SUBMISSIONS

Regulating Health Professions Consultation

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Via email PROREGADMIN@gov.bc.ca

Dear Steering Committee on Modernization of Health Professional Regulation:

Re: Regulating Health Professions Consultation

Please accept these submissions by West Coast Legal Education Action Fund ("West Coast LEAF") in response to your request for input on modernizing health professional regulation in British Columbia (BC).

About us

West Coast LEAF is a BC-based legal advocacy organization. Our mandate is to use the law to create an equal and just society for all women and people who experience gender-based discrimination. In collaboration with community, we use litigation, law reform, and public legal education to make change. In particular, we aim to transform society by achieving: access to healthcare; access to justice; economic security; freedom from gender-based violence; justice for those who are criminalized; and the right to parent. We have particular expertise in equality and human rights and we have done in-depth research on the impacts of BC's laws and policies on gender-based violence and access to healthcare.

Introduction

We welcome the Minister of Health's efforts to engage in a public consultation on the regulation of health professions under the *Health Professions Act* ("*Act*")[1] and regulatory framework. We have focused our submissions on question 4(n) of the *Modernizing the provincial health profession regulatory framework consultation paper*: "What measures should be considered in relation to establishing consistency across regulatory colleges regarding how they address sexual abuse and sexual misconduct?"[2]

In response to this question, we submit that, to fully modernize BC's health profession regulatory framework, the province must undertake a comprehensive, meaningful, and accessible consultation process that specifically focuses on addressing sexual abuse and misconduct and ensures that key stakeholders, including survivors, are adequately consulted. In lieu of a full consultation, we recommend that the Committee consider recommending the implementation of the following two essential amendments to the current regulatory framework:

1. The regulatory framework should provide greater direction to the colleges on measures that are necessary to prevent and address sexual misconduct by health professionals.

Since at least the 1990s, the Canadian health professional colleges have long known that sexual abuse of patients is not uncommon or anomalous.[3] In the early 1990s, numerous jurisdictions undertook studies to assess the prevalence of sexual misconduct in the health profession and implemented versions of a

[1] RSBC 1996, ch 183.

[2] Ministry of Health, British Columbia, Steering Committee on Modernization of Health Professional Regulation, *Modernizing the provincial health profession regulatory framework consultation paper* (November 2019) at 20.

[3] Sanda Rodgers, "Zero Tolerance Some of the Time? Doctors, Discipline and Sexual Abuse in Ontario" (2007) 15 Health L. J. 353 at para 1.

'zero tolerance for sexual abuse' policy. Nevertheless, recent research indicates that there continues to be institutional resistance within the self-regulated health profession that undermines the zero tolerance policies put in place in the early 1990s. In reviewing disciplinary hearing decisions for a five year period from the College of Physicians and Surgeons of Ontario (CPSO), Sanda Rodgers found that resistance to zero tolerance policies took a variety of forms including: "the persistent and unacknowledged requirement that the complaint [sic] be independently corroborated; the persistent criminalization of the disciplinary process; and the pathologizing of the complainant and the exculpation of the offender through defense reliance on psychiatric "expertise"".[4]

The prevalence of sexual abuse by health professionals is due in part to the nature of the health professional-patient relationship. Sexual abuse survivors face many barriers to disclosing abuse and these barriers are exacerbated when the perpetrator is a health professional in a position of power who often enjoys institutional and peer support.[5] As the Ontario Task Force on the Prevention of Sexual Abuse of Patients states:

> "Tolerance of abuse and resistance to the zero-tolerance standard have had tenacious holds on institutions. There can be an unequal match between an alleged abuser, who is well-known in the institution and holds a position of trust, and an often vulnerable complainant-victim whose credibility may be easily shredded and whose resources seldom match those of the institution and the professional."[6]

Not only does this power imbalance mean that many survivors of sexual abuse by a health professional are unlikely to report the abuse[7], it also means that a complainant-driven regulatory framework must include robust protections that address this power imbalance and ensure that survivors are not re-traumatized throughout the disciplinary proceeding.[8] For these reasons, sexual assault complaints cannot be handled through the same process as other professional misconduct complaints. Instead, there is a need for a complaints framework that is specific to sexual abuse and misconduct cases. In these submissions we set out some of the key elements of a distinct regulatory framework for preventing and responding to sexual misconduct complaints.

Definition of sexual abuse and purpose statement

The current *Act* does not contain a definition of sexual abuse and misconduct but rather identifies sexual misconduct as one form of professional misconduct.[9] By contrast, other provincial legislations that have undergone a thorough legislative reform with the aim of addressing sexual misconduct by regulated health professionals include a definition that does not distinguish between sexual abuse and misconduct and identifies "behaviour and remarks of a sexual nature" as conduct falling under the ambit of sexual abuse.[10] We recommend the inclusion of a definition of sexual abuse and misconduct that sets out a non-exhaustive list of conduct that can amount to sexual abuse. The addition of a definition would support a consistent understanding by the investigators, regulated professionals and the public of the type of conduct that amounts to sexual abuse.

We would also recommend the addition of a purpose statement that sets out the health profession's commitment to addressing sexual abuse and misconduct. For example, the Ontario legislation identifies

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[4] *Ibid* at 2.
[5] see Rodgers, *supra* note 2 at para 73.
[6] Ministry of Health and Long-Term Care, Ontario, *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the RHPA,* (2015) at 79 [*To Zero*].
[7] Rodgers, *supra* note 2 at para 17.
[8] *Ibid* at para 2.
[9] *Act*, *supra* note 2 at s 26.
[10] *Regulated Health Professions Act, 1991*, SO 1991, c 18, Schedule II *Health Professions Procedural Code* at s 1(2) [*Ontario Act*]

encouraging reporting, providing support for survivors, and eradicating sexual abuse as the guiding purposes of the legislative provisions regarding sexual abuse.[11]

Creating a separate process for handing sexual abuse and misconduct complaints

Due to the severity and complexity of these types of cases, sexual abuse and misconduct complaints should be handled through a distinct complaint process by specialized investigators and inquiry committee members.

Investigators and decision-makers should be experienced and have a thorough understanding of the complexities of sexual assault including the power dynamics of gender-based crimes, the ways in which myths and stereotypes impact legal processes, and the barriers specific groups face in accessing health care services and reporting mistreatment. Investigators and decision-makers should be trained and provided with guidance on conducting interviews and investigations in a trauma-informed and culturally safe way. As the Ontario Task Force on the Prevention of Sexual Abuse of Patients notes, "The highly trained expertise of the health practitioner who serves as a college member does not necessarily extend to an adequate knowledge base and expertise in the complex realm of sexual abuse."[12]

An adequate complaints process would include opportunities for investigators to flag potential risk factors early on in the complaints process and develop mechanisms to minimize the impact of the process on the survivor and ensure the survivor's safety and well-being. For example, written complaints should not be sent to the health professional without a full risk-assessment being undertaken by the investigator.

A trained neutral Complaints Officer to act as the first point of contact for complainants in sexual misconduct cases

The first point of contact for sexual assault complaints should always be a staff-member that is trained in trauma-informed and culturally safe practices, has experience working with survivors of sexual assault, and is familiar with the college's procedures for dealing with complaints. In *Crossing the Boundaries, The Report of the Committee on Physician Sexual Misconduct*[13]*,* the Committee on Physician Sexual Misconduct recommended that the first point of contact for complainants of sexual assault be with an independent Complaints Officer who has the requisite experience and training to work with survivors of sexual assault. The Committee recommended that the Complaints Officer be a neutral party who is not subject to disclosure of confidential information.[14] The Officer's functions would include receiving initial complaints, reporting to the college, and implementing educational programs for the profession and public. We encourage the Steering Committee to consider whether it is viable to legislatively mandate colleges to have a neutral Complaints Office who acts as the dedicated first-point of contact for complaints of sexual assault and is tasked with educating college staff and liaising with other colleges to develop best practice standards for addressing sexual misconduct.

Fast-tracking investigations of sexual misconduct complaints

Sexual abuse generally has dire implications for survivors, many of whom are likely to experience emotional and financial hardship following an abuse. Delays in legal proceedings compound these challenges in a number of ways. For example, some survivors who are able to access counselling support report investing time with their counsellor preparing for hearing dates and building up the courage to

[11] *Ibid* at s 1.1

[12] *To Zero*, *supra* note 5 at 79.

[13] Donlevy, M, Fisher, B et al, "*The College of Physicians and Surgeons of British Columbia, Crossing the Boundaries, The Report of the Committee on Physician Sexual Misconduct*" (Vancouver: 1992) at 89.

[14] *Ibid*.

testify only to be notified of delays in the process.[15] Many survivors have difficulty returning to their day-to-day lives including work and coping with the uncertainty of the ongoing proceedings. In *Crossing the Boundaries,* the Committee on Physician Sexual Misconduct recognized that "making a complaint of sexual misconduct against a physician represents a major disruption in [the complainants'] lives and it causes unnecessary distress when the process drags on too long, or they are kept in the dark".[16]

We recommend that colleges be legislatively mandated to prioritize and fast-track investigations of sexual abuse or misconduct complaints. We also recommend that colleges be obligated to establish clear timelines for the investigation, hearing, and decision-making stages of the process.

Limits on production orders of records where there is a reasonable expectation of privacy

The production and admissibility of third-party records in sexual assault proceedings has been an area of significant interest and activism by survivors of sexual assault and feminist organizations. Advocates have long been arguing for limits on the production and admission of third-party records to ensure that production of personal records does not act as a further barrier for reporting sexual assault and gendered myths and stereotypes about the "ideal victim" are not relied on by an alleged perpetrator to undermine the survivor's credibility.[17] This activism has led to the development of strict evidentiary rules in criminal proceedings and a general recognition of the need to limit disclosure of third party records to protect the constitutional rights of survivors of sexual assault.

Accordingly, we recommend that the Committee propose amendments to the *Act* that limit the production of third-party records in cases where there is an allegation of sexual misconduct. For example, Ontario passed amendments that identify 11 assertions that are insufficient for establishing the relevancy of a third-party record.[18] The Committee on Physician Sexual Misconduct recommended that the college adhere to the rules of evidence as applied in court and develop a rule modeled on the rape shield provisions in the *Criminal Code* which would define and restrict the scope of cross-examination of a complainant about her sexual history.[19] Panel members and the college's lawyer must fully understand the evidentiary rules and consistently apply them in hearings where there are allegations of sexual misconduct.

Furthermore, the complainant or witness should also be granted standing to make submissions on the issue of production.

Mandatory orders where there is a finding of sexual assault

Health professionals are in a position of public trust and power. As such, enforcement of provisions concerning sexual abuse or misconduct by health professionals is particularly important to ensure public interest and patient safety. Both Alberta and Ontario have amended their respective regulated health professional legislation to reflect the severity of sexual misconduct by establishing mandatory orders where there is a finding of sexual assault.

In Ontario, a member's certificate of registration is mandatorily revoked where there is a finding of sexual abuse and the professional cannot apply for reinstatement for five years.[20] In Alberta, a member's registration is also automatically revoked on a finding of sexual misconduct and that member cannot apply

[15] Prochuk, A. "*We Are Here: Women's Experiences of the Barriers to Reporting Sexual Assault*" West Coast LEAF (Vancouver: 2018) at 37.
[16] Crossing the Boundaries, *supra* note 13 at 97.
[17] *Ibid.*
[18] *Ontario Act*, *supra* note 10 at s 42.2.
[19] Crossing the Boundaries, supra note 13 at 110.
[20] *Ibid* at s. 51(5.2) and s. 72(3). [*Ontario Act*]

for reinstatement.[21] Under the current regulatory framework, BC does not have mandatory orders in cases where there has been a finding of sexual abuse or misconduct.

We recommend BC explore enforcement provisions that would support a zero-tolerance policy for sexual abuse similar to those set out in Ontario and Alberta. We also recommend that decision-making bodies be required to consider a written impact statement by the survivor prior to making their order.[22] Further, the panel should be legislatively obligated to make an interim order suspending a member's registration where there has been a finding of sexual misconduct.[23]

Strengthening measures for preventing and addressing sexual misconduct

The current *Act* places a duty on colleges to establish a patient relations program that seeks to prevent sexual misconduct. While this is an important obligation that is placed on colleges, there is very little direction in the legislation on the necessary elements of this program. We recommend that the *Act* include explicit direction to the colleges on the essential elements of this program including educational requirements for college staff and health professionals, the creation of an oversight committee that regularly reviews the effectiveness of the program, and mechanisms for keeping the public informed on the program. Colleges should also be required to submit the program and any amendments to the Health Professions Review Board for review and feedback.

2. Colleges should be required to develop and fund resources to support survivors of sexual assault.

Along with the above recommendations to the regulatory framework, we further suggest that colleges be required to develop and fund resources to support survivors of sexual assault. The following are some essential resources that must be put in place to ensure complaints mechanisms are adequately working for survivors of sexual assault:

a. a program for providing funding for therapy and counselling for persons alleging sexual abuse by a regulated health professional. Alberta and Ontario colleges are required to cover the cost of counselling for patients who have experienced sexual abuse or misconduct by a health professional.[24] In Ontario, colleges are legislatively permitted to recover costs from the registered member upon a finding of culpability.

b. a program for compensating complainants for legal costs incurred during the disciplinary process. The right to counsel that is set out in the *Act* for those testifying before a disciplinary hearing is rendered ineffective if a complainant cannot afford a lawyer. Given the significant private interest survivors of sexual assault have in disciplinary proceedings, the often significant disparity in financial resources between health professionals and patients,[25] and the public interest in encouraging reporting of sexual assault, we recommend that colleges be obligated to create compensation schemes to support complainants in recovering legal costs incurred for participating in disciplinary proceedings.

c. a framework for supporting patients in accessing a new health professional prior to filing a complaint. Many people in BC, particularly those experiencing intersecting forms of marginalization face challenges in accessing adequate healthcare. It is essential that the loss of healthcare services not be

[21] *Health Professions Act*, RSA 2000, c H-7 at s. 45(3) and s. 81.1(1).
[22] *Ontario Act*, supra note 10 at s 51(6).
[23] *Ibid* at s 51(4.2).
[24] *Health Professions Act*, RSA 2000, c H-7 at 135.9; *ibid* at s. 85.7.
[25] Rodgers, *supra* note 2 at para 79.

a factor in deciding whether to report sexual assault. Colleges, in their role as the regulating body, might be best positioned to link patients with a new health professional.

Conclusion

As is evidenced by the above submissions, the current regulatory framework falls far short of what is required to ensure that sexual misconduct by regulated health professionals is adequately addressed by colleges. In order to establish consistency among colleges in how they address sexual misconduct cases, the regulatory framework must include detailed minimum standards of practice that are developed in consultation with stakeholders, including survivors of sexual assault. An adequate regulatory framework must also impose obligations on colleges to fund resources for survivors including counselling services, legal representation, and support in finding a new health professional.