, January 2012.

⁸⁷ Ontario Optician Association submission to HPRAC, January 2012.

⁸⁸ Ibid 87.

⁸⁹ Ibid 87.

⁹⁰ College of Chiropractors of Ontario submission to HPRAC, January 2012.

The issue of reputation was consistently raised. These respondents noted that even when no penalty is associated with treating a spouse, without further change to the existing definition of sexual abuse in the RHPA, a health professional found “guilty” in a disciplinary proceeding, becomes guilty of “sexual abuse.” This offence remains permanently on a member’s college public record and may suffer professionally and personally because of this label. These respondents expressed concern that the current definition of “sexual abuse” that encompass spousal relationships, detracts from the very serious policy concerns that gave rise to the legislation and undermines the legislation’s purpose.⁹¹

Current reporting requirements for sexual abuse would make members obligated to report other members who are treating his/her spouse or be at risk of professional misconduct charges.⁹² This may lead to personal and interprofessional difficulties.

Change the Definition of Sexual Abuse to Exempt Spouses

HPRAC received a significant number of submissions supporting the exemption of the sexual abuse offence when a regulated health professional treats his/her spouse. These submissions concluded that the definition of sexual abuse in the RHPA needs to change to exclude the treatment of a spouse.⁹³

A number of these respondents suggested that an exemption should exist for the treatment of spouses only for incidental or emergency treatment or when the spouse is the only or the most appropriate health care provider available.⁹⁴ Other respondents suggested that it is part of some professional cultures to treat family members including spouses (e.g. dental, midwives and chiropractic communities); with 43% of the individual submissions from the dental community, many expressed outrage that dental treatment by a spouse should be immediately equated with sexual abuse.

The respondents who suggested a change in the definition used a number of rationales. One rationale referred to the perceived inherent power imbalance that gives rise to an opportunity for sexual abuse by regulated health professionals. It was noted that this imbalance, and the

⁹¹ Ontario Chiropractic Association submission to HPRAC, January 2012.

⁹² Ontario Chiropractic Association submission to HPRAC, January 2012; ODA presentation at Toronto Consultation.

⁹³ Canadian Dental Protective Association submission to HPRAC, January 2012; Canadian Institute for Comprehensive Dental Education submission to HPRAC, January 2012; Chiropractic Awareness Council of Ontario submission to HPRAC, January 2012; ODA submission to HPRAC, January 2012.

⁹⁴ College of Chiropractors of Ontario submission to HPRAC, January 2012; Ontario Podiatric Medical Association (OPMA) submission to HPRAC, January 2012; Ontario Society of Chiropractors submission to HPRAC, January 2012; College of Chiropractors of Ontario submission to HPRAC, January 2012; College of Optometrists of Ontario submission to HPRAC, January 2012; College of Respiratory Therapists of Ontario submission to HPRAC, January 2012; Nurse Practitioners’ Association of Ontario submission to HPRAC, January 2012; Ontario Athletic Therapist Association submission to HPRAC, January 2012; and BDDT-N submission to HPRAC, January 2012.

opportunity to abuse the trust in a relationship between a regulated health professional and their patient, is not the same for all regulated health professionals.⁹⁵ The risk for sexual abuse by a regulated health professional is historically highest among medical and mental health professions and lowest in more technical professions (such as dental technologists, optician, audiologists & speech language pathologists).⁹⁶ Further, this power imbalance is seldom present in a spousal relationship⁹⁷ or if it does exist, it is a result of strength of personalities, personal history, or relative financial independence and not from the health care provider-patient relationship.⁹⁸ At the very least, according to these respondents, there should not be the blanket prohibition on the treatment of a spouse by a regulated health professional as in the existing system.

There were some concerns that having a blanket exemption may be as problematic as having a blanket inclusion of spousal relationship within the definition of “sexual abuse”.⁹⁹ A blanket exemption might restrict the capacity of a college to exercise discretion to determine whether a health professional did in fact sexually abuse the spouse when treating him/her as a patient.¹⁰⁰ Although some respondents acknowledged that there is sexual abuse between some spouses, this should be viewed as the exception and not taken as generally characterizing of spousal relationships. In the few instances where this is the case, such abuse would be best adjudicated through the criminal law system and not the health regulatory process.¹⁰¹ A blanket exemption for treatment of a spouse might be seen by some as encouraging health professionals to provide health care services to their spouses.¹⁰²

HPRAC also heard some submissions state that treating a spouse might involve conflict of interest or impaired partiality but should not automatically be categorized as sexual abuse.¹⁰³

Concerns about the current legislation

While there was unanimous support for the intent of zero tolerance to sexual abuse from health care providers, HPRAC heard from a large number of respondents that the current legislation for sexual abuse was being misdirected towards spouses of health professionals and the mandatory revocation has had a detrimental impact on the professional care they would like to receive.

⁹⁵ Ontario Association of Optometrists submission to HPRAC, January 2012; Vision Council of Canada submission to HPRAC, January 2012.

⁹⁶ College of Audiologists and Speech Language Pathologists of Ontario (CASLPO) submission to HPRAC, January 2012; College of Chiropodists of Ontario submission to HPRAC, January 2012; OPMA submission to HPRAC, January 2012; Ontario Society of Chiropodists submission to HPRAC, January 2012; College of Opticians of Ontario submission to HPRAC, January 2012; and OSLA submission to HPRAC, January 2012.

⁹⁷ CASLPO submission to HPRAC, January 2012; College of Physiotherapists of Ontario submission to HPRAC, January 2012.

⁹⁸ Ontario Chiropractic Association submission to HPRAC, January 2012.

⁹⁹ College of Physiotherapists of Ontario submission to HPRAC, January 2012.

¹⁰⁰ College of Physiotherapists of Ontario submission to HPRAC, January 2012.

¹⁰¹ Ontario Medical Association submission to HPRAC, January 2012; Individuals #194, 222, 653, 704 submissions to HPRAC, January 2012.

¹⁰² COTO submission to HPRAC, January 2012.

¹⁰³ College of Physiotherapists of Ontario submission to HPRAC, January 2012; COTO submission to HPRAC, January 2012. OCP submission to HPRAC, January 2012; RCDSO submission to HPRAC, January 2012; CDHO submission to HPRAC, January 2012; OAPO submission to HPRAC, January 2012; and ODHA submission to HPRAC, January 2012.

A number of submissions referenced correspondence issued by the ministry in the early 1990's regarding the treatment of spouses by regulated health professionals.¹⁰⁴ It is apparent that while the language used in the zero tolerance provisions includes, by application of the definition of sexual abuse, the treatment of spouses, the interpretation may have varied and the actual intent may not have been to include spouses within the definition of sexual abuse.

Another commonly heard concern was about the loss of choice. Spouses of health professionals stated their right to choose health care provider is violated by the existing legislation. Some indicated that their spouse was the person they wanted to have as their health care provider. The lack of choice is particularly problematic for individuals who live in rural/remote regions of Ontario. For these individuals, their spouse may be the only health care provider within reasonable access. If these individuals are prohibited from choosing their spouse as provider, they may need to travel great distances to find another provider or face delays or compromised attention to the health care required. In such cases, the legislation increases risk of harm, creates unnecessary financial burden and affects timely access to care.

A number of respondents raised the issue of trust. Trust is an essential part of a provider-patient relationship. HPRAC heard from many spouses and practitioners in certain professions who described an enriched health care experience due to the deep trust that is shared between spouses. For example, HPRAC heard from a number of spouses who experienced severe anxiety when receiving dental treatment, which was alleviated when treated by their spouse. Many spouses reported difficulty in finding the same level of trust with another health care provider.

Concerns were also expressed that the current legislation can be misused maliciously to ruin the reputation of a health professional by a disgruntled partner, business associate or employee.¹⁰⁵ This malicious misuse of the legislation can have a lasting negative impact on a health professional's reputation. When a member of a regulated health profession is under review for professional misconduct for sexual abuse allegations, his/her name remains on the college's public registry with that allegation until the issue has been resolved. Even if the sexual abuse allegations stem from the treatment of a spouse, this public posting may have a lasting impact on the member's reputation long after the issue has been resolved.

Concerns were also raised about undermining effective reporting of true sexual abuse cases. Currently, under the RHPA there is a mandatory reporting requirement for all regulated health professionals to report sexual abuse.¹⁰⁶ This requirement may lead to high numbers of reports in professions where spousal treatment historically is common (e.g., dentistry, chiropractic). The volume of allegations would ultimately undermine the legitimacy of the sexual abuse provisions

¹⁰⁴ ODA submission to HPRAC, January 2012; RCDSO submission to HPRAC, January 2012; Ontario Chiropractic Association submission to HPRAC, January 2012; HPRAC Summaries of Consultation Meeting, Toronto2, Participant #3.

¹⁰⁵ CASLPO submission to HPRAC, January 2012; HPRAC town hall sessions Toronto, Hamilton.

¹⁰⁶ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 85.1.

as “over reporting” of sexual abuse cases regarding spousal treatment may diminish the importance of the legislation.¹⁰⁷

The requirement for mandatory reporting of sexual abuse for spousal treatment may also undermine the intent of sexual abuse provisions in the legislation. HPRAC heard that practitioners and the public may become apathetic and lose confidence in the legislation which may result in under-reporting of non-spousal sexual abuse cases. HPRAC also heard that there may be the potential for health practitioners to disregard a law that they perceive to be inappropriate and unfair.

Victims Groups

As indicated in Appendix C, invitations to respond were also sent to a number of special interest groups, including women’s and sexual abuse advocates. With the exception of a submission from the Cornwall Community Hospital Assault and Sexual Abuse Program and the key informant interviews conducted by HPRAC, no further special interest groups responded to the invitation.

¹⁰⁷ HPRAC town hall session in Toronto, participant #5.

8. HPRAC's Considerations & Recommendations

HPRAC carefully considered two perspectives regarding zero tolerance when formulating its recommendation to the Minister about the mandatory revocation provisions for the treatment of spouses. First, how is the RHPA's sexual abuse legislative framework positioned relative to other jurisdictions? And second, does zero tolerance impact on spouses appropriately?

Is the RHPA sexual abuse provision achieving the desired results?

Sexual abuse is addressed in a number of places within the RHPA. Of importance are section 1(3) and section 51(5) of Schedule 2 in the RHPA, the Health Professions Procedural Code (the Code). Section 1(3) defines the offence of patient sexual abuse, and Section 51(5), describes the minimum five-year mandatory revocation penalty for specified sexual acts committed by a regulated health professional. At the time this legislation was drafted, these provisions aimed to eradicate sexual abuse of patients.¹⁰⁸

Sexual abuse is unacceptable to the people of Ontario. In fact, the Honourable Deb Matthews confirmed the government's commitment to the "zero tolerance for sexual abuse" in her referral letter to HPRAC. The sexual abuse provisions in the RHPA, however, are a serious concern to health professionals who may consider treating their spouses. These individuals would be guilty of sexual abuse – as specified by the RHPA – and have their authority to practice their profession revoked for five years. To these health professionals, the provision of health care to spouses is a matter wholly unrelated to the offence of sexual abuse.

HPRAC heard during its consultation program that health professionals and members of the public understood that the intent of the zero tolerance was not to restrain members of certain health professions from treating their spouses.¹⁰⁹ Spouses of health professionals described the affect on their personal health as restricting their right to choose their preferred health care provider and placing unreasonable hardship on them to seek care elsewhere. In addition, some spouses of health professionals described "phobias" that could only be overcome by services being provided by the one person they had trust in – their spouse.

¹⁰⁸ Ontario Women's Justice Network, "Doctor-Patient Sexual Assault and Abuse," (2008).

¹⁰⁹ HPRAC Summaries of Consultation Meeting, Toronto2, Participant #3.

The strength of the sexual abuse provisions of the RHPA is unique to Ontario. HPRAC's Canadian jurisdictional review indicates five provinces have similar omnibus legislation to the RHPA governing health care providers. Of these, three address sexual misconduct, and, of those, only Ontario and Quebec have a legislated penalty related to sexual misconduct. No international jurisdictions reviewed by HPRAC had provisions as punitive as Ontario. In summary, despite the length of time that the sexual abuse provisions have been in place, no other jurisdictions have adopted Ontario's approach.

The uniqueness of Ontario legislation was given careful consideration when determining if alternatives should exist. Is it sufficient to have alternatives only for the mandatory revocation provision; or should broader reconsideration be given with respect to alternatives to the sexual abuse offence as it relates to the treatment of a spouse?

HPRAC consulted with legal advisors to determine if exceptions to a mandatory order exist in other pieces of Ontario legislation and was advised that exceptions, in fact, do exist. One example given was an offence in connection with the operation of a motor vehicle (if the vehicle is operated by a person other than the owner without the owner's permission).

HPRAC applied this legal notion to the treatment of a spouse – that is, a health professional being found guilty of sexual abuse for treating their spouse but exempted from the mandatory revocation penalty. Such an outcome with respect to the RHPA is not ideal from a number of standpoints. Any guilty finding related to a sexual abuse offence that does not carry a penalty provides the wrong message to sexual abusers and the public. This outcome may be perceived to lessen the importance of the zero tolerance provision. It may also imply that sexual abuse within spousal relationship is less important and does not warrant a severe punishment. There are also considerations of consistent implementation as well as practical time considerations of case-by-case review by colleges. The interests of a sexually abused patient are not well served by extensive delays and process.

Are spouses different as patients?

Where potential exists for sexual abuse, the zero tolerance provisions of the RHPA are an important deterrent. The potential for serious harm and the risk of recidivism by regulated health professionals who commit sexual abuse have been documented. The ethical concepts and principles of power imbalance, transference, trust and consent in the matter of health professional-patient sexual relationships which underpin the zero tolerance provisions have also been examined in the literature. In HPRAC's deliberations, these concepts were applied to spousal relationships and compared to health professional-patient relationships to determine if they are equivalent.

Power Imbalance and Transference

Power imbalance occurs between practitioners and all non-spousal patients. This imbalance stems from the patient being in a vulnerable position because he/she allows the health professional to conduct intimate physical examinations; relies on the professional to provide health care; provides sensitive information about themselves or family members; and may be unwell or in pain. As a result of this inherent inequality, the health professional-patient relationship may foster transference (i.e., when a patient idealizes the health professional leading to feelings of “submission”) which could then be exploited by health professionals for personal sexual gratification.¹¹⁰

In the case of a spouse, vulnerability as a result of power imbalance between the parties is not viewed as an issue because the physical intimacy and mutual knowledge and exchange of sensitive information between spouses are assumed. There is also routine and mutual provision of care between spouses, which may include some health care. An emotional dependence between spouses is integral to the spousal relationship especially when partners experience poor physical health or pain. The activities which contribute to a patient’s vulnerability and ensuing power imbalance in non-spousal health care provider-patient relationships are generally, more equally shared between spouses. Although inequalities may exist between spouses, the source of inequality differs from that of the health care provider-patient relationship.

Trust

Trust is a necessary precondition to patients divulging intimate details, taking potentially harmful medications and undergoing procedures when unconscious. Trust is fundamental to the health professional-patient relationship and includes the expectation of trustworthiness; implies the existence of a power differential; and assumes that interactions occur under conditions of privacy.¹¹¹ This trust relationship is also one-sided from the patient to provider (Fiduciary Relationship). Trust is an underlying principle of the concept of boundaries and it has been argued that it is a health professional’s breach of trust, not patient’s consent, which is the crucial issue regarding sexual impropriety.¹¹²

Trust within spousal relationship is foundational and necessary for all aspects of spousal life, including care of children, finances, and other highly sensitive activities. It is based in part on a history of shared emotional and significant life experiences.

¹¹⁰ College of Physicians and Surgeons of Nova Scotia, *Sexual misconduct in the physician-patient relationship* (December 2010); Katherine H. Hall, “Sexualization of the doctor-patient relationship: is it ever ethically permissible?” *Family Practice* 18, no.5 (2001): 511-515; R.I. Simon, “Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1,” *Psychiatric Annals* 24, no1 (1994): 509-515.

¹¹¹ Shirley Feldman-Summers, “Sexual contact in fiduciary relationships.” in *Sexual exploitation in professional relationships*, edited by G.O. Gabbard (Washington D.C: American Psychiatric Press, 1989), 193-209.

¹¹² R.I. Simon, “Therapist-patient sex. From boundary violations to sexual misconduct,” *Psychiatry Clinics of North America* 22, no1 (1999): 31-47; R.I. Simon, “Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1,” *Psychiatric Annals* 24, no1 (1994): 509-515; Joel Friedman, and Marcia Mobilia Boumil, *Betrayal of trust: sex and power in professional relationships* (Westport, CT: Praeger Publishers, 1995).

Consent

It is assumed that in the case of health professional-patient sexual relations, a patient is not considered capable of consenting to a sexual relationship with a health professional because of the existing power imbalance and potential for idealization. Even if consent is given, it can be argued that the fiduciary relationship gave the provider information about a patient's vulnerabilities that was exploited to give consent.¹¹³ In this case, there is no genuine consent in these circumstances.

The power imbalances found in a health professional-patient relationship are not a factor in spousal relationships. Likewise, idealization of the practitioner is not a risk between spouses. More importantly, in healthy spousal relationships, the presence of consensual sexual relations is presumed.

HPRAC concludes that the principles forming the foundation of zero tolerance for sexual abuse by health professionals are inappropriately applied when a patient is a spouse of the health care provider. While spousal sexual abuse does occur and can include all forms of sexual assault, sexual harassment or sexual exploitation,¹¹⁴ the mandatory revocation provisions in the RHPA are most effective in countering predatory, coercive sexual abuse between health care providers and their patients when those patients are not spouses of the health care provider.¹¹⁵

Other Ethical Concerns about the Treatment of a Spouse

There are many situations in which a provider should not treat a spouse, or for that matter, any member of their family when their judgment and ability to make sound, rational decisions is clouded by concern for a "loved one".

To this end, HPRAC surveyed the standards each health regulatory college uses for the treatment of spouses and discovered significant variation among health professions on the issue. For some colleges, it is part of the professional culture to treat a spouse or other family member (e.g., dentistry, chiropractic, midwifery). For other colleges (e.g. medicine and psychology), it is unacceptable for its members to treat a spouse or any family member due to the risk of compromised objectivity, confidentiality issues and the potential for fraud. From the consultations, HPRAC also heard that when there is an alleged sexual abuse violation of a college standard for treating a spouse, professional misconduct inquiries should focus on how the

¹¹³ Ibid 111.

¹¹⁴ "Spousal Abuse: A fact sheet from the Department of Justice Canada," Department of Justice, Family Violence Initiative, last Modified December 1, 2011.

¹¹⁵ Marilou McPhedran et al., The Final Report of the Task Force on Sexual Abuse of Patients, Commissioned by the College of Physicians and Surgeons of Ontario, (November 25, 1991): 12; *Mussani v. College of Physicians and Surgeons of Ontario*, [2004] OJ No. 5176.

health professional's ability to provide high quality care has been compromised, rather than focusing solely on the alleged sexual abuse.

HPRAC understood from the consultation that the current sexual abuse provisions may actually be undermining the objective of the legislation to protect victims of sexual abuse. The objective could be undermined because the mandatory reporting requirement in the RHPA¹¹⁶ may lead to high numbers of reports in professions where spousal treatment historically was common (e.g., dentistry, chiropractic). The volume of allegations would ultimately undermine the legitimacy of the sexual abuse provisions as:

- Over reporting of sexual abuse cases regarding spousal treatment may undermine the importance of reports involving actual sexual abuse victims.
- Mandatory reporting of sexual abuse for spousal treatment may also undermine the legitimacy of sexual abuse provisions in the legislation. Practitioners and the public may become apathetic and lose confidence in the legislation which may result in under-reporting of non-spousal sexual abuse cases; and
- The potential for health practitioners to disregard a law that they perceive to be inappropriate and unfair.

In addition, HPRAC heard during the consultation that certain communities among the regulated health professions were given the impression that spouses were not the target population that the sexual abuse provisions were created to protect.¹¹⁷ These impressions were conveyed in correspondence from an elected official as well a senior bureaucrat at the time.

HPRAC's Recommendation

Notwithstanding the appropriateness of the zero tolerance provisions for victims of sexual abuse at the hands of regulated health professionals, and any concerns related to the efficacy and adequacy of treating family members, HPRAC acknowledges the following:

- Spousal, health professional-patient relationships are different from non-spousal, health professional-patient relationships.
- Health professions' disciplinary committees, as well as courts of law, have confirmed the difficulty in being able to consider facts or circumstances (e.g. spousal relationship) in the face of the mandatory revocation provisions.

¹¹⁶ The purpose of the sexual abuse provisions, in part, is to encourage the reporting of abuse. Under the RHPA, practitioners are obligated to report sexual abuse if it has been observed. Section 85.1(1) of Schedule 2 of the Health Professions Procedural Code states: 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.

¹¹⁷ ODA submission to HPRAC, January 2012; HPRAC Summaries of Consultation Meeting, Toronto2, Participant #3.

- Negative unintended consequences have arisen since the provisions were given the force of law, which have been reflected in the experiences, and concerns of those responding to the consultation program.

HPRAC considered the varied concerns detailed above in preparing a response to the Minister's referral regarding whether alternatives to the mandatory revocation provisions should exist. HPRAC has concluded that a narrow focus on alternatives to the mandatory revocation provisions would not adequately address the issue and that consideration should be given for alternatives to the sexual abuse offence, strictly as it relates to the treatment of a spouse. HPRAC recommends that the treatment of spouses should be expressly exempted in the sexual abuse provisions. Specifically,

- The language of the RHPA should be amended to exempt spouses from the definition of sexual abuse; and
- Colleges, who wish to continue to prohibit their members from treating their spouse, should make profession-specific changes to professional misconduct regulations and/or standards of practice to enforce such practice.

HPRAC makes this recommendation with the understanding that regulatory colleges are best equipped to determine standards of practice for their respective professions. Where a prohibition on spousal treatment is addressed in professional misconduct regulations, a regulatory college's investigations and complaints process would be a logical outcome, procedurally fair, and understandable to the public. At the same time, to help protect patients from sexual abuse, the mandatory revocation provisions in the RHPA would remain and any health professional found guilty of sexual abuse of a patient would be subject to the full extent of the law. The zero tolerance for sexual abuse by regulated health professions remains in force and greater clarity is provided to the policy intent of the legislation: to eradicate sexual abuse by regulated health professionals.

Other Options Considered

HPRAC received, and gave careful consideration to, a number of proposed options during its consultation program. To evaluate the proposed options, HPRAC analyzed each option based on the risk of harm posed, impact on public interest and how well each option addressed the unintended impacts from the current statutory provisions. The definitions of risk of harm and public interest described in Section 3 of this report were used in the analysis.

Status quo option

HPRAC heard from some respondents who did not support change to the current sexual abuse provisions or the mandatory revocation provisions in the RHPA. These groups were concerned that any change to the current regime would weaken zero tolerance. Other concerns revolved around the logistics of changing the provisions. For example, HPRAC heard that any exemptions

could have the potential to create a double standard in how the colleges handle sexual abuse complaints. If spouses were exempt, the definition of “spouse” could be open to legal challenge for being under-inclusive. In either case, disciplinary hearings may be sidetracked and focus on whether a spousal relationship exists.

If the legislation remains status quo, HPRAC is unclear how the public interest could be served. If left unchanged, there is the potential to further hinder timely access to care for individuals who live in parts of Ontario where access to health care services are already a challenge. There is also the concern that a disgruntled partner, business associate or an employee could maliciously misuse the legislation. Furthermore, it was documented in some stakeholder comments that the flagrant disregard for the legislation could also undermine the legislation’s effectiveness to protect victims from sexual abuse.

For these reasons, HPRAC concluded that the status quo was not a preferred option.

Case-by-case option

Many respondents to the HPRAC consultation process supported changes to the current mandatory revocation provisions by allowing the regulating colleges the authority to determine the penalty on a case-by-case basis. Respondents promoted the option because it would allow colleges the discretion to determine if a member has sexually abused his/her spouse under the health care provider-patient relationship. A number of colleges who supported this option also expressed concerns about any blanket inclusion/exemption for sexual abuse in regards to the treatment of a spouse. A blanket exemption for the treatment of a spouse could be seen to encourage a health professional to provide health care services to their spouses.

HPRAC gave considerable thought to this option. As part of HPRAC’s research to understand the origins of zero tolerance and the provisions that were eventually incorporated into the RHPA, HPRAC found considerable historical concern about regulating bodies being able to appropriately adjudicate sexual abuse cases to protect the public. This concern was in part, the reason why the recommendation was made to include the mandatory revocation for sexual abuse.¹¹⁸ Even with the implementation of the sexual abuse provisions in the RHPA, there remained concerns about the adequacy and/or capacity of colleges’ complaints and discipline procedures to protect the public from sexual abuse by its members.¹¹⁹

Notwithstanding these concerns, there have been a number of changes to improve the colleges’ transparency and accountability to the public. Changes in the legislation helped to streamline how colleges’ complaints and discipline committees handled the complaints or investigation

¹¹⁸ Marilou McPhedran et al., *The Final Report of the Task Force on Sexual Abuse of Patients*, Commissioned by the College of Physicians and Surgeons of Ontario, (November 25, 1991): 98-104.

¹¹⁹ 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, ON, 2000).

reports about its members. Regulatory colleges also made changes to provide more informative websites to promote and enhance relations with their members, other colleges, key stakeholders and the public.¹²⁰ Many colleges have also stepped up their efforts to educate their members and the public about sexual abuse prevention.¹²¹

The ICRC at each regulatory college is an investigative body established to review formal complaints¹²² and Registrar's reports, including those related to professional misconduct.¹²³ When a sexual abuse complaint is made to the College, an ICRC investigation is initiated. The ICRC has discretionary powers to determine whether there is sufficient evidence to refer the matter to the DC.¹²⁴ The ICRC has the power to dismiss complaints if they are believed to be frivolous or vexatious in nature, based on the facts of each case.¹²⁵ The ICRC is not an adjudicator of complaints and is not required to hold public hearings or publish its decisions.¹²⁶ Unless the ICRC decision is appealed to the Health Professions Appeal and Review Board, the decision is not open to the public.¹²⁷ Hearings conducted by the DC and its findings are open to the public unless there is a compelling reason for privacy. HPRAC has determined that the lack of transparency on how the ICRC decides the outcome of its investigation for complaints is a concern when considering the case-by-case option. Without this transparency it would be difficult to ensure consistency in how colleges apply any exemption to the mandatory revocation provisions in the RHPA for sexual abuse allegations.

HPRAC also heard from a number of colleges that the case-by-case option could potentially add an administrative burden on colleges as the number of complaints for sexual abuse allegations may increase. Even in cases where the complaint may originate from a member who treated their spouse and no sexual abuse has occurred, the colleges are still required to go through an investigative process to come to that conclusion.

HPRAC also heard concerns about a member's reputation being unfairly tarnished. The member's name, who is under review for professional misconduct for sexual abuse allegations, remains on the college's public registry with that allegation until the issue has been resolved. This measure was designed to increase transparency and enhance the public's ability to know where there is a risk to the public. However, in situations where the sexual abuse allegations stem from the treatment of a spouse, this may have a lasting impact on the member's reputation long after the issue has been resolved.

¹²⁰ Health Professions Regulatory Advisory Council. *A Report to the Minister of Health and Long-Term Care on the Health Profession Regulatory Colleges' Patient Relations Programs* (Toronto, ON, 2008).

¹²¹ Ibid 120.

¹²² Section 25(4) of Health Professions Procedural Code states, "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."

¹²³ Complaints do not have to come from the patient or person affected by the conduct. The Registrar could be notified of a member's professional misconduct through a third party and initiate an investigation through the appointment of an investigator, with the approval of the ICRC.

¹²⁴ Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act* (Canada: Canada Law Book, 2011).

¹²⁵ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 26(4).

¹²⁶ Ibid 153. 5:60 Procedure before ICRC.

¹²⁷ Health Professions Appeal and Review Board, *Frequently Asked Questions*, April 13, 2012, http://www.hparb.on.ca/scripts/english/faq.asp#2_8.

After considering the potential implications of the case-by-case option, HPRAC concluded the public's interest is better served by amending the definition of sexual abuse to exclude spousal relationships, and have colleges amend relevant regulations and/or standards of practice to address the issue in terms of professional misconduct and not as a sexual abuse issue.

Other Consideration

During HPRAC's process to research and analyze information on whether alternatives should exist for the mandatory revocation provisions in the RHPA, a number of observations were made that may benefit further consideration.

- In looking at ways to support zero tolerance to eradicate sexual abuse by regulated health professionals, education of the health professional and the public is paramount.¹²⁸ To further support the zero tolerance, more research should be considered to determine how health professions' curricula address ethical boundaries from the patients' perspectives. Consideration should also be given on how to enhance the continuing education of regulated health professionals about the ethical boundaries of practice.
- Consideration should also be given to increase the colleges' consistency and clarity on their sexual abuse guidelines and professional misconduct regulations and standards of practice, along with their disciplinary processes.
- Consideration should also be given to strengthen the reporting of sexual abuse complaints by colleges to the Minister of Health and Long-Term Care. This will help to increase transparency and accountability of the colleges' complaints handling process.

¹²⁸Health 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, ON, 2000), 21.

Closing Remarks

The harm to a patient who is sexually abused by a health professional is profound. Health care providers must be held to an exceptional standard of legal and ethical propriety for the protection of patients. Obligations are appropriately placed on health care providers to respect these legal and ethical boundaries to ensure that encounters with patients are therapeutic. Sexual abuse by a regulated health professional can be viewed as an especially repugnant violation when committed by a health care provider in the therapeutic relationship.

The ethical principles of power imbalance, transference, trust and consent underpin the sexual abuse provisions in the RHPA and were introduced with the intent to eradicate sexual abuse of patients by health professionals. The provisions defined sexual abuse and prescribed a rigorous penalty. It was not the intent of the legislation to be misused maliciously or be the mechanism to deter certain professions from the treatment of their spouse.

Amending the Act to exempt spouses from the definition of sexual abuse, and allow for making profession-specific regulations and/or standards of practice for the treatment of a spouse, would provide clarity on how the law can be applied to those individuals who have actually violated professional boundaries and exploited their position of power for self gratification. It would also provide focus and attention to regulated health professionals with respect to the ethical issues surrounding the treating of a spouse.

The recommendation HPRAC is making in this report is intended to help strengthen Ontario's health profession regulatory framework and protect the public from harm by creating better transparency on how regulatory colleges handle sexual abuse complaints.

Appendix A

Inquiries, Complaints and Reports Committee and Discipline Committee of Regulatory Colleges

This chart summarizes the role of the Inquiries, Complaints and Reports Committee (ICRC) and Discipline Committee (DC) and outlines current powers of each body to review complaints of professional misconduct (including sexual abuse) brought forward to the college.

Table 2. Summary of ICRC and DC roles

Investigating Body	Mandate	Powers	Referral to DC	Appeals Process
Inquiries, Complaints and Reports Committees (ICRC)	Section 25(1) of the Code states: A panel shall be selected by the chair of the Inquiries, Complaints and Reports Committee from among the members of the	Section 26 (1) and 26(5) states: A panel, after investigating a complaint or considering a report, considering the submissions of the member and making	The ICRC could refer the complaint to the DC when it assumes the allegations are true and warrants a hearing, or when there is reason to believe that a finding will be made against the	Decisions made by the ICRC could be appealed to the Health Professions Appeal and Review Board (Board), unless one of the following decisions was: ¹³² (a) to refer an allegation

Investigating Body	Mandate	Powers	Referral to DC	Appeals Process
	<p>Committee to investigate a complaint¹²⁹ 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).</p> <p>It conducts an investigation and determines whether there is sufficient evidence to refer the matter to the DC.¹³⁰</p> <p>As the ICRC is not an adjudicator of complaints, it is not required to hold public hearings, or publish its decision.¹³¹</p>	<p>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:</p> <ol style="list-style-type: none"> 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 	<p>member.</p> <p>According to subsection 36. (2) of the Code, the ICRC has the discretion to decide whether or not to refer an allegation of sexual abuse of a patient to the DC.</p>	<p>of professional misconduct or incompetence to the Discipline Committee; or</p> <p>(b) to refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings.</p> <p>If the ICRC decision is appealed to the Board, the Board may decide to do any one or more of the following:¹³³</p> <ol style="list-style-type: none"> 1. Confirm all or part of the decision. 2. Make

¹²⁹ Subsection 25 (4) states: "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."

¹³⁰ Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act* (Canada: Canada Law Book, 2011).

¹³¹ Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act* (Canada: Canada Law Book, 2011).

¹³² *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 29 (2).

Investigating Body	Mandate	Powers	Referral to DC	Appeals Process
		<p>Committee under section 58 for incapacity proceedings.</p> <p>3. Require the member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned.</p> <p>4. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws.</p> <p>5. If the panel is satisfied, after</p>		<p>recommendations the Board considers appropriate to the Inquiries, Complaints and Reports Committee.</p> <p>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.</p>

¹³³ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 35 (1).

Investigating Body	Mandate	Powers	Referral to DC	Appeals Process
		<p>considering the written submissions of the complainant and the member, that a complaint was frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, the panel shall not take action with respect to the complaint.</p>		
Discipline Committees (DC)	<p>The DC holds hearings of professional misconduct / incompetence referred to the DC by the ICRC.¹³⁴</p> <p>A hearing conducted by</p>	<p>If a panel of the DC finds that 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</p>		<p>Decisions made by the DC could be appealed to the Divisional Court,¹³⁸ which has all powers of the DC when it hears an appeal.¹³⁹</p>

¹³⁴ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s.36 (1).

¹³⁵ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 45.

Investigating Body	Mandate	Powers	Referral to DC	Appeals Process
	<p>the DC is open to the public unless there is a compelling reason for privacy, and all decisions made by the DC are to be published in its annual report.¹³⁵</p> <p>All disciplinary decisions involving a finding against a member must be published in the college register.¹³⁶</p>	<p>the panel may do under section (2):¹³⁷</p> <ol style="list-style-type: none"> 1) Reprimand the member 2) Revoke the member's certificate if the sexual abuse consisted of acts under paragraph 2 of subsection 51. (5) 		

Analysis:

It is important to note the extent of discretion provided to the ICRC in referring sexual abuse complaints to the DC. As an investigative body established to consider the facts of each case to determine if a specific allegation of professional misconduct warrants further attention by the DC, the ICRC has the power to dismiss complaints believed to be frivolous or vexatious in nature, based on the facts.

¹³⁶ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 23 (1).

¹³⁷ Under subsection 51. (2) of the Code, the panel may make an order doing any one or more of the following: Revoke the member's certificate; Suspend the member's certificate; Impose terms, conditions and limitations on the member's certificate; Require the member to appear before the panel to be reprimanded; and Require that a member pay a fine (in accordance with paragraphs 5.1 and 5.2 of subsection 51. (2)).

¹³⁸ *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, s. 70(1).

¹³⁹ Richard Steinecke, *A Complete Guide to the Regulated Health Professions Act* (Canada: Canada Law Book, 2011).

Also, since the ICRC is not an adjudicating body it is not required to hold public hearings or publish its decisions relating to complaints of professional misconduct, including those involving sexual abuse. This absence of transparency would mean that the public would not have access to the ICRC's decisions on all sexual abuse complaints within each college, other than those complaints referred to the DC.

Appendix B

Table 3. Comparison of *Long-Term Care Homes Act, 2007* and *Retirement Homes Act, 2010*

Legislation	Spirit of the Act	Who Falls Under this Act?	Zero Tolerance Policy	Definition of Sexual Abuse	Are there Exemptions to the Sexual Abuse Offence?
<p><i>Long-Term Care Homes Act, 2007</i></p> <p>Ontario Regulation 79/10</p>	<p>The Act was designed to protect residents of long-term care homes in Ontario and support Ontario’s goal in providing quality care that is accessible and resident-centred.</p>	<p>The Act governs long-term care homes in Ontario.</p>	<p>Every licensee of a long-term care facility must ensure that there is a policy in place to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.¹⁴⁰</p>	<p>In the Act, “abuse” in relation to a resident, means physical, sexual, emotional, verbal or financial abuse, as defined in the regulations in each case.¹⁴¹</p> <p>In the regulation “Sexual abuse” means:¹⁴²</p> <p>(a) subject to subsection (3), any consensual or non-consensual touching,</p>	<p>Yes. In Section 2(3) of the Ontario Regulation 79/10, sexual abuse does not include the following:</p> <p>(a) touching, behaviour or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living, or</p> <p>(b) consensual touching, behaviour</p>

¹⁴⁰ *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8, s 20 (1).

¹⁴¹ *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8, s 1.

¹⁴² O. Reg. 79/10, s 2(1).

Legislation	Spirit of the Act	Who Falls Under this Act?	Zero Tolerance Policy	Definition of Sexual Abuse	Are there Exemptions to the Sexual Abuse Offence?
				<p>behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or</p> <p>(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.</p>	<p>or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member.</p>
<i>Retirement Homes Act, 2010</i> ¹⁴³	The Act was designed to protect seniors living in	The Act governs retirement homes in	Every licensee shall ensure that there is a written policy to	In the Act, “ abuse ”, in relation to a resident, means	Yes. In Section 1(3) of the Ontario Regulation 166/11,

¹⁴³ Note – only parts of the Act is fully enforced; the remainder of the Act will be proclaimed at a later date.

Legislation	Spirit of the Act	Who Falls Under this Act?	Zero Tolerance Policy	Definition of Sexual Abuse	Are there Exemptions to the Sexual Abuse Offence?
Ontario Regulation 166/11 ¹⁴⁴	retirement homes. It supports the operation of safe and quality homes where residents can live with dignity, respect, privacy and autonomy.	Ontario.	promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with. ¹⁴⁵	physical, sexual, emotional, verbal or financial abuse, as may be defined in the regulations in each case. ¹⁴⁶ In the regulation, “ Sexual abuse ” means, (a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or	sexual abuse does not include the following: (a) touching, behaviour or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living, or (b) consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the

¹⁴⁴ O. Reg. 166/11.

¹⁴⁵ *Retirement Homes Act, 2010, S.O. 2010, c. 11*, s. 67(4) outlines the zero tolerance provisions will be proclaimed at a later date.

¹⁴⁶ *Retirement Homes Act, 2010, S.O. 2010, c. 11*, s. 2(1).

¹⁴⁷ O. Reg. 166/11, s. 1(1).

Legislation	Spirit of the Act	Who Falls Under this Act?	Zero Tolerance Policy	Definition of Sexual Abuse	Are there Exemptions to the Sexual Abuse Offence?
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(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.¹⁴⁷

resident was commenced residency in the retirement home or before the licensee or staff member became a licensee or staff member.

Appendix C

Table 4. Stakeholder list for the Spousal Treatment Referral

Type	Organization/Individual
Regulatory College	College of Audiologists & Speech-Language Pathologists of Ontario
Regulatory College	College of Chiropodists of Ontario
Regulatory College	College of Chiropractors of Ontario
Regulatory College	College of Dental Hygienists of Ontario
Regulatory College	College of Dental Technologists of Ontario
Regulatory College	College of Denturists of Ontario
Regulatory College	College of Dietitians of Ontario
Regulatory College	College of Massage Therapists of Ontario
Regulatory College	College of Medical Laboratory Technologists of Ontario
Regulatory College	College of Medical Radiation Technologists of Ontario
Regulatory College	College of Midwives of Ontario
Regulatory College	College of Nurses of Ontario
Regulatory College	College of Occupational Therapists of Ontario
Regulatory College	College of Opticians of Ontario
Regulatory College	College of Optometrists of Ontario
Regulatory College	College of Physicians and Surgeons of Ontario
Regulatory College	College of Physiotherapists of Ontario
Regulatory College	College of Psychologists of Ontario
Regulatory College	College of Respiratory Therapists of Ontario
Regulatory College	Ontario College of Pharmacists
Regulatory College	Royal College of Dental Surgeons of Ontario
Regulatory College	Transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario
Regulatory College	Transitional Council of the College of Homeopathy of Ontario
Regulatory College	Transitional Council of the College of Kinesiology of Ontario
Regulatory College	Transitional Council of the College of Naturopathy of Ontario

Type	Organization/Individual
Regulatory College	Transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario
Regulatory College	Board of Directors of Drugless Therapy - Naturopathy
Regulated Professional Association	Association of Dental Technologists of Ontario
Regulated Professional Association	Association of Ontario Midwives
Regulated Professional Association	Denturists Association of Ontario
Regulated Professional Association	Dietitians of Canada
Regulated Professional Association	Nurse Practitioners' Association of Ontario
Regulated Professional Association	Ontario Association of Medical Laboratories
Regulated Professional Association	Ontario Association of Medical Radiation Technologists
Regulated Professional Association	Ontario Association of Naturopathic Doctors
Regulated Professional Association	Ontario Association of Optometrists
Regulated Professional Association	Ontario Association of Psychological Associates
Regulated Professional Association	Ontario Association of Speech-Language Pathologists and Audiologists
Regulated Professional Association	Ontario Chiropractic Association
Regulated Professional Association	Ontario Dental Association
Regulated Professional Association	Ontario Dental Hygienists' Association
Regulated Professional Association	Ontario Medical Association
Regulated Professional Association	Ontario Nurses' Association
Regulated Professional Association	Ontario Opticians' Association

Type	Organization/Individual
Regulated Professional Association	Ontario Pharmacists' Association
Regulated Professional Association	Ontario Physiotherapy Association
Regulated Professional Association	Ontario Podiatric Medical Association
Regulated Professional Association	Ontario Psychiatric Association
Regulated Professional Association	Ontario Psychological Association
Regulated Professional Association	Ontario Society of Medical Technologists
Regulated Professional Association	Ontario Society of Occupational Therapists
Regulated Professional Association	Ontario Society of Chiropractors
Regulated Professional Association	Registered Massage Therapists' Association of Ontario
Regulated Professional Association	Registered Nurses' Association of Ontario
Regulated Professional Association	Registered Practical Nurses Association of Ontario
Regulated Professional Association	Respiratory Therapy Society of Ontario
Organization/Group	Aboriginal Studies, University of Toronto
Organization/Group	Action Ontarienne Contre La Violence Faite Aux Femmes
Organization/Group	Canadian Mental Health Association
Organization/Group	Centre for Research on Inner City Health
Organization/Group	Centre for Treatment of Sexual Abuse and Childhood Trauma
Organization/Group	Echo: Improving Women's Health in Ontario
Organization/Group	Federation of Medical Women of Canada
Organization/Group	Metropolitan Action Committee on Violence Against Women and Children
Organization/Group	Minwaashin Lodge-Aboriginal Women's Support Group
Organization/Group	National Association of Women and The Law

Type	Organization/Individual
Organization/Group	Ontario Association of Community Care Access Centre
Organization/Group	Ontario Health Coalition
Organization/Group	Ontario Hospital Association
Organization/Group	Ontario Long-Term Care Home Association
Organization/Group	Ontario Native Women's Association
Organization/Group	Ontario Network of Sexual Assault/Domestic Violence Treatment Centres
Organization/Group	Ontario Women's Directorate
Organization/Group	Ontario Women's Health Network
Organization/Group	Ontario Women's Justice Network (OWJN)
Organization/Group	Rainbow Health Ontario
Organization/Group	Step It Up Ontario
Organization/Group	The Men's Project (Ottawa)
Organization/Group	Women's Action Centre Against Violence
Organization/Group	Women's Health in Women's Hands
LHIN	Central
LHIN	Central East
LHIN	Central West
LHIN	Champlain
LHIN	Erie St. Clair
LHIN	Hamilton Niagara Haldimand Brant
LHIN	Mississauga Halton
LHIN	North Simcoe Muskoka
LHIN	North East
LHIN	North West
LHIN	South East
LHIN	South West
LHIN	Toronto Central
LHIN	Waterloo Wellington
Health Professional	Dr. Harvey Armstrong
Health Professional	Dr. Rachel Edney

Type	Organization/Individual
Health Professional	Roz Roach
Health Professional	Dr. Chaim Bell
Academic/Expert	Dr. Marilou McPhedran, University of Winnipeg
Academic/Expert	Prof. Sanda Rogers
Academic/Expert	Dr. Kathryn Morgan, Women's Studies Program & the Centre for Bioethics, University of Toronto
Academic/Expert	Dr. Karen Abrams, University of Toronto
Academic/Expert	Dr. Brenda Toner, University of Toronto/CAMH
Academic/Expert	Dr. Carolyn Bennett MP
Academic/Expert	Prof. Diana Majury

Appendix D

Consultation Questionnaire

1. In your view, should alternatives to the mandatory revocation provisions currently mandated in the RHPA with respect to the treatment of a spouse by a regulated health professional, be considered? If yes, please propose appropriate alternatives.
2. If you find that there are appropriate alternatives to the mandatory revocation provisions currently mandated in the RHPA with respect to the treatment of a spouse by a regulated health professional, in your view;
 - A. Do the alternatives pose a risk of harm to the public?
 - B. Do the alternatives best serve the public interest?
3. Do you have any other general comments about the issue of mandatory revocation provisions and treatment of spouses by regulated health professionals?

Appendix E

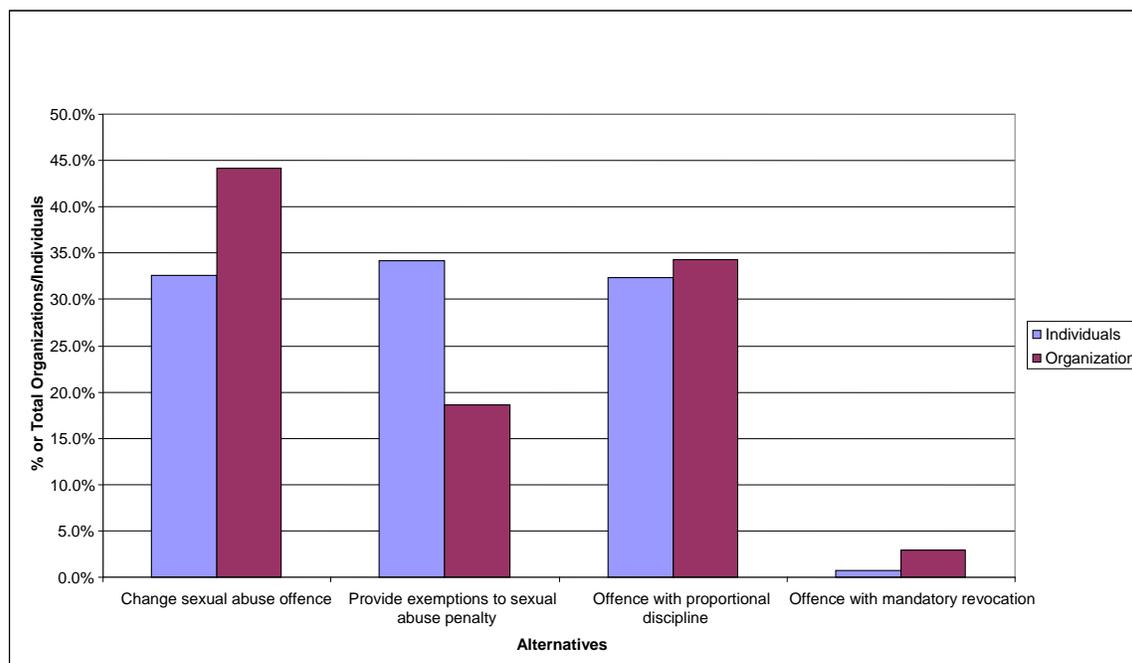


Figure 1: Consultation Data Summary

The chart summarizes the percentage of individual/organization responses for each option.

Appendix F

Summary of Proposed Options

This document provides a summary of alternatives gathered from stakeholder feedback related to alternatives to mandatory revocation of a health provider’s authority to practice their profession for the treatment of a spouse. All alternatives provided to HPRAC have been grouped into categories for analysis purposes. An explanation of each option as well as its application is also provided in the chart.

A) Change the definition of the sexual abuse offence in the RHPA – Make changes to the definition of sexual abuse in the RHPA which may include an exemption to all or some regulated health professions (e.g. Dentists) from sexual misconduct sanctions for treating their spouse.

Table 5. Summary of proposed alternative: changing the definition of sexual abuse

Alternative Proposed	Explanation	Application
<p>Define terms and/or nature of relationship</p>	<p>Define – “patient” and/or “spouse” and/or “treatment” and/or redefine sexual abuse.</p> <p>Consider certain characteristics of the relationship.</p>	<p>Terms will be defined in order to exempt spouses from the offence. In particular, sexual relationships which predate the provider-patient relationship should be exempt from the sexual abuse offence.</p> <p>And/or, treatment will be defined to exclude incidental and episodic care as well as all care provided in rural communities.</p>
<p>Exempt treatment of</p>	<p>Provide an exemption to the sexual abuse offence for the</p>	<p>The legislation will provide an exemption to the offence and the</p>

Alternative Proposed	Explanation	Application
spouses from the offence (all cases)	treatment of a spouse for all regulated health professions.	mandatory revocation provisions will not apply for the treatment of a spouse for all regulated health professionals.
Exempt treatment of spouses from the offence (some cases)	Provide an exemption to the sexual abuse offence for the treatment of a spouse for some regulated health professions.	<p>The sexual abuse provisions will not apply to spousal treatments by members of health professions granted an exemption to the offence.</p> <p>An exemption to the offence could be provided through the RHPA and or profession-specific Acts.</p>
Exemption to offence for circumstantial treatment of a spouse	<p>Treatment of a spouse in rural communities where there is limited access to health care should be defined in order to exempt those actions from the sexual abuse offence.</p> <p>Incidental, occasional and routine care should also be exempt from the sexual abuse provisions.</p> <p>Note: An exemption to the offence for rendering first aid or temporary assistance in an emergency is currently provided in the RHPA under subsection 29. (1).</p>	Provide in the legislation an exemption to the offence for routine, episodic treatment of spouses - and care for spouses in locations where health services are limited.
Remove sexual abuse offence	The legislation would no longer capture sexual abuse	A health professional who has sexually abused a patient will be

Alternative Proposed	Explanation	Application
from the RHPA	offences committed by health care providers.	charged with the offence outside of the RHPA.

B) Maintain the sexual abuse offence and permit an exemption to the penalty – Sexual abuse remains an offence under the RHPA but exemptions may be provided as alternatives to mandatory revocation.

Table 6. Summary of proposed alternative: exemption to penalty

Alternatives	Explanation	Application
Spousal exemption for <u>all</u> regulated health professionals	Provide an exemption to the penalty for the treatment of a spouse for all regulated health professions.	The sexual abuse provisions will continue to apply to all regulated health professionals, but an exemption to the mandatory revocation penalty will be provided in the legislation for treating a spouse.
Spousal exemption for <u>some</u> regulated health professionals	Provide an exemption to the penalty for the treatment of a spouse for some regulated health professions.	Each profession, through its regulatory college will determine whether the treatment of a spouse is acceptable. Allow each profession the discretion to decide, through different mechanisms (i.e. regulations, codes or standards) whether to allow an exemption to the mandatory revocation penalty. A profession-specific exemption to mandatory revocation for the treatment of a spouse could be provided using the following mechanisms, subject to the review of government:

Alternatives	Explanation	Application
		<ul style="list-style-type: none"> • change the RHPA, • change profession-specific Acts, or • change Regulation.
Spousal exemption where explicit consent exists for treatment	Provide an exemption to the penalty where a formal, documented, written consent to treatment is provided by a spouse.	<p>A signed consent form to treatment could be used between the health provider and their spouse to permit treatment without penalty.</p> <p>The consent form may also include details of what the treatment will entail and any risks associated with providing consent.</p>
Remove sexual abuse penalty from the RHPA	Sexual abuse penalties of a patient (including spouse) could be dealt with outside RHPA legislation.	A health professional found guilty of sexual abuse of a patient by the DC will be charged under the <i>Criminal Code</i> and not under health legislation.

C) Maintain the sexual abuse offence and permit proportional penalties – All sexual abuse remains an offence however discipline is determined on a case-by-case basis depending on circumstances or, by setting a “provisional” minimum penalty that must be given for sexual abuse (including a case of spousal treatment), which still allows for leeway on a case-by-case basis.

Table 7. Summary of proposed alternative: proportional penalty

Alternatives	Explanation	Application
Review individual complaints on a case-by-case basis	Allow colleges to determine penalty related to individual findings of sexual abuse for the treatment of a spouse.	Provide the ICRC discretion to refer complaints of sexual abuse in respect to the treatment of a spouse to the DC.

Alternatives	Explanation	Application
		Allow DC to determine appropriate penalty based on the facts of each case.
Change length / severity of punishment	Reduce the five-year mandatory revocation of a health provider’s certificate of registration for sexual abuse with respect to the treatment of a spouse.	RHPA to be amended to allow other penalties for the treatment of a spouse (e.g. one year revocation, fines, etc.).
Abolish Punishment	Remove all penalty and sanctions for sexual abuse of patients by regulated health providers from the legislation.	Allow DC to determine the penalty.

D) Maintain the status quo– all regulated health professionals who treat their spouse will be subject to the sexual abuse provisions including the “mandatory revocation provision” for five years (i.e. status quo).

Table 8. Maintain the status quo

Alternatives	Explanation	Application
Maintain offence with mandatory five-year revocation of a health provider’s authority to practice their profession for sexual abuse including	No changes will be made to the legislation.	The treatment of a spouse would be considered sexual abuse under the RHPA with mandatory revocation of a health provider’s certificate of registration for five-years.

Alternatives	Explanation	Application
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treatment of a spouse

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