# Submission by the Ontario Nurses' Association (ONA) to the Ontario Health and Long-Term Care Minister's Task Force on the Prevention of Sexual Abuse of Patients

**June 2015**

The Ontario Nurses' Association (ONA) represents more than 60,000 registered nurses (RNs) and allied health professionals employed in hospitals, long-term care facilities, public health, community health, Canadian Blood Services, clinics and industry across Ontario, as well as more than 14,000 nursing student affiliates.

Ninety-five per cent of ONA's members are RNs, and the overwhelming majority of its members are female.

ONA has an interest in the work of the Task Force as its members have been subjected to workplace violence, including sexual harassment and abuse, some at the hands of other health-care professionals. ONA members have also been respondents at their college on issues of alleged sexual abuse.

ONA has very serious concerns with respect to the broad reach of the current *Regulated Health Professions Act (RHPA)* provisions aimed at sexual abuse. We have detailed the basis of those concerns for your review. In doing so, we appreciate that your task is to make recommendation on "ways that the current legislation can best ensure that every interaction by patients and witnesses with regulatory colleges in relation to issues involving sexual abuse and colleges' processes are sensitive, accessible and timely, and identification of best practices from leading jurisdictions around the world."

As clarified at the roundtable discussion, the agenda therefore is focused on the concerns of patients and witnesses and not the concerns of the health-care professionals. However, in any legislative review, it is assumed that the legislature will be looking for the most appropriate solutions and one that balances the interest of patients and witnesses but also takes into account the interests of the general public. We also assume that any legislative review would keep in mind the interests of health-care professionals. Our public education system invests tremendous resources in training these professionals, upon whom our health-care system ultimately relies. Their entitlement to fair treatment and natural justice cannot be ignored.

We would also note that legislation, which is overly broad and over-reaching, will ultimately lack credibility in the public eye. It will also result in decisions being made by committees, prosecutors and others to avoid blatantly unjust consequences to individual practitioners. In ONA's view, it is preferable to have legislation that, on its face, achieves equitable results for all involved.

**Concerns with the Current Legislation**

It is ONA's position that proven sexual abuse of a patient is a very serious matter that warrants a finding of professional misconduct. However, the mandatory revocation provisions are currently too broadly drafted and inappropriately depart from the legislative scheme for all other cases of professional misconduct (including serious matters such as physical abuse) by unnecessarily removing the powers of the Discipline Committee to consider relevant evidence and determine appropriate penalties. It may be that revocation is the appropriate penalty in certain cases, but given that there is a broad range of sexual and intimate conduct that is covered by the provisions, the penalty should be determined by the Discipline Committee of the colleges, taking into account the circumstances of each case, including issues relating to

consent, age, sex, race, the nature of the relationship and whether there was in fact any power imbalance.

The provisions in question apply uniformly to all regulated health professions in Ontario. However, there is a wide range of professionals who have differing relationships with patients; it cannot be assumed that the same power imbalance applies in the many cases that are captured at present by the provisions in question.

**College of Physicians and Surgeons of Ontario (CPSO) Task Force on Sexual Abuse of Patients**

Sexual abuse provisions were added to the *Ontario Human Rights Code* in 1993, in response to recommendations made by the Task Force on Sexual Abuse of Patients established by the CPSO in 1991. The Task Force's mandate was "to seek information from the public, the College and individual doctors" about how to address the serious problem of sexual abuse of patients by physicians.

**Final Report of the Task Force on Sexual Abuse of Patients: An Independent Task Force Commissioned by the CPSO (November, 1991) [CPSO *Final Task Force Report*]**

***Power Imbalance***

The Task Force report emphasized that the physician-patient relationship is characterized by an imbalance of power in favour of the physician over the patient. This power imbalance flows from at least three different social realities. First, the physician is in a position of power by virtue of being in a position to offer professional services that are needed by the patient for health and well-being. Second, the physician is in a position of power by virtue of the relatively high social and economic status of physicians in our society. Third, because most sexual abuse involves male physicians and female patients, the physician-patient relationship will also be affected by the imbalance of power between men and women in our society.

> "Doctors occupy a privileged position in society on the basis of their education, status and access to resources, including legal representation provided by the Canadian Medical Protective Association. Very rarely will the patient be on an "equal footing" with the doctor – the patient's need for something only a doctor can provide automatically introduces an element of vulnerability. Since the overwhelming majority of sexual abuse/impropriety cases involve female patients and male doctors, the gender dynamic cannot be ignored." CPSO *Final Task Force Report*, p. 80

***CPSO Discipline Committee Failed to Protect the Public in Cases of Sexual Abuse of Patients by Physician***

In deciding to recommend mandatory penalties for sexual abuse, the Task Force was strongly influenced by evidence that the CPSO, and its Discipline Committee, had failed to deal appropriately with sexual impropriety by physicians.

CPSO *Final Task Force Report*, pp. 21-22

Based on the CPSO's record of dealing with complaints of sexual impropriety, the Task Force concluded that "[l]ack of faith in the College's ability to self-regulate effectively was one of the clearest messages we received from our hearings."

CPSO *Final Task Force Report*, p. 21

The CPSO *Task Force Report* recommended that its "zero-tolerance philosophy" be extended to all of the health professions regulated by the *RHPA*. This recommendation was not based on

any information concerning the incidence of sexual abuse among other health professions or how other colleges had handled complaints of sexual impropriety.

CPSO *Final Task Force Report*, p. 20
In her statement to the Standing Committee on Social Development on November 22, 1993, the Minister of Health reported that when the CPSO Task Force began its public hearings, a Canada Health Monitor commissioned by the CPSO indicated that almost 1 in 10 women in Ontario said that she had been sexually harassed or abused by a physician at least once. She described this finding as an "intolerable situation."

*Official Report of Debates (Hansard*), Legislative Assembly of Ontario, Third Session, 35th Parliament, Standing Committee on Social Development, Monday 22 November 1993 (*Hansard* 22/11/93), p. S-522
The Association of Occupational Therapists appeared before the Standing Committee on Social Development, urging the government to consider the differential impact the proposed amendments would have on different professions, taking into account factors including the differences in gender composition and incidence of sexual abuse among different health professions:

> "We would urge you to consider the impact of Bill 100 on each of the professions regulated under the bill. These professions vary greatly in many ways, including salary, size, gender proportions, personal contact with the public and incidence of sexual abuse. Occupational therapy, for example, has approximately 2,500 members in the province, is 97 per cent female, has a relatively low salary scale and little documented history of sexual abuse of clients." *Official Report of Debates (Hansard*), Legislative Assembly of Ontario, Third Session, 35th Parliament, Standing Committee on Social Development, Monday 6 December 1993 (*Hansard* 6/12/93), p. S-681

**Nursing and other Professions which differ from the Medical Profession**
Other health professions differ in a number of significant ways from physicians. For example, nursing remains an overwhelmingly female-dominated profession (approximately 96 per cent of nurses in Ontario are women) as compared to the medical profession, where approximately 72 per cent of Ontario physicians are men. Because nursing is a heavily female-dominated profession, the risk and incidence of sexual abuse by nurses is lower than in male-dominated health professions. Furthermore, nurses are actually subject to a high frequency and high level of physical violence, verbal abuse, sexual harassment and sexual abuse, primarily at the hands of patients and their families.

In addition, not all health professions have the same control over their work or enjoy the same occupational status as physicians. Nearly half of all nurses in Ontario work in part-time or casual positions. Unlike most physicians, nurses overwhelming provide care to patients as employees of institutions rather than as independent practitioners. Nurses do not have control over who the patients of a hospital or health facility are, and have little or no control over what patients are assigned to them on a daily basis and when patients are transferred or discharged. The mandatory revocation provisions presupposes that all health professions have the same kind of power relationship with their patients that physicians have, while in reality this is simply not the case.

ONA is also concerned that the mandatory penalty of licence revocation for a minimum five year period takes away the Discipline Committee's discretion to apply the general principles for determining the appropriate penalty in cases of professional misconduct by a health-care professional. In other situations, the Discipline Committee has the discretion to apply a wide

range of penalties for all other forms of professional misconduct, including other forms of serious professional misconduct such as physical abuse, verbal abuse, theft and breach of trust.

In exercising its discretion, the Discipline Committee applies a range of factors that include the seriousness of the misconduct, rehabilitation and specific and general deterrence. Therefore, it is submitted that the imposition of a mandatory penalty for serious sexual abuse is not in keeping with the approach the *Code* takes to all other serious professional misconduct. Additionally, ONA is concerned that the application of the impugned provisions can have different implications in different professional contexts.

**Contextual Factors**

ONA submits that three contextual factors are particularly significant to the issues discussed above. First, the sexual abuse provisions were legislated in response to concerns about the incidence of sexual improprieties between physicians and patients, and the failure of the CPSO to respond appropriately to this conduct. Regardless of whether or not mandatory licence revocation may have been appropriate legislative response to the CPSO *Task Force Report*, and ONA submits that it was not, there was no documented record of similar concerns within other health professions and no effort to determine whether there were similar concerns of other health professions.

Second, the positions of social and occupational privilege occupied by members of the medical profession, in conjunction with the male dominance of the profession, affect the power dynamics in the relationships between physicians and patients. The government made no effort to determine what impact the sexual abuse provisions would have on professions that are female-dominated and which occupy relatively less privileged positions within society and the health-care sector.

Third, what is at issue is the imposition of a penalty which the courts have recognized as constituting a "professional death penalty." Revocation is the most severe penalty that can be imposed by a professional regulatory body. By removing any discretion that the Discipline Committee otherwise has in assessing the appropriateness of the penalty to be given in any case, the provisions automatically apply the harshest penalty to every case meeting the broad criteria for revocation set out in the legislation, regardless of the actual circumstances.

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

ONA submits that the mandatory revocation provisions are broader than necessary to achieve the government's purpose, and that they do not strike a fair balance between the interests of the patients and the interests of the health professionals. Provisions, such as the mandatory consideration by the Discipline Committee of an impact statement in cases of sexual abuse as required by the legislation, can adequately address the public policy concerns arising from the CPSO *Task Force*. ONA further submits that the impugned provisions are presumptively overbroad in their application to female-dominated health professions, which do not occupy a position of social or occupational privilege.

The purpose of the provision requiring licence revocation for a minimum five-year period is to provide the most serious penalty for sexual conduct by health professionals, on the assumption that it involves an abuse of power in the therapeutic relationship between patient and health

professional. The provisions are premised on the paradigm of the concrete imbalance of power within a male-dominated health profession, in which the overwhelming majority of documented complaints are about sexual conduct by male physicians towards female patients.

ONA submits that power imbalance is not a homogenous characteristic of all relationships between patient and health professional. This premise cannot be simply applied to fit all health professional contexts, and in particular those contexts which are female-dominated and which do not occupy a privileged social and occupational status. Furthermore, the mandatory revocation provisions are enacted across all professions, even though there was no indication that there were concerns about sexual abuse within other professions, particularly with female-dominated health professions.

ONA submits that mandatory licence revocation is too broad and too blunt a legislative response for the range of circumstances in which sexual conduct involving a health-care professional and a patient can occur. The mandatory revocation provisions should be repealed such that, in cases involving allegations of a sexual nature, the Discipline Committee has discretion to consider all of the circumstances and factors of each case when determining the appropriate penalty, as it currently does in all other cases. While the Discipline Committee may determine that licence revocation is the appropriate penalty in any given case, ONA submits that mandatory revocation is not an appropriate legislative response because the provisions can apply to situations which, given the particular circumstances of the case, do not require or warrant such a severe and draconian response.

***Examples of How the Impugned Provisions can Apply Beyond their Intended Reach***

The structures of the nursing profession and of the nurse-patient relationship have particular implications for how the sexual abuse and mandatory revocation provisions of the *Code* operate in practice. The operation of these structures further demonstrates the disproportional and unnecessary reach of the impugned provisions. ONA provides the following hypotheticals to demonstrate the ways in which the impugned provisions go well beyond the reasonable and necessary scope of their application.

Nurses are employed in a wide variety of situations, many of which involve typically brief encounters with patients, which do not allow for the development of ongoing professional, therapeutic relationships. Such situations include a hospital where an otherwise healthy man is treated for a broken leg. Such a patient may have a brief professional encounter with various nurses in the emergency department, including the triage nurse, the assessment nurse, a nurse who administers one pain medication and one who responds to a single call bell. This same patient will likely have professional encounters with many nurses in his progress through the Operating Room, the Recovery Room, the Surgical Unit, the Rehabilitation Unit and the Outpatient Orthopaedic clinic. Many of these professional relationships will be brief and transitory. However, should this patient develop a social relationship with a nurse he has encountered on this health care journey, and should this relationship develop into a consensual sexual relationship, the nurse may be exposed to prosecution for professional misconduct and to mandatory revocation of her professional status for five years.

The statutorily mandated penalty, which is unduly focussed on the characterization of the sexual relationship, may not allow for sufficient consideration of the nature of the professional relationship, the consensual nature of the social and sexual relationship, the harm to the patient or the usual factors of deterrence and rehabilitation.

The uni-dimensional approach of the mandatory revocation penalty provisions also preclude consideration of common sense circumstances, such as age, gender and socio-economic

status, and even physical setting, which in a particular case, arguably counter the presumptive imbalance in power categorically assumed to tip in favour of the health-care professional. A sexual relationship between a 20-year-old female Registered Practical Nurse (RPN) and a 50-year-old male bank president initiated when she takes vital signs for an insurance medical in his office, is assumed, by the legislation, to be subject to the same dynamics of power imbalance as a sexual relationship between a well-established male charge nurse (or psychiatrist) and a young, mentally-ill, bed-ridden female patient in an institution in which he works.

The legislation also does not permit consideration of personal circumstances of health-care professionals who are suffering from depression or other mental conditions, which make them more vulnerable to becoming involved in a sexual relationship with a patient. This factor is discussed further below.

In the case of *College of Nurses of Ontario (CNO) v. C.J.S.,* a nurse was prosecuted for physical abuse when she slapped a male patient who sexually assaulted her while she was providing home care nursing services at his place of residence. While the charges were ultimately dismissed by the Discipline Committee, this case illustrates the fact that sexual conduct can be directed at nurses by patients, including nurses who must go into a patient's home to provide care and find themselves in a particularly vulnerable situation. If such a sexual assault by the patient was of a form requiring mandatory revocation (e.g. sexual intercourse), the mandatory revocation of the victim's license would, on a strict reading of the statute, apply. The CNO might argue that it would not prosecute a nurse for sexual abuse in these extreme circumstances. However, ONA submits that nurses should not have to rely upon a decision by the College not to prosecute in order to avoid unreasonable application of the sexual abuse provisions. As long as the provisions can be invoked, the nurse remains vulnerable to prosecution.

*CNO v. C.J.S.*, (Discipline Committee of the CNO, December 24, 1990)
ONA submits that mandatory licence revocation is too broad and too blunt a legislative response for the range of circumstances in which sexual conduct involving a health-care professional and a patient can, and do, occur.

**Respondents (Health Professionals) with Mental Health Disabilities as a Contributing Factor to Allegations of Sexual Misconduct**

We would also point out that, in addition to considering the interests of patients and the other interests at play under the *RHPA*, the government has an obligation to consider the impact of any legislation of persons with disabilities. Under the *Ontario Human Rights Code*, regulators have the duty to treat their members equally, without discrimination and harassment because of disability. They have a further duty to accommodate such persons.

In its recent policy on preventing discrimination based on mental health disabilities and addictions, the Ontario Human Rights Commission challenged regulators (amongst others) to review systems to eliminate barriers for persons with disability and to eliminate policies and practices that disadvantage people with psychosocial difficulties. Accordingly, in passing or implementing legislation that impacts on health professionals with mental health disabilities or addiction problems, the ultimate responsibility for maintaining the human rights of those persons rests with the responsible parties, including professional regulators. Furthermore, the United Nations Convention on the Rights of Persons with Disabilities (2006), binding on Canada and Ontario, reinforce Canada's *Charter* in prohibiting discrimination on the basis of disability. Accordingly, in reviewing the *RHPA,* any existing legislation or amendments thereto must be viewed through the *Charter* lens to ensure that it does not impinge on health professions with disabilities.

*Policy on Preventing Discrimination Based on Mental Health Disabilities and Addictions*, Ontario Human Rights Commission, June 18, 2014
While ONA accepts that the existence of a disability may not be a complete defence to sexually abusive actions, it could be a relevant factor in determining the circumstances of the conduct and the appropriate penalty. Accordingly, it is necessary, in ONA's submission, that any legislation ensure that, to the extent the defendant's conduct in a sexual abuse case is attributable to or impacted by a mental health disability, consideration of that factor be allowed.

**Recommendation Regarding Mandatory Revocation**
ONA recommends that the current mandatory revocation penalty be replaced with sentencing guidelines that would take into account the usual sentencing principles of deterrence and rehabilitation as well as identified aggravating and mitigating circumstances.

ONA suggests that aggravating circumstances would include:
- Significant imbalance of power, which could be a rebuttable presumption.
- Seriousness of the abuse, which could be a rebuttable presumption.
- Vulnerability of the complainant based on age disability or other grounds.
- Significant impact on the complainant.

ONA suggests that mitigating circumstances would include:
- Minimal imbalance of power.
- Consensual nature of the relationship.
- Contribution of the respondent's mental health issues to the conduct.
- Minimal impact on the victim.

Alternatively, ONA recommends that an exception be added to the mandatory revocation provisions for sexual abuse that would take into account the mitigating circumstances set out above in allowing the imposition of a lesser penalty.

**ONA's Position on the Questions Raised at the Task Force Roundtable Held on May 12, 2015**

***Mandatory reporting to the police: Is this advisable? If so, when and under what circumstances? How will the privacy rights of the patient be protected?***
It is ONA's very firm position that mandatory reporting to the police by the regulator in all instances of alleged sexual abuse is NOT advisable. This view is informed by the following observations:
- Complainants should be able to control whether or not they want involvement of the police.
- Subjecting complainants and respondents to a further layer of investigation can be time consuming and ultimately may be harmful to both parties; it increases the possibilities of inconsistent statements.
- The definition of sexual abuse under the *Code* is broader than under the *Criminal Code;* the College does not have the expertise to determine possible criminal liability.
- Police do not have a good understanding of the complexities of the health-care system; the regulator is in the best position to enforce the professional standards regarding the therapeutic relationship.

**Recommendation**
Consideration be given to requiring regulators to advise complainants in appropriate cases of the possibility of reporting the matter to the police.

***Plea Bargaining: Under what, if any, circumstances should it be permitted where the allegations, if proven, would result in mandatory revocation of license?***
It is ONA's position that plea bargaining should be allowed in appropriate circumstances. This view is informed by the following considerations:

- Not all allegations are provable.
- The prosecutor should retain the discretion that is available to Crown prosecutors in circumstances where there is little or no reasonable prospect of prosecution.
- The prosecutor should be given the discretion to take a plea where exceptional circumstances (as discussed above) exist.

***Should the Complainant Have any Input into the Decision to Enter Into a Plea Bargain?***
It is ONA's position that complainants should not have input into plea bargaining. They should however be advised of a plea bargain and the reasons behind it. This view is informed by the following considerations:

- The prosecutor and not the complainant is in the best position to know whether or not the case has a reasonable prospect of success and/or what if any exceptional circumstances exist.
- Allowing for the complainant's input would allow for undue influence on the complainant and for the consideration of factors that should be extraneous and irrelevant to the ultimate outcome.
- Allowing the complainant to have input would lead to inconsistent results for similar cases.

***Section36(3) RHPA: In light of the jurisprudence should this provision be amended?***
ONA's position on this is NO, subject to the following qualification:

- In the event that the respondent misstates the outcome of a college proceeding in a subsequent proceeding, a challenge through cross-examination should be allowed.

***The definition of sexual abuse under the mandatory revocation provision:***

***(a) Does it adequately capture sexual misconduct warranting mandatory revocation?***
ONA's position on this, for the reasons already outlined in the overview, is that the definition is already overly broad. Mandatory revocation should be reserved for cases meriting the ultimate penalty.

***(b) Should mandatory revocation be extended to sexual abuse committed in the workplace?***

It is not clear what is meant by this suggestion. However, ONA is of the view that the location of the sexual abuse should not be a relevant consideration. Mandatory revocation raises the concerns discussed above; ONA does NOT support any expansion of its use.

***HPARB: Is it working? If not, can it be fixed and if so how? If not, what is the alternative?***
ONA makes no comment.

***Any suggestions for amendments to the RHPA or Health Professions procedure Code that would modernize the sexual abuse related provisions, and improve patient safety and accessibility to college process?***
It is ONA's position that investigations of sexual abuse complaints and/or reports should continue to be investigated internally by the college in question. This view is informed by the following:

- Individually, colleges are in the best position to understand the profession, the workplace and the dynamics of the profession.

- The individual colleges are clearly in the best position to investigate standards complaints/reports; query whether there are sufficient sexual abuse complaints, across all colleges, to occupy a fully trained investigation staff.
- Independent investigators would not be in the best position to identify the relevant evidence.

***(c) Should complainants be accorded party status in discipline hearings? If so, full or partial?***

ONA is very strongly of the view that complainants should not be accorded party status. This view is informed by the following:

- As in criminal matters the matter the prosecution should be handled by a professional prosecutor who is in the best position to advance the case.
- The role of the complainant should be as a witness and to provide a victim impact statement on sentencing.
- Adding a third party on the side of the prosecution could compromise the prosecution and is certainly unfair to the respondent.
- While respondents are typically well represented in proceedings before the CPSO where members have access to the *CMPA*, respondents at many of the other colleges are often unrepresented; to have the complainants represented by counsel would, in those circumstances, clearly be inappropriate and unfair to the respondent.

***(d)* What changes would improve the liaison between colleges and complainants? For example, should there be more legal and therapeutic supports made available to complainants? In what ways could complainants be accorded meaningful ways to participate and become engaged in the college process?**

ONA is of the view that, at least with respect to the CNO, adequate support is provided is already being provided. This view is informed by the following:

- Based on our experience in the representation of members, complainants are treated with respect and dignity in the College's process.
- Given that many respondents, including at the CNO, are unrepresented and some struggle with English as a second language, it would be unfairly prejudicial to provide complainants with counsel who would then act as a second prosecutor.
- If complainants were provided with legal support then so too should unrepresented respondents.

***(e) Should colleges be required to refer complainants to lawyers for summary legal advice? If so, should colleges be required to pay a flat summary fee for this summary advice?***

Please see comments above.

***(f) Should the Inquiries, Complaints and Reports Committee (ICRC) have the discretion to decline to send a complaint which makes allegations of sexual abuse of patients which, if proven, would attract mandatory revocation, to the Discipline Committee as a sexual abuse case or at all? If so, under what circumstances?***

It is ONA's strongly held view that there should be discretion at both the ICRC stage and at the prosecutor stage to either not forward a case to the Discipline Committee and/or to withdraw or settle cases which are referred. This view is informed by the following:

- Not all cases are capable of proof; cases in which there is not a reasonable prospect of success should not be prosecuted.
- Exceptional circumstances as discussed above may exist which makes the mandatory sentence in appropriate.

**Should the New Zealand System of One Discipline Committee to Cover All Professions be Recommended?**

ONA is of the view that this proposal should be further studied and perhaps adopted. It would seem that there are the following potential advantages to having one disciplinary committee for all professions:

- The sharing of administrative and other resources.
- The provision of a common form of education and advice.
- Significant advantages for small colleges who have neither the resources nor the numbers to have a fully functional Disciplinary Committee.
- The commonality of approach; it should ensure consistency and decision-making regardless of the profession involved and counter the perceived view that some colleges are more lenient than others.
- Perceived independence from the investigatory and prosecutorial arm of the colleges; at the moment, both complainants and respondents perceive potential conflict between the college sitting as decision-maker on cases in which that same college has investigated and is prosecuting the case.
- Assurance that decisions are based on the evidence before the Committee rather than on information brought to the decision-making process by committee members based on their own professional experience.
- The Integrated Discipline Committee would have the perceived credibility to impose a balanced outcome including in cases of alleged sexual abuse rather than be assumed to be "protecting their own."

Potential disadvantages include:

- The professions may no longer be perceived as "self-regulating;" this could be countered by having the participation on each committee of at least one representative from the profession in question.
- Lack of understanding on the committee of the background information regarding the profession itself; this could be countered by ensuring that expert evidence would be provided to the Committee.

**Conclusion**

ONA thanks the Task Force for considering its submission, particularly related to the importance of discretion in administering penalties for sexual abuse. The Task Force's recommendations and any legislative changes will have a broad impact not only on physicians, but on nurses and other regulated health professionals across Ontario. Any recommendations and legislative changes must take into account the rights of regulated health professionals, including the very different contextual factors that are relevant to an assessment of sexual abuse in professions outside of medicine.

Nurses and other health professionals do not have the same history of sexual impropriety as physicians, nor do they enjoy the same power and control. Moreover, all health professionals are entitled to equal treatment by their colleges without discrimination on the basis of disability.

Any revision of the legislation should take these factors into account and allow for additional discretion in addressing claims of sexual abuse.