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COURT OF APPEAL FOR BRITISH COLUMBIA

BETWEEN:

TREVOR JAMES SCOTT

RESPONDENT
(PETITIONER)

AND:

COLLEGE OF MASSAGE THERAPISTS OF BRITISH COLUMBIA

APPELLANT
(RESPONDENT)

AND:

COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

INTERVENOR

AND:

REGISTERED MASSAGE THERAPISTS' ASSOCIATION OF BRITISH COLUMBIA

INTERVENOR

AND:

WEST COAST LEGAL EDUCATION ACTION FUND

INTERVENOR

FACTUM OF THE INTERVENOR WEST COAST LEGAL EDUCATION AND ACTION FUND

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OPENING STATEMENT

The central issue in this appeal is the evidentiary threshold applicable to decisions made under s. 35(1) of the *Health Professions Act* concerning complaints of sexual misconduct.

West Coast LEAF submits that allegations of sexual misconduct are among the most serious complaints that regulators might receive and they require urgent action to protect the public. Allegations of sexual misconduct in the health care setting are serious because women are disproportionately the victims of sexual violence (including sexual misconduct) and because most health care professional-patient relationships are characterized by a significant power imbalance which provides health care practitioners with particular opportunity to sexually exploit patients, primarily women.

West Coast LEAF further submits that myths and stereotypes about women, men and sexual violence have no place in the analysis to be undertaken pursuant to s. 35(1) of the *HPA*. A requirement for corroboration, the belief that there are "reasonable" responses to sexual assault, and the belief that only certain types of men can be perpetrators all reflect myths and stereotypes that are without empirical foundation. These myths and stereotypes have a significant negative impact on women's equality.

The evidentiary threshold applicable to determinations made under s. 35(1) must take into account the gendered nature of sexual violence, the power imbalance at play between patient and health care professional, and the negative impact that reliance on myths and stereotypes has on women's equality. A failure to take these factors into account stands to significantly erode regulators' powers to use s. 35(1) to protect the public, particularly women.

PART 1 – STATEMENT OF FACTS

1. The West Coast Women's Legal Education and Action Fund ("West Coast LEAF") adopts the appellant's statement of facts, as set out in Part 1 of the appellant's factum.

PART 2 – ISSUE ON APPEAL

2. The central issue in this appeal is the evidentiary threshold applicable to decisions made under s. 35 of the *Health Professions Act*, R.S.B.C 1996, c. 183 (the "HPA") which empowers regulators of various health care professions to impose limits or conditions on a registrant's practice if it considers the action necessary to protect the public pending the investigation or hearing of a complaint.

PART 3 – ARGUMENT

3. West Coast LEAF is an advocacy organization seeking to further women's equality by changing historic patterns of discrimination against women through litigation, law reform and public legal education. West Coast LEAF – along with its affiliated organization, LEAF – has significant expertise in legal principles and processes relating to sexual violence and women's constitutional right to equal protection of the law as enshrined in ss. 15 and 28 of the *Canadian Charter of Rights and Freedoms*.

4. West Coast LEAF respectfully submits that the evidentiary threshold applicable to determinations made under s. 35 of the HPA must take into account: a) the inherently gendered nature of sexual violence; b) the imbalance of power that characterizes health care professional-patient relationships; and c) the need to avoid discriminatory myths and stereotypes about women and sexual violence. West Coast LEAF submits that an evidentiary threshold which fails to take these factors into account will have a significant negative impact on women's equality.

Allegations of Sexual Violence are Serious

A. Gendered Nature of Sexual Violence

5. Sexual misconduct is among the most serious complaints a regulator might receive about a health care professional. West Coast LEAF submits this is so because sexual violence is inherently gendered and has a significant negative impact on women's equality:

> It cannot be forgotten that a sexual assault is very different from other assaults. It is true that it, like all the other forms of assault, is an act of violence. Yet it is something more than a simple act of violence. Sexual assault is in the vast majority of cases gender based. It is an assault upon human dignity and constitutes a denial of any concept of equality for women.
>
> The reality of the situation can be seen from the statistics which demonstrate that 99% of the offenders in sexual assault cases are men and 90% of the victims are women....[emphasis added]
>
> *R. v. Osolin,* [1993] 4 S.C.R. 595 at paras. 33-34

6. The overwhelmingly gendered nature of sexual violence is well established:

> Sexual assault is not like any other crime. In the vast majority of cases the target is a woman and the perpetrator is a man (98.7 per cent of those charged with sexual assault are men: *Crime Statistics 1986* (Ottawa: Centre for Criminal Justice Statistics, 1986), quoted in T. Brettel Dawson, "Sexual Assault Law and Past Sexual Conduct of the Primary Witness: The Construction of Relevance" (1988) 2 C.J.W.L. 310, at p. 326, note 72. Unlike other crimes of a violent nature, it is for the most part unreported. Yet, by all accounts, women are victimized at an alarming rate, and there is some evidence that an already frighteningly high rate of sexual assault is on the increase. The prosecution and conviction rates for sexual assault are among the lowest for all violent crimes. Perhaps more than any other crime, the fear and constant reality of sexual assault affects how women conduct their lives and how they define their relationship with the larger society. Sexual assault is not like any other crime. [emphasis added]
>
> *R. v. Seaboyer,* [1991] 2 S.C.R. 577 at para. 143
> See also: *R. v. Ewanchuk,* [1999] 1 S.C.R. 330 at para. *68*

7. Unfortunately, the grossly disproportionate representation of women as victims of sexual violence has not changed significantly over time. According to police-reported data, there were over 21,000 incidents of sexual assault in Canada in 2012, and over 90% of the victims were women. Multiples studies have observed that almost all accused perpetrators of sexual violence against women (99%) are males.

> Cecilia Benoit et al., *Issue Brief: Sexual Violence Against Women In Canada* (Commissioned by the Federal – Provincial – Territorial Senior Officers for the Status of Women, May 2014) at pp. 13 and 15
>
> See also *Osolin, supra* at paras 33-34

8. The health care setting is no exception. The Supreme Court of Canada considered the gendered nature of sexual assault by medical practitioners in *Norberg* v. *Wynrib*. In *Norberg,* Mclachlin J. (as she then was) noted the following from the *Final Report of the Task Force on Sexual Abuse of Patients* (the "Final Report"), commissioned by the College of Physicians and Surgeons of Ontario and released in 1991:

> Women, who can so easily be exploited by physicians for sexual purposes, may find themselves particularly vulnerable. That female patients are disproportionately the targets of sexual exploitation by physicians is borne out by the Task Force's report. Of the 303 reports they received of sexual exploitation at the hands of those in a position of trust (the vast majority of whom were physicians), 287 were by female patients, 16 by males: at p. 10.
>
> *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 at para. 77

9. Moreover, of the 15 disciplinary actions taken by the appellant College against 9 individuals for sexual misconduct in 2014 and 2015, all involved male massage therapists and female victims.

> See: http://www.cmtbc.ca/public/notices

10. The negative impact of sexual violence on women's equality has been repeatedly recognized by the Supreme Court of Canada.

> *Janzen v. Platy Enterprises Ltd.,* [1989] 1 S.C.R. 1252 at para. 44
> *R v. Mills,* [1999] 3 S.C.R. 668 at para. 48
> *R. v. Osolin, supra* at para. 33
> *Ewanchuck*, *supra* at para. 69

11. The recognition that sexual violence negatively impacts women's equality is also echoed in international human rights instruments such as the UN *Convention on the Elimination of All Forms of Discrimination against Women* (the "*CEDAW*") to which Canada is a signatory. *CEDAW* requires that signatory states take all reasonable measures, including legislation, to eliminate discrimination against women.

   Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, 1249 UNTS. 13; Can TS 1982 No 31 at article 2.

12. The obligation to eliminate discrimination against women under *CEDAW* includes the duty to eliminate discrimination in the form of violence against women, and to "ensure that laws against family violence and abuse, rape, sexual assault and other gender-biased violence give adequate protection to all women, and respect their integrity and dignity."

   Committee on the Elimination of Discrimination against Women, General Recommendation 19: Violence Against Women, contained in UN Doc A/47/38 (1992) at para 24(b)

13. S. 35 of the *HPA* is one such protection, enabling regulations – like the appellant College – to respond quickly to allegations of sexual misconduct and take steps to prevent harm to women pending a full investigation and hearing.

14. West Coast LEAF submits that the deeply harmful and gendered nature of sexual violence and its role in perpetuating women's inequality necessitates an approach to s. 35(1) which provides meaningful protection to women.

B. Imbalance of Power Between Health Care Professionals and Patients

15. West Coast LEAF further submits that allegations of sexual misconduct fall on the serious end of the spectrum to which s. 35 of the *HPA* might apply because of the power imbalance between health care professionals and patients, and the substantial harm that results when this power is abused.

16. As recognized in the *Final Report of the Task Force on Sexual Abuse of Patients,* there is an unequal distribution of power, status and authority in health care professional-patient relationships. The very essence of this relationship is trust. For this reason, health care professionals have a particular opportunity to sexually exploit patients:

> Patients seek the help of doctors when they are in a vulnerable state – when they are sick, when they are needy, when they are uncertain about what needs to be done.
>
> The unequal distribution of power in the physician-patient relationship makes opportunities for sexual exploitation more possible than in other relationships. This vulnerability gives physicians the power to exact sexual compliance. Physical force or weapons are not necessary because the physician's power comes from having the knowledge and being trusted by patients.
>
> *Final Report of the Independent Task Force on the Sexual Abuse of Patients* (Commissioned by the College of Physicians and Surgeons of Ontario, 1991) (Chair: Marilou McPhedran) at pp. 10-11, cited with approval in *Norberg v. Wynrib, supra* at para 76

17. Beyond the trust placed in health care professionals by their patients, the conditions of the standard health care appointment may further exacerbate a patient's vulnerability. In *Norberg*, McLachlin J. (as she was then) highlighted the unique factors in physician-patient relationships which render a patient particularly vulnerable:

> ... A physician holds great power over the patient. The recent decision of the Ontario Court (General Division) in *College of Physicians & Surgeons (Ontario) v. Gillen* (1990), 1 O.R. (3d) 710, 42 O.A.C. 173, contains a reminder that a patient's vulnerability may be as much physical as emotional, given the fact that a doctor (at p. 713) "has the right to examine the patient in any state of dress or undress and to administer drugs to render the patient unconscious." Visits to doctors occur in private: the door is closed, there is rarely a third party present, everything possible is done to encourage the patient to feel that the patient's privacy will be respected. This is essential to the meeting of the patient's medical and emotional needs; the unfortunate concomitant is that it also creates the conditions under which the patient may be abused without fear of outside intervention. Whether physically vulnerable or not, however, the patient, by reason of lesser expertise, the "submission" which is essential to the relationship, and sometimes, as in this case, by reason of the nature of the illness itself, is

typically in a position of comparative powerlessness. The fact that society encourages us to trust our doctors, to believe that they will be persons worthy of our trust, cannot be ignored as a factor inducing a heightened degree of vulnerability: see Feldman-Summers, "Sexual Contact in Fiduciary Relationships", in Gabbard, ed., *Sexual Exploitation in Professional Relationships*, at pp. 204-205. [emphasis added]

Norberg, *supra* at para. 76

18. Although *Norberg* and the *Final Report of the Task Force on Sexual Abuse of Patients* both speak directly to doctor-patient relationships, West Coast LEAF submits that the same principles apply to many regulated health care professionals, particularly massage therapists. Indeed, there are aspects of massage therapy which may exacerbate patient vulnerability. These factors include: the length of an appointment; the fact that physical contact is necessary for treatment (and a patient may therefore wrongly assume sexual violations form part of the treatment; the fact that massage therapy is often performed with the patient in a significant state of undress; and the fact that treatment often takes place while a patient is face down on a massage table and therefore unable to observe the actions of their treating practitioner.

19. The factors described above, however, represent only part of the vulnerability equation. Women who have a history of abuse, addiction, depression, or family difficulties, women with disabilities, young women or women who are Aboriginal may be even more vulnerable to abuse at the hands of a health care profession to whom they turn for healing:

> Relying in part on the work of Morgan in *Philosophical Analysis: Permissibility of Sexual Contact Between Physicians and Patients* (Pt. III) — Department of Philosophy and Centre for Bioethics, University of Toronto, the Task Force noted (at Legal Appendix, p. 2) that the power imbalance inherent in the physician-patient relationship:
>
> > ... is exacerbated when the doctor/patient roles are combined with certain other factors relating to personal characteristics of the parties. For example, an adult doctor and a child patient have a relationship with an even greater element of vulnerability present. The same may be argued for other groups in society, such as the handicapped and visible minorities, etc. *Since the overwhelming majority of sexual abuse/impropriety cases involve female patients and male doctors,*

> *the gender dynamic cannot be ignored. Professor Kathleen Morgan has argued that the stereotypical norms of behaviour for males and females throughout society correlate to the paternalistic model of doctor/patient relationships.* [emphasis added]

Norberg, supra at para. 76-77
See also, Rodgers, Sandra, "Zero Tolerance Some of the Time? "Doctors, Discipline and Sexual Abuse in Ontario" (2007) 15 *Health L.J.* 353 at p. 388

20. Because of the power imbalance between health care professionals and their patients, when patient trust is abused, the results are often devastating. In the *Final Report of the Task Force on Sexual Abuse of Patients,* the authors discuss serious and considerable harm to those who have been sexually abused by their physician. These harms include psychological and physical health problems such as: anxiety, depression, suicidal ideation, difficulty developing or maintaining an intimate relationship, flashbacks, nightmares, sleep disorders, abdominal pain, headaches, eating disorders and drug or alcohol abuse. Patients who have been sexually abused by a health care professional may be unable to trust doctors or other health care providers again and may avoid future medical care.

Final Report, supra at p. 14

21. Thus, West Coast LEAF submits the impact of sexual abuse of a patient by a health care professional has both far-reaching personal and societal consequences.

22. Unfortunately, the sexual abuse of a patient is often not an isolated event. In the *Final Report of the Task Force on Sexual Abuse of Patients,* the authors note the likelihood that, if one patient has been sexually exploited, other patients of the abuser may well be at risk.

Final Report, *supra* at p. 188
R.A.R. v. College of Physicians and Surgeons (Ontario), [2006] O.J. No. 4380 (CA) at para. 24
Mussani v. College of Physicians and Surgeons (Ontario), [2004] O.J. No. 5176 (CA) at para. 21
Leery v. College of Chiropractors (Ontario), 2010 ONCA 87 at para. 26

23. West Coast LEAF accordingly submits that it is vitally important that the appellant College – and other professional regulators - be able to take urgent action to protect the public from further sexual abuse where such an allegation has been made. The evidentiary threshold necessary in order for health care regulations to engage the powers contained within s. 35(1) of the *HPA* cannot be so rigorous as to render ineffective regulators' power to protect the public in sexual misconduct cases.

Reliance on Myths and Stereotypes Furthers Women's Inequality

24. Despite decades of jurisprudence addressing the subject, myths and stereotypes about women and sexual violence continue to inform adjudicators' interpretation of evidence respecting sexual violence. The perpetuation of such myths and stereotypes, and, in particular, reliance upon them, has a significant negative impact on women's substantive equality and their ability to seek meaningful legal redress when they have experienced sexual violence or assault.

25. Myths and stereotypes act as oversimplified and rigid cognitive schemas about sexual assault, complainants and perpetrators. Like most stereotypes, they provide a flawed framework around which the complex information pertaining to a sexual assault is then interpreted and organized.

26. Because myths and stereotypes operate at a subconscious level, they are often difficult to identify and confront directly.

> This list of stereotypical conceptions about women and sexual assault is by no means exhaustive. Like most stereotypes, they operate as a way, however flawed, of understanding the world and, like most such constructs, operate at a level of consciousness that makes it difficult to root them out and confront them directly. This mythology finds its way into the decisions of the police regarding their "founded"/"unfounded" categorization, operates in the mind of the Crown when deciding whether or not to prosecute, influences a judge's or juror's perception of guilt or innocence of the accused and the "goodness" or "badness" of the victim, and, finally, has carved out a niche in both the evidentiary and substantive law governing the trial of the matter.
>
> *Seaboyer, supra* at para. 154

See also discussion by McLachlin J. (as she then was) in *R. v. Williams*, [1998] 1 S.C.R. 1128 at para 21 and 22

27. In the case at bar, the Chambers Judge:

(a) repeatedly referred to the complaint as "unsubstantiated";

(b) noted that the complainant did not observe the registrant masturbating or look up to confirm that he was doing so;

(c) noted an absence of other complaints against the registrant or a criminal record; and,

(d) repeatedly suggested that the complainant imagined that the registrant was masturbating.

Reasons for Decision, Appeal Record, pp. 43-58 at paras 52 - 55 and 59.

28. In the following paragraphs, West Coast LEAF will identify and address myths and stereotypes around three key themes as are reflected in the Chambers Judge's decision: corroboration; "reasonable" victim responses; and the typical perpetrator.

A. Corroboration

29. Independent corroboration is an extraordinary requirement that has historically applied uniquely to allegations of sexual violence. The requirement has its genesis in the myth that female complainants are unreliable and untrustworthy. It is informed by the further myth that women secretly desire the sexual contact being forced on them, that women fantasize about rape, or that women make up stories of sexual abuse to seek revenge on men.

Osolin, supra at para. 194
Seaboyer, supra at para. 151

30. It is on the basis of these myths that decision-makers have viewed sexual assault complainants with a higher degree of skepticism than complainants of almost any other crime. It is also why unique rules of evidence such as the corroboration requirement have historically been applied to the evidence of sexual assault complainants.

31. Corroboration used to be an exception to the general rules of evidence that apply to every criminal offence other than sexual assault. As noted by L'Heureux-Dube in her partial dissent in *R. v. Seaboyer*:

> The corroboration rules were also exceptions to traditional evidence principles. Generally, "the court may act upon the uncorroborated testimony of one witness, and such requirements as there are concerning a plurality of witnesses, or some other confirmation of individual testimony are exceptional" (*Cross* at p. 224). Certain classes of witnesses were thought to be unreliable, such as children of tender years, accomplices and, interestingly, victims of sexual offences, almost always women. ...The rationale for corroboration also finds its genesis in the traditional distrust of a complainant's veracity in sexual offences.
>
> *Seaboyer, supra* at para. 180

32. Stereotypical assumptions which link a witness' credibility to his or her gender are antithetical to a fair and equitable legal system. As affirmed by J. Major in *R. v. R.D.S.*:

> Canadian courts have, in recent years, criticized the stereotyping of people into what is said to be predictable behaviour patterns. If a judge in a sexual assault case instructed the jury or him- or herself that because the complainant was a prostitute he or she probably consented, or that prostitutes are likely to lie about such things as sexual assault, that decision would be reversed. Such presumptions have no place in a system of justice that treats all witnesses equally. Our jurisprudence prohibits tying credibility to something as irrelevant as gender, occupation or perceived group predisposition.
>
> *R. v. R.D.S.,* [1997] 3 S.C.R. 484, at para. 16
> See also *Ewanchuk*, *supra* at para. 95

33. In actuality, false allegations of sexual assault are rare. Police statistics confirm that only three percent of reports of sexual abuse are false, about the same as false reports for other crimes. Indeed, the real issue around sexual abuse is under-reporting. The shame, anger and self-blame experienced by survivors of sexual abuse and the fear of not being believed are powerful deterrents to coming forward.

> *Final Report, supra* at pp. 13-14
> *Osolin*, *supra* at para. 195
> *A.(L.L.) v B.(A.)*, [1995] 4 S.C.R. 536 at paras 58-60

34. The requirement of independent corroboration has been explicitly repealed in the criminal context. Legislatures and courts have found the requirement irrational, discriminatory and unconstitutional. Likewise, there is no reference to any formal requirement for corroboration anywhere in the *HPA.* Despite this absence, an implied requirement of corroboration still regularly surfaces in regulatory decisions. This is so even though the standard of proof applicable to these decisions is lower than the standard applicable in the criminal context.

> *Zero Tolerance Some of the Time, supra* at pp. 371-372

35. In her paper examining the decisions of the College of Physicians and Surgeons of Ontario Complaints and Discipline Committees concerning sexual abuse, Professor Sandra Rodgers notes that corroboration requirements continue to persist when health care regulatory bodies consider sexual assault claims.

> This is demonstrated by the response of CPSO staff members and committees to complaints of sexual abuse perpetrated by physicians. The persistence of discriminatory stereotypes and resistance to the full implementation of zero tolerance provisions demonstrates the survival of these assumptions and stereotypes and their replication in the regulatory context. This is despite a strong legislative message that sexual abuse by professionals should not be tolerated.
>
> Extraordinary requirements with regard to corroboration have been a continuing and pernicious marker of law's resistance to the eradication of male sexual violence against women and to legal and social recognition of the full equality and personhood of women. The most striking subversion of the implementation of a policy of zero tolerance in the regulatory context is the apparent persistence of an unwritten and uncommented upon requirement for independent corroboration of the complaint, and resistance to proceeding where the only evidence of sexual abuse is provided by the women herself. This is despite the fact that nowhere in the *Act* is there reference to any formal requirement for corroboration and despite the explicit repeal of such requirements in the criminal context. [emphasis added]

> *Zero Tolerance Some of the Time, supra* at pp. 371-372

36. This practice of requiring corroboration is striking both because the need for corroboration has been specifically rejected by courts and because cases of sexual violence or misconduct where corroboration is possible are rare. As noted above,

sexual abuse in general, and abuse by a health care professional in particular, usually occurs out of sight and behind closed doors, making corroborative evidence unlikely.

> *Zero Tolerance Some of the Time, supra* at p. 377
> *Final Report,* at p. 187

37. The evidentiary standard applicable to determinations made under s. 35(1) of the *HPA* must recognize the inherent likelihood that evidence of sexual misconduct in the health care setting will often be limited to a complainant's word against a registrant's. Reintroducing a requirement for independent corroboration ignores the nature of sexual misconduct and the context in which it usually occurs.

38. West Coast LEAF submits that an evidentiary approach to determinations made under s. 35(1) of the *HPA* which requires corroboration stands to practically prevent health care regulators from protecting the public in response to allegations of sexual misconduct. This, in turn, will have a significant negative impact on women's substantive equality, including access to safe health care, because women are disproportionately and overwhelmingly the victims of sexual misconduct.

B. "Reasonable" Responses to Sexual Assault

39. Although the Chambers Judge states that the fact that a complainant does not see any misconduct is not a basis to dismiss a complaint without further investigation, she goes on to repeatedly note that the complainant did not look up to visually confirm that the respondent was masturbating or that his penis was on her wrist. The inference to be drawn from her emphasis on this point is that the complainant, if actually subjected to sexual misconduct, would or should have resisted or responded by seeking to confirm the registrant's activity.

40. The expectation that "real" victims of sexual abuse will respond in predictable ways is a stereotype without empirical support. It is, however, a myth that remains pervasive when a complainant's evidence of sexual violence is assessed.

41. Responses that are deemed "reasonable" include active resistance, hysteria and the pursuit of criminal justice. As the myth goes, when being sexually assaulted, violated or raped, a woman who is truly unwilling will vigorously verbally and/or physically resist the attack. Not only should ideal victims resist, but the resistance should be capable of independent corroboration through physical injury or witness accounts. There is also an expectation that the victim will be visibly upset, both during the attack and after. This is because women are seen as more emotional than men. Accordingly, if a victim is able to remain calm, people will assume nothing inappropriate has happened.

    Seaboyer, *supra* at para. 151
    Randall, Melanie, "Sexual Assault Law, Credibility and Ideal Victims: Consent, Resistance, and Victim Blaming" (2010) 22 *CJWL* 397 at p. 398, 415 and 417
    Regina Schuller et al., "Judgments of Sexual Assault: The Impact of Complainant Emotional Demeanor, Gender and Victim Stereotypes" (2010) 13 *New Crim. L.R.* 759 at p. 767

42. This ideal victim myth works to undermine the credibility of women who are seen to deviate too far from stereotypical notions of the "reasonable" victim response.

43. In *Judgments of Sexual Assault: The Impact of Complainant Emotional Demeanor, Gender, and Victim Stereotypes,* Professors Regina Schuller and Barbara Masser report the results of a juror simulation examining the impact of a victim's level of resistance and post-assault demeanor on judgments. Results revealed that the complainant's emotional display had a powerful impact on participants' judgments. Complaints were viewed as more valid when the complainant was portrayed as tearful/upset as opposed to calm/controlled. The study also found that complainants who resisted their attacker both physically and verbally were viewed as more believable compared to women whose only resistance was verbal.

    Judgments of Sexual Assault, supra at p. 775

44. The assumption that a woman should fight back against assault ignores the fact that many women choose not to resist because they feel their safety is better protected by not resisting. These women would not be wrong. The experience and knowledge of

women is reflected by the *Canadian Urban Victimization Survey: Female Victims of Crime* (1985) cited by Justice L'Heureux-Dube in *Seaboyer*:

> Sixty percent of those who tried reasoning with their attackers, and 60% of those who resisted actively by fighting or using weapon [sic] were injured. Every sexual assault incident is unique and so many factors are unknown (physical size of victims and offenders, verbal or physical threats, etc.) that no single course of action can be recommended unqualifiedly.
>
> *Seaboyer*, *supra* at para. 149

45. Some women do not resist an attacker or perpetrator because, upon being assaulted, invaded or intimidated, their psychological response is to dissociate. Dissociation is a psychological defense mechanism, involving detachment from real events. It is particularly common among individuals who have been victims of childhood sexual abuse, and is a coping mechanism which assists some individuals in tolerating stress or trauma.

    Sexual Assault Law, Credibility and Ideal Victims, supra at p. 419

46. In sum, women's actual responses to sexual assault are extremely varied:

> The ways in which those whose lives have been harmed by experiences of sexual assault make sense of, respond to, and heal from these events, therefore, are complex and multi-layered and are also at once individually and socially constituted. There are identifiable and patterned responses to traumatic events such as sexual assault, and these are well documented in the research and clinical literature in this area. However, while there are common reactions, there is also a great deal of variability in the ways in which women are affected by experiences of sexual assault and a great deal more variation in the ways in which the emotional and psychological impacts of violence are expressed.
>
> *Sexual Assault Law, Credibility and Ideal Victims, supra* at p. 429

47. As Justice L'Heureux-Dube acknowledges in *Seaboyer,* there are similarly a number of reasons why women choose not to report sexual abuse. They include fear of reprisal, fear of a continuation of their trauma at the hands of the police and the criminal justice system, low conviction rates and lack of desire to report due to the

typical effects of sexual assault such as depression, self-blame or loss of self-esteem.

Seaboyer, *supra* at para. 145

48. West Coast LEAF submits that myths pertaining to "reasonable" victim responses ignore what we know about women's varied responses to sexual violence and have a significant negative impact on the extent to which a woman's complaint of sexual violence will be perceived to be valid.

C. The Stereotypical Perpetrator

49. In pointing out the registrant's lack of a criminal record or previous history of sexual misconduct complaints, the Chambers Judge infers that the registrant would be unlikely to have committed the alleged sexual misconduct. In doing so, she reinforces the common myth that sexual assault is committed only by deviant, rather than by otherwise "normal", men.

50. The stereotype that perpetrators of sexual violence fit a certain archetype is often reflected in the regulatory context when counsel attempt to discredit a complaint by distinguishing the registrant from the mythic abuser by describing or portraying him as "normal." As Professor Sandra Rodgers notes in *Zero Tolerance Some of the Time? Doctors, Discipline and Sexual Abuse in Ontario:*

> Evidence also often is offered of biochemical, phallometric, psychological and physiological testing to support the claim that no "major illness or personality disorder" is present. In one case, expert evidence was offered that because the accused physician had a "partner" (wife) who was a psychiatrist, it was unlikely he would have committed the abuse. In another, the fact that the physician had been in a stable relationship for the last 10 years was offered as exonerating evidence.

Zero Tolerance Some of the Time, p. 392-393
Seaboyer, *supra* at para. 149

51. Neither a man's marital status, nor the presence or absence of previous complaints against him, is any indicia of the likelihood that a complainant's allegations are more or less valid.

College of Chiropractors (Ontario) v. Kovacs, [2004] O.J. No. 4353 (Ont Div. Ct) at para 40, 41 and 43

52. Moreover, emphasis or reliance on an absence of previous complaints against a registrant will make the creation of an initial disciplinary record extremely difficult thereby insulating those without a prior disciplinary or criminal history from initial disciplinary or interim action.

53. West Coast LEAF submits that reliance on the myth of the stereotypical perpetrator – namely the myth that perpetrators will be identifiable as deviant or have a reported history of sexual misconduct – creates a distorted lens through which women's evidence of sexual violence is filtered and places women at risk of harm by insulating registrants lacking a criminal or complaints history from disciplinary action or scrutiny.

54. The ways in which myths and stereotypes about women and sexual violence negatively impact perceptions about the validity of a complainant's allegations is well illustrated in *College of Chiropractors (Ontario) v. Kovacs,* which is similar in many respects to the case on appeal.

55. In *Kovacs*, the complainant alleged that she was the victim of sexual assault on two occasions by the respondent chiropractor. The complainant, a 21 year old registered nurse, was referred to the respondent for low back pain and received treatment from him on four occasions. During the third appointment, the respondent massaged the complainant around her head, temples, underarms and arms, breasts, abdomen and upper groin area. She testified that she thought this was part of the "lymphatic drainage procedure" he recommended. During the fourth appointment, he massaged her breasts, vagina, thighs and buttocks, and inserted his ungloved fingers into her vagina.

56. The complainant testified that she was upset and that after she left the fourth appointment, she spoke to her boyfriend who was a police officer. She reported the events to the police the next day and made a written complaint to the College of Chiropractors.

57. A majority of the Discipline Committee in *Kovacs* dismissed the complaint, finding that the case turned on an assessment of the relative credibility of the complainant and the respondent. In addition to the majority's adverse credibility findings against the complainant, it found that parts of the complainant's evidence did not make "common sense". The majority found, *inter alia*, that it did not make common sense for a nurse to allow someone to insert an ungloved finger into her vagina without protest. As well, the majority found it did not make sense that the complainant, having been trained as a nurse, was not more concerned about sexually transmitted diseases and did not have a medical examination.

Kovacs, supra at para. 18

58. The majority also considered certain factors that, in their view, tended to disprove the College's case:

(a) The lack of a history of complaints against the respondent;

(b) The fact that the complainant was an unlikely victim because she was educated and her father was a patient; and

(c) The fact that no other victims came forward despite publicity.

The majority also thought it was "highly unreasonable" that an individual in the respondent's position would risk losing everything by engaging in the alleged misconduct.

Kovacs, supra at paras. 18-19

59. On appeal, a majority of the Ontario Superior Court of Justice (Divisional Court) set aside the Committee's majority decision on the basis that it was unreasonable. In addition to finding the majority's assessment of the complainant's credibility to be flawed, the Court noted that the decision was heavily reliant on myths and stereotypes. The majority found that "[r]ather than focus on the testimony of the parties before it, the majority appears to have used myths and stereotypes about sexual assault victims and perpetrators which have influenced their decision in a manner which does not appear fair to all the interested parties." These stereotypes

related to particular characterizations of victims, perpetrators and responses to sexual victimization:

> The majority's reasons rest on stereotypes about both possible victims of sexual assault and possible perpetrators. They have assumed that a woman, especially a nurse, would have responded in a particular way to sexual assault, without considering other factors in the situation, such as the age of the Complainant, the fact that she was alone in the office with the Respondent, the fact that he had explained the lymphatic system and massage therapy to her, and the fact that, in her words, she was "shocked." With respect to the risk of STD's, they failed to address her evidence that she believed that the risk was very low, and she took the antibiotics for peace of mind (at p. 388 of the transcript). She also explained that she saw no reason for a medical examination, given that she did not feel any injury, and time had gone by since the assault.
>
> Moreover, the majority assumed that a person in the Respondent's position would be unlikely to commit the alleged acts. As egregious as the alleged acts are, there are many examples of individuals in a position of power who have sexually abused others, whether patients, students or other vulnerable individuals. The majority should not have treated this as a factor tending to disprove the College's case.
>
> *Kovacs*, *supra* at para. 40-41

60. The Court went on to decide that it was an error for the majority to consider the fact that there were no previous or other complaints against the respondent was a factor that diminished the complainant's credibility: "The fact that there were no previous or other complaints against the Respondent does not confirm his version of events, nor damage the Complainant's credibility." [emphasis added]

    Kovacs, *supra* at para. 43

61. As *Kovacs* illustrates, a reliance on myths and stereotypes about sexual violence in order to search for an "air of reality" to complaints erroneously leads to an analysis that is both discriminatory and unreasonable. Such an approach ignores decades of law and social science research regarding complainants' accounts of their sexual assault experiences. As noted by J. L'Heureux-Dube in *Ewanchuk*:

> Complainants should be able to rely on a system free from myths and stereotypes, and on a judiciary whose impartiality is not compromised by these biased assumptions. The *Code* was amended in 1983 and in 1992 to eradicate reliance on those assumptions; they should not be permitted to resurface through the stereotypes reflected in the reasons of the majority of the Court of Appeal. It is part of the role of this Court to denounce this kind of language, unfortunately still used today, which not only perpetuates archaic myths and stereotypes about the nature of sexual assaults but also ignores the law.
>
> *Ewanchuk, supra* at para. 95

62. Any requirement for corroboration or reliance on myths and stereotypes pertaining to women, men and sexual violence will have a significant negative impact on women's equality by preventing health care regulators from utilizing s. 35(1) of the *HPA* to protect the public, particularly women, in cases of sexual misconduct.

63. West Coast LEAF submits that the evidentiary threshold applicable to determinations made under s. 35 of the *HPA* must take into account the disproportionate impact that sexual violence has on women; the imbalance of power inherent in health care professional-patient relationships; and the effect that discriminatory myths and stereotypes about women and sexual violence have on women's equality. West Coast LEAF submits that any evidentiary threshold which fails to take these factors into account will have a significant negative impact on women's substantive equality.

PART 4 – NATURE OF ORDER SOUGHT

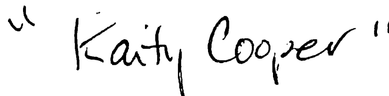
64. West Coast LEAF takes no position on the outcome of this appeal.

65. West Coast LEAF seeks leave to make oral submissions at the hearing of this appeal, not to exceed 20 minutes.

66. West Coast LEAF does not seek costs and asks that costs not be ordered against it.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

Dated: December 4, 2015



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APPENDIX: ENACTMENTS

Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.R.), 1982, c. 11

Equality Rights

15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

General

28. Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons.

Health Professions Act, R.S.B.C. 1996, c. 183

Extraordinary action to protect public

35 (1) If the inquiry committee considers the action necessary to protect the public during the investigation of a registrant or pending a hearing of the discipline committee, it may, by order,

(a) impose limits or conditions on the practice of the designated health profession by the registrant, or

(b) suspend the registration of the registrant.

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