The Regulation of Professional Penalties for Physicians & Surgeons in Ontario

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I. Introduction

In January 2015, the Minister of Health and Long-Term Care (the 'Minister'), Dr. Eric Hoskins, appointed a Task Force on the Prevention of Sexual Abuse of Patients and the *Regulated Health Professions Act, 1991* (the 'Task Force'). The goal of the Task Force was, among other efforts, to assess the effectiveness of the zero-tolerance policy under the *Regulated Health Professions Act, 1991* (*RHPA*)[1] regarding the sexual abuse of patients by healthcare professionals. In response, the Task Force created a report which proposed several changes to the *RHPA*. Following the release of the Task Force's report, the Minister introduced Bill 87[2] in December 2016. Bill 87, if passed, would amend the *RHPA* to capture more sexual acts which would trigger the mandatory revocation of physician's license to practice medicine.

This paper will be guided by the question: how does Bill 87 impact the degree of procedural fairness owed to physicians in professional discipline cases involving allegations of sexual abuse? Moreover, since the new amendments will empower the legislature to revoke a physician's licence in more instances, are physicians entitled to a heightened degree of procedural fairness when facing discipline proceedings in a case involving sexual abuse, than is currently owed to them? To answer this question, the paper will discuss the statutory history of the regulation of physicians, explain the current status of the regulations regarding sexual abuse and explain the proposed changes in Bill 87. This paper will provide a case study of the College Discipline Committee's penalty decisions in order to evaluate the effectiveness of the Committee in disciplining physicians in cases of sexual abuse. The physician discipline case study will be

contrasted with a case study on the effectiveness of the Law Society of Upper Canada in disciplining lawyers in cases involving an analogous abuse of power. This comparison will aid the analysis of whether it is necessary or appropriate for the legislature to be involved in regulating what is regarded as a self-regulating profession. The case studies will be followed by a critique of the Task Force's report which incited Bill 87. This critique will demonstrate that there is a reasonable apprehension of bias in the report which has subsequently leaked into the proposed changes in Bill 87. This reasonable apprehension of bias demonstrates a lack of procedural fairness to physicians. Issues of procedural fairness are at the centre of the study of Bill 87 because the discipline of physicians is an "administrative decision that affects the rights, privileges or interests of an individuals [which] is sufficient to trigger the application of the duty of fairness."[3] This paper will discuss the impact that Bill 87 will have on physicians alongside an analysis of the principles of procedural fairness in the professional discipline arena.

This paper will conclude that because the proposed changes to the *RHPA* under Bill 87, if passed, enhance the legislature's control over the discipline of physicians, the Bill triggers a higher duty of procedural fairness than is currently accorded to physicians facing discipline proceedings in cases involving allegations of sexual abuse. Although physicians are currently granted the application of the duty of fairness under the current disciplinary regime, Bill 87 will expand the Minister's impact on the "rights privileges or interests of an individual" [4] and thus the application of the duty of fairness should also be expanded to strike a fair and just balance between state control and individual rights. Further, if Bill 87 is passed, the standard of proof beyond a reasonable doubt is required in this disciplinary context in order to provide physicians

with adequate procedural fairness in cases where the punishment is professional capital punishment.

II. The Legislation of Professional Discipline of Physicians & Surgeons

A) The Statutory History of the Regulation of Sexual Abuse under the *RHPA*

In January 1991, the College of Physicians and Surgeons of Ontario (the College) commissioned a Task Force on Sexual Abuse of Patients by Physicians to make recommendations on how the College could effectively deal with patient sexual abuse. The Task Force conducted a study of the penalty decisions of the College Discipline Committee and met with victims of sexual abuse by doctors who had returned to practice.[5] In May 1991, the Task Force released its preliminary report, the *Interim Report of the Task Force on Sexual Abuse of Patients*[6], in which it had reached two important conclusions:

1) There was a 'lack of severity of penalties imposed by the College [that] reflects a profound non-appreciation of the harm done to victims, and

2) Some members of the committees retained an attitude that discredited the patient's experience of the abuse.[7]

The Task Force found that due to the broad range of penalties available under the *RHPA* predecessor, the *Health Disciplines Act*, the Committee was able to gravitate toward lesser penalties in cases of sexual abuse. In response to these findings, and guided by a 'zero tolerance' philosophy, the Task Force made several recommendations including that 'sexual abuse' be deemed an offence with a strict penalty under the *RHPA*. The Task Force suggested that the offence should involve any sexual conduct, including touching and kissing, and that the penalty for the offence be the permanent removal of the license to practice medicine and a fine.[8]

The Task Force released its final report on November 25, 1991 in which it recommended that the offence of sexual abuse should attract a different penalty regime.[9] A distinct penalty regime in cases of sexual abuse, would, the Task Force said:

a) Provide a mechanism to relate the penalty to the nature of the abuse and create a distinction that will ensure a more severe penalty for more severe forms of abuse and

b) Provide the clearer definitions for sexual abuse that [the Task Force believed] are needed.[10]

The Task Force acknowledged that its penalty recommendations had severe consequences for physicians but it reasoned that the suggested penalty provisions were appropriate for several reasons, including that "a physician who has sexually violated a patient has seriously betrayed the fundamental trust society places in a member of the medical profession, thereby damaging the integrity of the profession."[11] The report prompted the Minster to introduce Bill 100 which was passed and amended the *RHPA* in 1993.[12] Bill 100 contained the following key provisions:

- A definition of "sexual abuse" which included physical sexual relations, touching of a sexual nature and behaviour or remarks of a sexual nature between a health professional and a patient;
- Mandatory reporting of sexual abuse by regulated health professionals;
- Mandatory development of measures to prevent and deal with sexual abuse by Patient Relations Committees in each professional college, who have a legislative mandate to educate members, set out guidelines for conduct of members with their patients, train college staff, and provide information to the public;
- New procedural powers and more effective protection for and participation by sexual abuse witnesses in discipline hearings;
- A requirement that each college establish a program to provide funding for therapy and counselling for patients who were sexually abused by practitioners; and

- **Enhanced penalties** including the impugned Mandatory Revocation Provisions for sexual intercourse or other specified acts of physical sexual relations between health professional and patient.[13]

There is an important distinction to be made between the recommendations from the Task Force and the proposed changes under Bill 100: the mandatory revocation recommendations were broader in scope under the Task Force recommendations as compared to the amendments introduced under Bill 100. Whereas the Task Force recommended the mandatory revocation of a license to practice in all cases of sexual touching other than kissing, Bill 100 imposed the mandatory revocation provision only in cases of certain types of sexual touching. All other forms of sexual touching which did not fall into the mandatory revocation category were subject to a range of penalties from reprimand to license revocation.[14] Bill 100, however, demonstrates an important shift toward tighter legislation on professional discipline in cases of sexual abuse. In conclusion, Bill 100 introduced five major changes in the professional discipline of physicians in cases of sexual abuse[15]:

1. A specific definition of sexual abuse. The definition will be discussed below, but the significance of the existence of the definition cannot be overlooked. The legislative introduction of a specific definition under the *RHPA* exhibits the Legislature's involvement in determining acts of professional misconduct in what is otherwise considered to be a self-regulating profession.

2. The new changes under Bill 100 require the College to develop measures to prevent and eradicate sexual abuse.

3. Changes to the discipline system to more effectively deal with sexual abuse allegations. The second recommendation (to develop measures to prevent sexual abuse) alongside the legislative changes to the discipline system demonstrate the decision by the Legislature that despite the fact that this is a self-regulating profession, certain acts have an impact on society as a whole and accordingly attract legislative control.

4. The mandatory reporting of sexual abuse. This requirement validates the zero-tolerance philosophy with regards to patient sexual abuse.

5. A funding program for therapy and counselling for those who have been sexually abused by practitioners. This change can be explained by the abovementioned finding by the Task Force that under the previous regime, there had been "a profound non-appreciation of the harm done to victims."[16]

These changes to the professional discipline of physicians manifest themselves in the current sexual abuse provisions under the *RHPA*, which are discussed below.

B) Sexual Abuse Provisions under the *RHPA*

Schedule 2 of the *RHPA* sets out the *Health Professions Procedural Code* (the *Code*) which contains the mandatory revocation provisions in cases of patient sexual abuse. It is necessary to outline the most relevant provisions pertaining to patient sexual abuse which will be referred to throughout this paper.

First, s.1.1 of the *Code* outlines the purpose of the sexual abuse provisions. S. 1.1 is likely to be used by the courts in cases where there is any ambiguity in interpreting the sexual abuse provisions.[17] The *Code* defines the purpose for the abuse provisions as follows:

> The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members.[18]

Section 1(3) of the *Code* outlines the definition for sexual abuse of a patient:

> (3) In this Code, "sexual abuse" of a patient by a member means,
> (a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
> (b) touching, of a sexual nature, of the patient by the member, or
> (c) behaviour or remarks of a sexual nature by the member towards the patient.

Section 1(4) of the *Code* carves out an exception necessary for physicians to conduct medical examinations: "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided."

Section 1(5) of the *Code* creates an exception for spouses: "conduct, behaviour or remarks" that would otherwise be considered "sexual abuse" under the definition outlined in s.1(3) does not constitutes sexual abuse if,

> (a) the patient is the member's spouse; and
> (b) the member is not engaged in the practice of the profession at the time the conduct, behaviour or remark occur. [emphasis added]

Sexual abuse is a prescribed act of professional misconduct under s.51(1) of the *Code*:

> (1) A panel shall find that a member has committed an act of professional misconduct if,
>
> (a) the member has been found guilty of an offence that is relevant to the member's suitability to practice;
>
> (b) the governing body of a health profession in a jurisdiction other than Ontario has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct as defined in the regulations;
>
> (b.0.1) the member has failed to co-operate with the Quality Assurance Committee or any assessor appointed by that committee;
>
> (b.1) the member has sexually abused a patient; or
>
> (c) the member has committed an act of professional misconduct as defined in the regulations.

Where the sexual abuse consists of certain sexual acts, the penalty is a mandatory revocation of a physician's license to practice medicine. This is outlined in s.51(5) of the *Code*:

(5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
    i. sexual intercourse,
    ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
    iii. masturbation of the member by, or in the presence of, the patient,
    iv. masturbation of the patient by the member,
    v. encouragement of the patient by the member to masturbate in the presence of the member.

It is important to note that the *Code* defines sexual abuse without the use of the word 'consent'. Thus, a physician will be found guilty of sexual abuse regardless of whether the sexual relationship with the patient was consensual.

C) The Minister's Current Powers Under the *RHPA*

Bill 87, introduced in December 2016, proposes to expand the powers of the Minister with regards to the administration of the *RHPA*. The following paragraphs will address the status of the Minister's duties under the current regime, prior to the introduction of Bill 87.

The Minister is responsible for the administration of the *RHPA*. Among the Minister's duties are the duties to regulate the health profession, monitor standards of practice, and "foster sensitivity and response by health practitioners towards patients."[19] Under the current regime, the Minister does not typically pry into the administration of the *RHPA* by self-regulating colleges. Instead, the Minister's focus has traditionally been in areas of policy and by-law changes. [20]

This lack of interference with self-regulating colleges supports the principle that an administrative tribunal be given the deference to be a master of its own procedure.[21] This

deference was demonstrated in the 1989 Schwartz Review proposal which recommended that the Minister be empowered to intervene in the operation of committees of Colleges, including authorizing the Minister to order a discipline hearing of a member.[22] However, this recommendation was rejected on the basis that self-regulating colleges be given the deference to control their own procedures. This "hands off" approach to self-regulation of professional colleges has been upheld by the courts.[23] Bill 87, however, which will be discussed throughout this paper, contradicts this principle of deference.

Despite the general principle, under the current regime, that the Minister is not to interfere in the discipline process by the colleges, the Minister is nonetheless given broad powers under the *RHPA*. The Minister is entitled to appeal a decision of a Discipline Committee[24] and;

> (a) Inquire into or require a Council to inquire into the provision of health care;
> (b) Obtain information about and review the activities of a Council of a College;
> (c) Require a College Council to make or change a regulation;
> (d) Require Councils to do anything they are able to do under the *RHPA*, the health profession Acts or the *Drug and Pharmacies Regulation Act*; and
> (e) Appoint an auditor to review the affairs of the College; and
> (f) Appoint a supervisor to take over the operations of the Council and the College.[25]

Richard Steinecke offers insight on the likeliness of expanding the Minister's control over the self-regulating profession. In his 2015 Guide[26], he notes:

> Such action by a Minister would be so inconsistent with the principle of self-regulation that it is unlikely to occur and would be vigorously resisted. The Minister's role is to 'serve as guardian of the public interest' and not to intervene in individual investigations or similar matters.[27]

Richard Steinecke also refers to the Minister's authority to abolish the Colleges and regulate the professions directly through the Ministry.[28] Steinecke notes that this power has been

exercised "a few times over the years when a significant public controversy has arisen."[29] The aforementioned recommendations from the Schwartz Review proposal were "so inconsistent with the principle of self-regulation" [30] and would empower the Minister to regulate the profession through the Ministry. Despite the fact that Steinecke considered such changes "unlikely to occur" [31], Bill 87 proposes to enforce similar changes. The proposed changes to the *RHPA* under Bill 87 will be discussed in the following paragraphs.

D) Bill 87: The Protecting Patients Act, 2016

In December 2016, following the release of the 2015 Task Force's report, the Ministry introduced Bill 87. Bill 87, if passed, would result in major changes to the self-regulating profession insofar as more acts of professional discipline will be captured by the legislation. The proposed changes which are most relevant to this paper are as follows.

1. The Minister will be empowered to require the Council of a health professions college to provide the Minister with personal health information about any member of the college "to the extent necessary in order to allow the Minister to determine if the College is fulfilling its duties."[32]

2. The Minister is given the power to make regulations respecting College committees and panels.[33]

3. For the purposes of the sexual abuse provisions of the *Code*, the definition of 'patient', without restricting the ordinary meaning of the term, is expanded to include an individual who was a member's patient within the last year or within such longer period of time as may be prescribed, and an individual who is determined to be a patient in accordance with the criteria set out in the regulations.[34]

4. The Inquiries, Complaints and Reports Committee (ICRC) and its panels may make an order for the interim suspension of a member's certificate of registration at any time

following the receipt of a complaint or report, instead of only when a matter is referred for discipline or incapacity proceedings.[35] [emphasis added].

5. The imposition of gender-based terms, conditions or limitations on a member's certificate of registration is prohibited.[36]

6. The grounds for mandatory revocation of the certificate of registration of a member who has sexually abused a patient are expanded, and the suspension is made mandatory in sexual abuse cases that do not involve conduct requiring mandatory revocation.[37] [emphasis added].

7. The penalties for failing to report sexual abuse of patients are increased. [38]

Hence, the Bill would amend the *RHPA* to capture more sexual acts which would trigger the mandatory revocation of physician's license to practice medicine. The current sexual acts, as outlined in the *RHPA*, which trigger the mandatory revocation of a physician's license are outlined in the previous section. The Bill adds the following: "touching of the patient's genitals, anus, breasts or buttocks"[39] and "other conduct prescribed in regulations made pursuant to clause 43(1)(u)" of the *RHPA*. If a panel finds that a physician has committed one of the added sexual acts[40], the Bill amends the *RHPA* to include an immediate suspension of the physician's license "until such time as the panel makes an order under subsection (5)."[41]

The above changes are concerning for a number of reasons. First, the changes propose an enormous expansion in both the ICRC's power over physicians. This expansion of power (change #4) is particularly concerning: it allows the ICRC to suspend a physician's license to practice prior to any disciplinary proceedings. This raises major concerns in the realm of the principles of fundamental justice: the effect of the change is that the physician is punished before being found 'guilty' of any offence. The expansion of the ICRC's ability to suspend a physician's license to practice, an act which can have lifelong consequences on the physician, without a

disciplinary proceeding also raises a reasonable apprehension of bias: the message is that any physician who has received an allegation against them is guilty until proven innocent. Further, the changes will simultaneously expand the Minister's power over the self-regulating profession and remove the College's ability to self-govern. The proposed changes will result in more circumstances in which the 'self-regulating' profession will not, in fact, be self-regulated but instead be regulated by the legislature, a significant shift in the administrative law scheme. The fact that the proposed changes will legislate more acts that trigger the most severe penalty (mandatory revocation) raises issues of procedural fairness and the standard of proof, which will be discussed in the following paragraphs.

III. Professional Discipline of Physicians and Surgeons Governed by the CPSO

A) Administrative Tribunals & Procedural Principles

Two important legal standards must be addressed when discussing procedure before the Discipline Committee in cases involving the potential revocation of a physician's license on grounds of sexual abuse: 1) the requisite standard of proof and 2) the standards of procedural fairness. Both legal standards pertain to whether a tribunal is justified in revoking a physician's license: the tribunal will not be justified in revoking a physician's license if the standard of proof was not met or if the physician's rights to procedural fairness were breached during the course of the proceeding. The standard of proof before administrative tribunals will first be explained followed by a discussion on procedural fairness.

1) *The Standard of Proof Before Administrative Tribunals*

There are three cases which will be addressed in the following paragraphs to explain the evolution of the standard of proof before the College Discipline Committee. The first case is *Bernstein and College of Physicians and Surgeons of Ontario*.[42] In this 1977 decision before the Divisional Court of Ontario, the court held that the standard of proof in disciplinary hearings required the evidence be "clear and convincing and based upon cogent evidence which is accepted by the tribunal."[43] The court in *Bernstein* recognized that the severity of the penalty of revoking a professional license to practice is tantamount to professional capital punishment:

> [T]he seriousness of the charge is to be considered by the tribunal in its approach to the care it must take in deciding a case which might in fact amount to a sentence of professional death against a doctor.[44]

Although the tribunal is "entitled to act upon the balance of probabilities" [45], a complete lack of evidence confirming the sexual assault is a "serious factor for the tribunal to consider." [46] It is only in the rarest of circumstances that a tribunal should revoke a physician's license in the absence of cogent evidence.[47] In light of the lack of evidence in the case before the court, the court found that the Discipline Committee was incorrect to "believe the complainant wherever her evidence conflicts with that of the physician."[48]

The court in *Bernstein* quashed the Committee's decision to suspend the physician's licence on the grounds that the Committee did not apply the appropriate clear, cogent and convincing standard of proof to establish guilt in the disciplinary context.[49] This case not only stands for the proposition that the physician should be presumed innocent until proven guilty but it also demonstrates that evidence must be credible and trustworthy and should not be accepted on its face in order to revoke a physician's license. This suggests that the tribunal should

scrutinize the evidence comparable to how it would scrutinize evidence in a criminal proceeding and accordingly, a higher standard of proof than a balance of probabilities is required before the Discipline Committee.

Following *Bernstein*, the jurisprudence established that the standard of proof in a civil case which involves "criminal or morally blameworthy conduct"[50] shifts to require something *more* than proof on a balance of probabilities but something *less* than proof beyond a reasonable doubt. In other words, the seriousness of the allegation would determine the standard of proof required.[51]

The Supreme Court of Canada, however, put this notion to rest in 2008 in *McDougall*. The case involved a former student of a residential school who sued a school official for damages for sexual abuse that allegedly took place in the 1960s. Due to the fact that the student remained silent about the abuse for 30 years, the only evidence of the abuse was the student's own testimony, which was denied by the respondent. In giving his testimony, the student was inconsistent as to the nature and frequency of the abuse. These facts gave rise to the question of what the appropriate standard of proof should be in civil cases, and whether the standard of proof if the civil case involves criminal or morally blameworthy conduct.[52]

The court in *McDougall* held that it was "inappropriate" to employ "different levels of scrutiny of the evidence depending upon the seriousness of the case."[53] In a unanimous decision, the court held, "in civil cases there is only one standard of proof and that is proof on a balance of probabilities."[54] The seriousness of the allegation does not change the degree to which the standard must be satisfied.[55] To satisfy proof on a balance of probabilities, the "evidence must always be sufficiently clear, convincing and cogent." [56] There is not an "objective standard to

measure sufficiency."[57] Instead, the trial judge must carefully scrutinize the evidence to determine whether the plaintiff has satisfied the balance of probabilities test.[58]

The *McDougall* precedent, that the standard of proof in civil cases is a balance of probabilities regardless of the seriousness of the alleged conduct, would be applied to administrative law cases involving physician discipline. This was affirmed in *Osif v College of Physicians and Surgeons of Nova Scotia*.[59] This case involved findings of professional misconduct and professional incompetence of an emergency room physician, Dr. Osif. Two penalties were at issue: the Discipline Committee ordered that Dr. Osif be restricted from practicing in an emergency room (her specific field of practice) and that Dr. Osif successfully pass the CCFP examination.[60] Dr. Osif argued that these penalties were "so serious"[61] that her case necessitated a "'higher standard of civil proof."[62] She submitted that her rights to procedural fairness were infringed upon and consequently the penalties imposed upon her were unfair.[63]

The Nova Scotia Court of Appeal in *Osif* applied *McDougall* and held "there is but one standard of proof."[64] That standard is proof on a balance of probabilities.[65] Evidence must be "sufficiently clear, convincing and cogent to satisfy the balance probabilities test."[66] It is the task of the trier of fact to carefully scrutinize the evidence to "determine whether it is more likely than not that an alleged event occurred." [67] The court in *Osif* found that the Discipline Committee sufficiently analyzed the evidence which satisfied the standard of proof of a balance of probabilities and accordingly there was "no basis for interference by the appellate court."[68] In conclusion, the application of *McDougall* in *Osif* confirmed the court's acceptance that the standard of proof before administrative tribunals in professional discipline cases is the civil

standard of proof: proof on a balance of probabilities. The seriousness of the alleged conduct or corresponding penalty does not change the standard of proof to be applied.

2) Procedural Fairness Before Administrative Tribunals

Baker v Canada (Minister of Citizenship and Immigration)[69] is a precedent-setting case in the area of procedural fairness in administrative law. The case is relevant when addressing the question of whether Bill 87 triggers a higher level of procedural fairness than is currently owed to physicians before the Discipline Committee in cases involving alleged sexual abuse. *Baker* was a case which involved a decision made by the Minister of Citizenship and Immigration to deport an immigrant who worked illegally as a domestic caretaker in Toronto. This case established the framework to apply in cases involving judicial review on grounds of procedural fairness. Justice L'Heureux-Dubé said the following in reference to when the duty of procedural fairness applies,

> The fact that a decision is administrative and affects 'the rights, privileges or interests of an individual' is sufficient to trigger the application of the duty of fairness.[70]

Baker established that the content of the duty of procedural fairness contains three criteria; participatory rights, reasons and that there is no reasonable apprehension of bias in the decision by the administrative decision-maker. If an administrative decision does not satisfy any of the three criteria, the duty of procedural fairness has not been satisfied. The content of the duty of participatory rights and the requirement for reasons are outside the scope of this paper.[71] The procedural fairness component relevant to this paper is the existence of a reasonable apprehension of bias. On the issue of bias, the court in *Baker* established the following test to apply in order to determine whether an administrative decision was biased:

> The apprehension of bias must be a reasonable one, held by reasonable and right minded persons, applying themselves to the question and obtaining thereon the required information... [T]hat test is "what would an informed person, viewing the matter realistically and practically -- and having thought the matter through -- conclude. Would he think that it is more likely than not that [the decision-maker], whether consciously or unconsciously, would not decide fairly.[72]

The *Baker* test for whether there is a reasonable apprehension of bias will become relevant when analyzing whether there is sufficient procedural fairness for physicians under the proposed changes to the *RHPA* in Bill 87. This will be explored in Sections IV and V of this paper.

B) The College Discipline Committee: A Case Study

The following paragraphs will provide a case study on discipline cases involving sexual abuse before the Discipline Committee at the College of Physicians and Surgeons of Ontario. Three cases will be analyzed; *Seidman (Re) v College of Physicians and Surgeons of Ontario*[73], *XYZ (Re) and the Ontario College of Physicians and Surgeons*[74] and *Sliwin (Re) v College of Physicians and Surgeons of Ontario*[75]. This section will outline the distinguishing facts of each case and an analysis of the decisions will follow under the next subheading.

Seidman (Re) v College of Physicians and Surgeons of Ontario[76] was a discipline hearing which involved allegations of sexual abuse by a paediatrician. In 1999, one of Dr. Seidman's patients (Patient A) complained to the College, alleging that he had sexually abused her. In December 2002, the Discipline Committee found that Dr. Seidman committed professional misconduct on the grounds of sexual abuse.[77] The Committee ordered the immediate revocation of Dr. Seidman's license in November 2003.[78] Patient A also made a complaint to the police in respect of the sexual assault allegations of Dr. Seidman. Dr. Seidman pleaded guilty and was convicted of sexual exploitation under s.153 of the *Criminal Code*.[79] Dr. Seidman was sentenced

to fifteen months to be served in the community, this included five months' house arrest, a three-year probation and he remains on the National Sex Offender Registry.[80]

Five years later, Dr. Seidman was eligible to apply for the reinstatement of his license[81] and he applied for reinstatement in 2009. In 2010, the College decided it would not oppose his reinstatement under certain conditions. [82] However, the College thereafter received information that Dr. Seidman was identifying himself as a doctor on Facebook (during the time in which his license had been revoked) and that he had young female Facebook friends. The College investigator posed online as a 17-year old girl named 'Emily' who befriended Dr. Seidman on Facebook. 'Emily' was "sexually aggressive in her language and Dr. Seidman responded."[83] The two agreed to meet in person and Dr. Seidman arrived, however 'Emily', obviously, did not.[84] Following this incident, the College opposed the reinstatement of Dr. Seidman's license to practice medicine. The Committee correspondingly decided to dismiss Dr. Seidman's Application for Reinstatement. There are several factors that influenced the Committee's decision including; Dr. Seidman's lack of credibility in testimony, his lack of honesty and his inability to respect doctor-patient boundaries.

The issue of credibility arose in the context of an analysis of whether the standard of proof had been met. The Committee clearly states that the standard of proof on an application for reinstatement is proof on a balance of probabilities.[85] The burden of proof is on the applicant and the "evidence must be clear, cogent and convincing to satisfy the balance of probabilities test."[86] In evaluating the evidence of Dr. Seidman's credibility, the Committee described Dr. Seidman as "unwilling or unable to give direct answers to straightforward questions."[87] The Committee states that Dr. Seidman was "unnecessarily discursive, and avoided answering questions,

apparently fearing that he was being tricked that counsel was looking for a hidden meaning."[88] In response, Dr. Seidman explained that he was not being deliberately deceptive but rather trying to be careful in answering counsel's questions to avoid incriminating himself.[89] The Committee nonetheless decided that Dr. Seidman was not credible.

The Committee found that Dr. Seidman's lack of honesty demonstrated that he continued to pose a risk to the public. Dr. Seidman's inability to provide the Committee with "simple, clear and straightforward responses" [90] demonstrated that Dr. Seidman did not understand or appreciate the relevant issues.[91] Dr. Seidman's lack of honesty demonstrated a lack of understanding and remorse for his wrongdoing. The implication of his lack of honesty and remorse was that if he could not acknowledge his wrongdoing, he would be likely to repeat the same impugned behavior if his license was reinstated.

The Committee decided that Dr. Seidman was incapable of respecting doctor-patient boundaries. This was evidenced by Dr. Seidman's continued treatment of Patient A (after the sexual abuse). The Committee held this was "inexcusable" [92] and "not in the patient's best interests."[93] The Committee found that Dr. Seidman was either unable to understand, set and maintain professional boundaries or that he was aware of the need for professional boundaries but "chose to ignore them."[94] The lack of appreciation of professional boundaries was "critical" in the Committee's decision to refuse the reinstate of his license.[95]

The Committee considered Dr. Seidman's "profound need to be needed" [96] and his lack of honesty and integrity in his misrepresentations to clients, Facebook friends, his assessors, the College and when testifying before the Committee. [97] Dr. Seidman's lack of candour in all of these interactions was particularly troubling to the Committee. The Committee was especially

troubled by Dr. Seidman's specific vulnerability in his attraction to young women. [98] The Committee also said that his remorse for the impact his actions had on the patients was "superficial." [99] Based on these findings, the Committee concluded that Dr. Seidman lacked the necessary insight and understanding needed for the Committee to reinstate his license. The Committee concluded its decision by answering two guiding questions:

1) What is the risk of further misconduct, and if there is a risk, is it manageable with terms, conditions and limitations?

2) Is the applicant suitable to practise both in terms of protection of the public and the confidence of the public in the profession's ability to govern itself?

On the first question, in light of the above findings, the Committee determined that there is a risk of further misconduct and the Committee "could envision no terms, conditions or limitations that could adequately address its concerns" regarding the risk to the public and the profession if Dr. Seidman returned to practice.[100] With respect to the second question, it is unsurprising, that the Committee reached the conclusion that Dr. Seidman was not suitable to practice medicine. [101] Hence, the Committee dismissed Dr. Seidman's Application for Reinstatement for his license to practice medicine.

The second case is *XYZ (Re) and the Ontario College of Physicians and Surgeons*.[102] This case is different from *Seidman* insofar as *XYZ* involved the potential revocation of a physician's license and not the reinstatement of an already revoked license. In *XYZ*, College counsel brought charges against Dr. XYZ and alleged that he committed an act of professional misconduct under s.51(1)(b.1) of the *Health Professions Procedural Code* when he allegedly engaged in sexual abuse of a patient. Dr. XYZ denied the allegations.[103] Ultimately, the Committee dismissed the allegations of professional misconduct for the following reasons.

In making its decision, the Committee held that the principles set out in *McDougall* apply to discipline proceedings involving physicians.[104] Hence, the College had the onus of proving the allegations against Dr. XYZ on a balance of probabilities. [105] The evidence must be "clear, cogent and convincing" [106] to satisfy the standard of proof.

The issue before the Committee was that it was "presented with two significantly divergent stories with minimal corroboration for the veracity of either."[107] In this "he said-he said" [108] circumstance, the Committee said, "an assessment of the credibility of the witnesses was key" to determining whether the evidence proves the allegation of misconduct on a balance of probabilities.[109] In assessing the credibility of the witnesses, the Committee compared the testimony of the complainant with the testimony of Dr. XYZ. The Committee found that Patient A's account of the alleged events was "highly improbable."[110] The Committee found that Patient A's testimony was inconsistent and that he "showed repeated evidence of significant carelessness with the truth."[111] Thus, the Committee concluded that Patient A was not credible.

By contrast, the Committee found that Dr. XYZ presented his evidence "calmly, logically and reasonably."[112] There were no "significant internal or external inconsistencies" [113] with Dr. XYZ's testimony and his testimony was corroborated by other credible witnesses.[114] In this "he said-he said" situation, the Committee concluded that Dr. XYZ's account "was by far the more likely to be the truth and was supported by evidence that was clear, cogent and convincing."[115]

The Committee concluded that College counsel did not produce evidence that was "clear, cogent and convincing"[116] and thus the standard of proof on a balance of probabilities was not met.[117] Appropriately, the Committee dismissed the allegations of professional misconduct and did not revoke Dr. XYZ's license to practice medicine.[118]

The third and final case in this study is *Sliwin (Re) v College of Physicians and Surgeons of Ontario*.[119] There is a long and convoluted history between Dr. Sliwin and Ms. A, the most important points are as follows. Dr. Sliwin was a plastic surgeon and Ms. A worked intermittently as his receptionist over several years. On March 8, 2001, during the course of her employment, Ms. A and Dr. Sliwin began a sexual affair. Shortly after March 16, 2001, their relationship changed from a romantic, employer-employee relationship to a doctor-patient relationship, and thereby a relationship which was subject to professional discipline proceedings. On March 16, 2001, Ms. A asked Dr. Sliwin to perform a breast augmentation on her. Dr. Sliwin replied that if he performed the surgery, Ms. A would become Dr. Sliwin's patient and they would consequently have to end their affair. Ms. A elected to proceed with the surgery and the affair continued. Dr. Sliwin and Ms. A continued the affair for several years. During the years in which they conducted the affair, Dr. Sliwin continued to perform medical procedures on Ms. A. The affair eventually ended in 2007. In 2008, on the advice of a lawyer friend, Ms. A filed a complaint with the College which resulted in the impugned allegations being brought for the Discipline Committee.[120]

The issue before the Committee was not whether a sexual relationship occurred but rather whether the sexual relationship was concurrent with the doctor-patient relationship. If the sexual relationship was not concurrent with their doctor-patient relationship, the allegations would be dismissed.[121] To determine whether the sexual relationship amounted to patient sexual abuse as defined by s.51(1)(b.1) of the *Code*, the Committee sought to answer four questions.

First, was there a doctor-patient relationship between Dr. Sliwin and Ms. A? The defence challenged Ms. A's status as a patient on the grounds that she consented to a sexual relationship

with Dr. Sliwin prior to becoming his patient which put her in a different "category"[122] of 'patient'. The Committee rejected this argument and concluded that the very purpose of the aforementioned provisions in the *Code* is to establish that due to the inherent power imbalance between doctor and patient, a patient can never truly consent to having a sexual relationship with the doctor.[123] The Committee thereby concluded that Ms. A was in a doctor-patient relationship with Dr. Sliwin.

The second question before the Committee was whether the doctor-patient relationship was concurrent with the sexual relationship. The Committee found that, despite gaps in their sexual relationship, "it was clear on the evidence" [124] that the sexual relationship continued during the period of time in which Dr. Sliwin performed surgical procedures on Ms. A. This established that there was a concurrent sexual and doctor-patient relationship.[125]

Third, if there was a concurrent sexual and doctor-patient relationship, did the legal doctrine of "Officially Induced Error" provide a defence to the allegation of sexual abuse? To rely on this defence, Dr. Sliwin had to show that he reasonably relied on erroneous legal advice to continue the sexual relationship.[126] Dr. Sliwin submitted that he relied on his own interpretation of the periodic publications of the College policies. The Committee did not accept that the College provided Dr. Sliwin with erroneous legal advice nor did it accept that Dr. Sliwin reasonably relied on erroneous advice. Therefore, he was not entitled to rely on the defence of "Officially Induced Error."[127]

Lastly, would the conduct of Dr. Sliwin with Ms. A be reasonably regarded by members as disgraceful, dishonourable or unprofessional? The Committee found that Dr. Sliwin disregarded "the well understood principle"[128] that a doctor-patient sexual relationship is "not in a patient's

best interest and violates the clear prohibition of the College against such conduct." The Committee also said that it is the responsibility of the doctor, not the patient, to maintain proper doctor-patient boundaries, and in failing to do so, Dr. Sliwin's conduct was unprofessional.[129] Thus, the Committee answered this fourth question in the affirmative and revoked Dr. Sliwin's license to practice medicine under the mandatory revocation provisions of the *Code*.[130]

C) The College Discipline Committee: An Analysis of the Case Study

The above case study leads to five conclusions. First, the case study demonstrates that the Committee effectively utilizes the *RHPA* to reach appropriate and just professional penalties in cases of patient sexual abuse. Second, the appropriateness of the Committee's decisions supports the proposition that increased legislative control is not necessary to protect the public. In each of the above cases, the physicians faced license revocation because of their sexual relationships with patients. The existence of license revocation did not deter the physicians from committing acts of sexual abuse. Thus, more legislative control in the form of Bill 87 would not necessarily deter sexual abuse but it would nonetheless have a severe effect on physicians. Third, the case study supports the argument that the Committee requires the freedom to be a master of its own procedure to not only penalize physicians for wrongdoing but do so in a way that upholds the values of the profession. Fourth, the presumption of innocence is an issue of procedural fairness and its importance in the context of professional capital punishment supports the argument that the standard of proof of beyond a reasonable doubt is the more appropriate standard in this context. Lastly, the *Sliwin* case demonstrates that the Committee can display reasonable apprehensions of bias. This is a problem when the penalty imposed by the Committee is

professional capital punishment and this problem can be safeguarded against by a heightened standard of proof. The existence of a reasonable apprehension of bias under the current regime will only be aggravated by Bill 87, which will be explained below. Support for these arguments is as follows.

Seidman supports the argument that the Committee be given the deference to be a master of its own procedure because its decision demonstrates that the Committee can effectively employ the *RHPA* in the context of sexual abuse and simultaneously uphold the standards of the profession without increased legislative control. The following factors were relevant in the Committee's decision making process:

> (a) the nature and circumstances of the misconduct that led to the revocation (sexual abuse);
> (b) other past behaviour of concern that is relevant to the practice of medicine;
> (c) character, including personal driving forces, honesty and integrity and vulnerabilities;
> (d) whether Dr. Seidman has demonstrated insight, understanding, and appreciation for the impact of his actions on the victim;
> (e) changes in Dr. Seidman's behaviour since revocation;
> (f) current health;
> (g) proposed plan for reinstatement;
> (h) competency to practise; and
> (i) the effect of reinstatement on the public and the profession.[131]

The breadth of these factors signals a fundamental principle in administrative law: it is the administrative tribunal that contains the requisite expertise to apply these discipline-specific factors within the context of a home statute interpretation.[132] The *RHPA* and the *Code* work in tandem to outline what professional misconduct is and what acts (i.e. sexual abuse) amount to professional misconduct. In this case, the Committee has demonstrated its expert ability to determine in the professional discipline context what acts amount to professional misconduct, as

outlined by the *RHPA*, and should be subject to license revocation. The Committee's expertise in interpreting its home statute and applying the statute to the relevant factors is demonstrated in its finding that Dr. Seidman committed professional misconduct:

> 1. under clause 51(1)(b.1) of the Code, in that he sexually abused patients;
>
> 2. under paragraph 27.29 of Ontario Regulation 448 and paragraph 29.30 of Ontario Regulation 548, made under *the Health Disciplines Act*, in that he engaged in sexual impropriety with patients; and
>
> 3. under clause 1(1)33 of O. Reg. 856/93 and under paragraphs 27.32 of O. Reg. 448 and paragraph 27.33 of O. Reg. 548 made under *the Health Disciplines Act*, in that he engaged in conduct or an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.[133]

These findings demonstrate the Committee's ability to interpret its home statute and apply it in the context of the case to reach the appropriate conclusion that Dr. Seidman was not fit to practice and his license should not be reinstated. The Committee reached this conclusion without increased interference by the legislature.

XYZ supports the proposition that the civil standard of proof is not the appropriate standard to apply in a professional discipline case involving the revocation of a license to practice; the standard of beyond a reasonable doubt is more appropriate. The decision in *XYZ* supports this position in two ways. First, the decision demonstrates that issues of credibility and corroboration of evidence are integral to determining whether the evidence before the Committee is clear, cogent and convincing. The emphasis on evidentiary issues, specifically corroboration, in determining a penalty is akin to the procedure in a criminal trial. Second, the fact that the Committee did not blindly accept the complainant's testimony as truth but rather compared his

credibility with the credibility of the doctor demonstrates the Committee's acceptance of a presumption of innocence, a principle which is not notable when applying the civil standard of proof but one which is crucial in criminal trials. This pays homage to the *Bernstein* decision, addressed above, insofar as the committee did not "believe the complainant wherever [his] evidence conflicts with that of the physician."[134] The Committee's recognition of a presumption of innocence demonstrates that a higher standard of proof does exist in this context. While the court in *McDougall* held that "in civil cases, there is no presumption of innocence",[135] *Bernstein* and *XYZ* stand for the proposition that the physician is owed a presumption of innocence in these cases, a presumption which only exists when the higher standard of proof, beyond a reasonable doubt, is applied.

The issue in this paper is whether, as suggested by the Task Force, the College does not effectively employ the mandatory revocation provisions and accordingly whether increased legislative control over the discipline of the profession is justified. *Sliwin* counters the Task Force's argument. In *Sliwin*, the Committee clearly states that it "must comply with the *Code* and apply the mandatory revocation provision to Dr. Sliwin for the finding made against him."[136] This statement suggests that the College does effectively respect and employ the legislation. This counters the argument made by the Task Force that another government body is needed to process cases of patient sexual abuse.

Sliwin also demonstrates, however, that there is some inconsistency with regards to how different panels weigh evidence in different cases. In *XYZ*, the panel did not accept the complainant's evidence wherever his evidence conflicted with the doctor's. By way of contrast, in *Sliwin*, the Committee accepted Ms. A's evidence wherever her evidence conflicted with that

of Dr. Sliwin.[137] This appears to contradict the Committee's approach in XYZ. This discrepancy can be reconciled by the fact that in *Sliwin*, Ms. A kept a diary of her encounters with Dr. Sliwin and the Committee found her to be credible. Hence, they accepted her evidence over that of Dr. Sliwin because the Committee found his memory regarding the dates of their sexual encounters to be unreliable.[138] However, despite the ability to reconcile the two cases, the decisions demonstrate that different panels weigh evidence differently. This highlights a tension with regards to what procedural standards a Committee should employ with regards to credibility and standards of proof.

Lastly, the *Sliwin* decision exhibits a reasonable apprehension of bias insofar as it makes numerous references to the fact that both parties were married during the affair. At the beginning of its decision, the Committee makes a noticeable reference to the fact that Ms. A was a "married mother of two when she first met Dr. Sliwin" [139] and that Dr. Sliwin was "also married and a father."[140] At the end of its decision, the College designates a single paragraph to note that "Dr. Sliwin remains married"[141] but that Ms. A left her marriage (the inference being that she left her marriage for Dr. Sliwin or that her marriage crumbled because of the affair). Respectfully, a doctor's marital status or existence of children is none of the College's concern because marital status or parenthood are not requirements for professional competency. The issue in the case was whether Dr. Sliwin's sexual relationship overlapped with his doctor-patient relationship with Ms. A, thereby resulting in an act of professional misconduct. The extra-marital affair with a secretary, however tawdry, is not within the College's jurisdiction. The College demonstrated a reasonable apprehension of bias when it judged the personal decision of Dr. Sliwin to conduct an affair as if cheating on his wife somehow affects his capabilities of a doctor. Although his wife

may beg to differ, one has nothing to do with the other and such judgement on Dr. Sliwin's obligations as a husband has no place in the Committee's decision on Dr. Sliwin's professional duties. The judgement on his performance as a husband raises a reasonable apprehension of bias in the Committee's decision and suggests that the Committee does not always fulfill its obligation in the context of procedural fairness. The issue of procedural fairness is itself an important issue but it is an issue that is especially in need of attention in the face of increased legislative control which further jeopardizes a doctor's right to fairness in disciplinary proceedings. The fact that the College decisions demonstrate a reasonable apprehension of bias is reason to enhance procedural safeguards for physicians under the current regime, not enhance the legislature's and regulatory body's authority to revoke a license in more circumstances, as proposed under Bill 87. In other words, Bill 87 moves issues of procedural fairness in the wrong direction.

IV. Should Professional Regulations be Legislated? Consider the Legal Profession

The following section will analyze the professional regulation and discipline of lawyers as governed by the Law Society of Upper Canada (the 'Law Society'). As explained above, the regulation and discipline of physicians in sexual abuse cases has been subject to legislation. Unlike physicians, the regulation and discipline of lawyers is left entirely to the self-regulating body; the Law Society. The following paragraphs will examine three cases in which a lawyer abused a trust account to determine whether self-regulating professions can effectively discipline and deter bad conduct without the involvement of the legislature.

It would be incorrect, however, to compare cases in which patients are sexually abused by their doctors with cases in which lawyers had sexual relationship with clients because the two situations are not analogous; clients are not in the compromising position of being alone in an examining room with their clothes off in front of their lawyer. In this way, lawyers do not have the same unfettered access to their client's bodies as doctors have with regards to their patients. Lawyers do, however, have comparable access to the client's money in the trust account. A client puts blind faith when she transfers money to a lawyer and the lawyer has complete access to the money in the trust account. If a client's money is stolen from the trust account, that theft can have serious consequences for the client. In this respect, the client's money is exposed to the lawyer's control. Hence, while the comparison is not without its flaws[142], it is more accurate to compare the sexual abuse of patients with the lawyer's abuse of a trust account because both situations involve an abuse of trust and power: a lawyer's abuse of a client's trust likens a doctor's abuse of a patient's trust. Therefore, the following paragraphs will analyze cases in which the Law Society has disciplined lawyers in cases of an abuse of power involving a trust account to determine whether the Law Society effectively self-governs without the interference of the legislature.

A) The Law Society of Upper Canada: A Case Study

The following paragraphs will provide a case study on how the Law Society disciplines lawyers in cases involving a lawyer's abuse of a trust account. Three cases will be analyzed; *Law Society of Upper Canada v Rosenthal*[143], *Law Society of Upper Canada v Puskas*[144] and *Law Society of Upper Canada v Sriskanda*[145].

Rosenthal[146] involved the professional discipline of a lawyer for professional misconduct in the context of a criminal conviction for fraud. In brief, Mr. Rosenthal used his trust account to collect $1.89 million from investors. Mr. Rosenthal transferred the money from his trust account to his personal corporation and the investors lost all their money.[147] Mr. Rosenthal was suspended from March 24, 2000 to January 28, 2003 for professional misconduct due to his convictions under s.11 *Criminal Code*[148] for fraud, using forged documents, fraudulent use of a credit card, knowingly making a false document, possessing instruments of forgery, failing to comply with conditions of his recognizance and attempting to obstruct the course of justice.[149] In addition to the findings of professional misconduct relating to the criminal convictions, the hearing panel made a number of findings of professional misconduct (the complete list can be found at paragraph 43[150]) including failing to fulfill financial obligations in relation to his practice.[151] He was suspended for three years at which time the hearing panel allowed him to return to practice with the several conditions. [152]

The penalty hearing commenced on December 2010. The penalty tribunal found that the hearing panel's penalty (the period of suspension followed by supervision) was not the appropriate penalty in this case. The penalty tribunal found that the lawyer was ungovernable and ordered that his license be revoked immediately. The penalty tribunal provided two main aggravating factors in reaching its decision; 1) the lawyer failed to produce the records requested by the law society, and 2) the professional misconduct at issue before the penalty tribunal occurred during the period of time in which he was under supervision.[153] These factors demonstrated that the lawyer was not governable by the Law Society. Furthermore, while the evidence did not confirm the misappropriation of client funds, due to the lawyer's refusal to keep

proper records as instructed by the Law Society, it was "impossible to determine whether or not the $1.89 million [had] been misappropriated or not."[154] The penalty tribunal emphasized that the importance of a lawyer's cooperation with the Law Society is fundamental to the Law Society's ability to self-govern and protect the public.[155] The penalty tribunal concluded:

> The Lawyer has put the interests of the public at risk since 1995, and measures short of revocation have failed to cause him to maintain proper books and records, and to co-operate with the Law Society. The Lawyer has been given innumerable opportunities to comply with the Rules of the Law Society and has failed, or refused to do so. In the circumstances, we find the Lawyer ungovernable and order that his licence be revoked immediately.[156] [emphasis added]

The second case in this case study is *Puskas*,[157] a case involving a lawyer with a practice in several areas of law including real estate and criminal law. In this case, the tribunal found that Mr. Puskas abdicated his professional responsibility in operating his law practice by failing to properly supervise his paralegal, Ms. Spinks, when he allowed her to access the trust account pertaining to his real estate law practice. Ms. Spinks subsequently stole $893,000 from the trust account.[158] The tribunal found that Mr. Puskas committed an act of professional misconduct in this context but the tribunal suspended his license to practice, rather than revoking it. The tribunal gave the following reasons in reaching its decision.

The tribunal noted that there were several factors which mitigated the act of professional misconduct. First, a key mitigating factor was that Mr. Puskas demonstrated remorse and complete cooperation with the Law Society. The tribunal noted, several times throughout its decision, that Mr. Puskas "co-operated with the Law Society from the outset of the investigation and admitted wrongdoing. He signed a full ASF, saving the complainants from having to re-live a difficult period in their lives."[159] By way of contrast, Mr. Rosenthal's lack of cooperation

(discussed above) was an aggravating factor in the Law Society's decision to revoke the licence to practice.

The second mitigating factor was the expert medical evidence. The tribunal accepted an expert medical report submitted by Dr. Chaimowitz; an "extremely well-respected [expert] in his field and an accepted expert in the courts, where he has provided diagnoses of accused persons' past state of mind, when an offence was committed."[160] Dr. Chaimowitz concluded that Mr. Puskas suffered from depression which was causally connected to Mr. Puskas' failure to appropriately attend to the administrative aspects of his practice.[161] The tribunal concluded this evidence was sufficient "to constitute medical factors that led to his failure to supervise Ms. Spinks." [162]

The tribunal also accepted that Mr. Puskas' faced several personal circumstances including; his mother's illness and subsequent death, the breakdown of his marriage, and "two back-to-back murder trials with uncertain payments by legal aid causing financial stress and the arson in his building compounded by the denial of insurance coverage."[163] These personal circumstances were "significant enough to divert him from the day to day administrative tasks of his law practice." [164]

Lastly, the tribunal gave significant weight to the evidence that Mr. Puskas was viewed by the legal community to be of good character and very competent in criminal law.[165] This was corroborated by the good character witness testimony[166] and the fact that Mr. Puskas had no prior disciplinary history.[167] The tribunal also noted, although it did not include this in its list of mitigating factors, that the fraud committed by Ms. Spinks was facilitated by the TD Bank manager who failed to require a transfer slip, something that is required in every other case.[168]

The tribunal was persuaded by the evidence of the mitigating factors in this case, particularly Mr. Puskas' remorse and complete cooperation with the Law Society. The tribunal concluded that Mr. Puskas could maintain his license following a "very significant suspension, coupled with a prohibition on practising real estate law in the future." [169] This penalty, the tribunal concluded, would achieve"[170] the goals of general deterrence and maintenance of public confidence in the Law Society's ability to self-govern.[171]

The third and final case in this study is *Sriskanda*[172], in which a lawyer appealed an order which revoked his license to practice law.[173] The hearing panel found that Mr. Sriskanda committed acts of professional misconduct when he "knowingly assisted or participated in 12 fraudulent mortgage transactions, failed to be honest and candid and to serve his clients to the standard of a competent lawyer, acted while in a conflict of interest, and misapplied client funds."[174] The hearing panel further found that he "engaged in professional misconduct by attempting to mislead the Law Society during its investigation by fabricating notes on files."[175] Hence, his license to practice law was revoked. The lawyer appealed the decision to the Law Society Tribunal but the tribunal dismissed the appeal.[176] Nonetheless, the case is relevant to this paper with respect to the tribunal's findings on whether the hearing panel's conduct gave rise to a reasonable apprehension of bias, one of the grounds on which Mr. Sriskanda appealed. Henceforth, the following paragraphs will address how a claim of a reasonable apprehension of bias is addressed by the tribunal in the context of a revocation of a license to practice.

Mr. Sriskanda raised the argument that there was a reasonable apprehension of bias in the panel's decision because the process followed by the hearing panel was "unfair and indicative of bias."[177] The tribunal recognized that the test for a reasonable apprehension of bias is the

informed person test.[178] The tribunal said, however, that the allegation of bias must be supported by material evidence and "cannot rest on mere suspicion, pure conjecture, insinuations or mere impressions of an applicant or his counsel."[179] Further, the tribunal held, disagreements between the panel and counsel do not create a reasonable apprehension of bias.[180]

The tribunal examined the evidence to determine whether the panel conducted itself unreasonably and accordingly gave rise to a reasonable apprehension of bias. Three points were in issue. First, Mr. Sriskanda submitted that "the approach taken by the hearing panel on the motion for leave to withdraw deemed admissions"[181] was unreasonable. The tribunal found that the hearing panel was asked to relieve against deemed admissions and it did so, therefore it did not conduct itself unreasonable on this matter.[182] Second, the tribunal assessed whether the hearing panel acted unreasonably in the context of its conditional order that "that Mr. Sriskanda admit that which he was prepared to admit by the following day."[183] Mr. Sriskanda submitted this order demonstrated a reasonable apprehension of bias against him. The tribunal found "no unfairness in this condition"[184] because Mr. Sriskanda was not required to admit *anything*; the condition was that he was required to only admit "<u>that what he was prepared to admit</u>" [185] by the following day. On this same issue, Mr. Sriskanda also submitted that the hearing panel only gave him one day to fulfill the order which, he argued, was insufficient time. The tribunal held that "there is no unfairness in this either"[186] and that "adjourning the scheduling hearing for a full day…is sensible hearing management."[187]

Lastly, Mr. Sriskanda submitted that the panel demonstrated a reasonable apprehension of bias when it referred to the Agreed Statement of Facts as "hot off the press."[188] The tribunal found that referring to the Agreed Statement of Facts "hot off the press"[189] was an expression to

describe the most recent version and recently printed document. The tribunal appropriately concluded that the description, "hot off the press"[190] was not unreasonable nor an indicator of bias. The tribunal concluded that the evidence did not support a finding of a reasonable apprehension of bias in the panel's decision making. The tribunal dismissed Mr. Sriskanda's appeal.

B) The Law Society Discipline Tribunal: An Analysis of the Case Study

The above case study highlights two issues. First, the factual differences of each case support the argument that self-regulating professional bodies can make fair and just decisions without interference from the legislature. Moreover, the self-regulating body requires the flexibility to be a master of its own procedure to reach such appropriate conclusions. Second, there is a parallel between the revocation of a license to practice and a criminal punishment. On the first issue, the case study on the Law Society demonstrates that a self-regulating body can effectively self-govern and protect the public without interference by the legislature. In both *Rosenthal* and *Sriskanda*, the lawyers' licenses were revoked. In *Puskas*, however, the lawyer's license was suspended, not revoked. Despite the fact that all three cases involved an abuse of a trust account, the decisions can be reconciled by considering how the Law Society applied its mandate to the specific facts of a case. The facts make the misconduct in *Puskas* undeniably different than the misconduct in *Rosenthal* and *Sriskanda*. In both *Rosenthal* and *Sriskanda*, it was the lawyers who wrongfully took money from their trust account. In *Puskas*, it was Mr. Puskas' paralegal who stole the money from the account, not Mr. Puskas. Further, Mr. Puskas only allowed the paralegal access to the account in hopes she would assist with the administration of his law

practice. The cases were also very different because in *Rosenthal* and *Sriskanda*, the lawyers' lack of honesty and cooperation was an aggravating factor in both decisions to revoke the licenses to practice. By way of contrast, in *Puskas*, the Law Society explained that the demonstration of Mr. Puskas' honesty, genuine remorse and acknowledgement of his wrongdoing coupled with his complete cooperation was a major mitigating factor in its decision to suspend, rather than revoke, his license.

In *Puskas*, the tribunal said that it must consider "both the protection of the public and the public's confidence in the legal profession"[191] when fulfilling its mandate to "govern the profession in the public interest."[192] The penalty in *Puskas* was a "very significant suspension, coupled with a prohibition on practising real estate law in the future."[193] This would prevent Mr. Puskas from practicing real estate law (the area of law in which the misconduct occurred) but allow him to continue practicing criminal law, an area of law in which he was highly regarded by his peers.[194] This penalty is a perfect example of how the Law Society, without interference from the legislature, successfully fulfills its mandate by determining punishments that deter bad conduct, protect the public and uphold the values of the profession, without destroying a person's life where it does not need to do so.

Rosenthal demonstrates that the Law Society can apply its mandate to determine the appropriate professional penalty in the context of a criminal conviction. *Sriskanda* demonstrates the Law Society's ability to analyze issues involving administrative law and bias in the context of a panel's decision. *Puskas* demonstrates that in certain cases, a one size fits all approach is not the appropriate approach in cases of misconduct. The common thread amongst these decision, however, is the Law Society's ability to weigh aggravating and mitigating factors to create a fact-

specific and appropriate punishments that uphold both the Law Society's mandate and protect the public. This demonstrates the need for the Law Society to have the authority to apply its own mandate according to the specific facts, as opposed to having legislated penalties, to decide a case appropriately and fairly for the profession, the professional, and the public.

The case study also highlights a parallel between the revocation of a professional license to practice and a criminal punishment. This parallel is most obvious in *Puskas.* In *Puskas,* the Law Society placed significant weight on the expert report of Dr. Chaimowitz because his expert's reports are "often relied upon by the courts when an accused's liberty is at stake in a criminal trial." [195] This reference to the criminal sphere sparks two comparisons. First, it draws a parallel between the professional and criminal spheres insofar as the Law Society has recognized that if medical evidence that speaks to an accused's state of mind can mitigate a criminal punishment, the Law Society can similarly consider such evidence when determining whether to revoke a professional's license to practice. This recognition connects to the second comparison: the revocation of a license to practice one's profession is so severe that it is arguably more similar to a criminal punishment than a civil order to pay damages. The revocation of a license to practice will destroy a person's life, but such a decision is justified by the Law Society when the lawyer would otherwise pose an ongoing threat to the public. The severity of the penalty and the parallels that can be drawn between professional and criminal punishments raises the question of whether the standard of proof should be higher in these cases. This question will be addressed in the conclusion of this paper.

V. Issues with The Task Force Report That Inspired *Bill 87*

In December 2014, the Minister of Health and Long-Term Care, Dr. Eric Hoskins, appointed a Task Force on the Prevention of Sexual Abuse of Patients and the *RHPA*. The goal of the Task Force was, among other efforts, to assess the effectiveness of the zero-tolerance policy under the *RHPA* regarding sexual abuse of patients. The Task Force reported that a new approach to regulating sexual abuse of patients is required "immediately."[196] The Task Force recommends that a zero-tolerance policy should be applied in all cases of sexual abuse to protect the public.[197] The report provides a comprehensive list of recommended changes to the system including changing definitions under the *RHPA* to broaden the scope of what constitutes sexual abuse. Changes to no gender-based restrictions, fast tracking sexual abuse complaints, patient privacy and confidentiality, expert witness testimony, therapy and counselling for patients, and accreditation standards are among the recommendations.

The Task Force suggestions undermine the administrative principle that a tribunal be the master of its own procedure.[198] The first chapter of the Task Force Report provides significant insight into how the Task Force has arrived, with such certainty, that immediate and extreme changes must be made to the *RHPA* and self-regulating Colleges. The task force assessed how the *RHPA* "creates a disciplinary process that runs parallel to the criminal legal system under the *Criminal Code of Canada*."[199] The Report highlights that sexual abuse in the disciplinary process results in the revocation of a license to practice with an option to apply for reinstatement but if a "similar assault" [200] occurred "on the street" [201], the criminal punishment is, obviously, prison.[202] The report adds "but [criminal punishment] is not the system that colleges are required to administer under the *RHPA*."[203] The Task Force's report demonstrates a reasonable apprehension

of bias toward physicians. On page 6 the Report reads: "the CPSO has not undertaken to report to police, however, until *after* completing its adjudication – a process that can take years."[204] The insinuation is that doctors should be subject to criminal action *sooner*. However, there is an important reason why the CPSO will wait until after the discipline proceeding to report the alleged conduct to the police: the discipline proceeding may prove that no offence, under the *RHPA* or the *Criminal Code*, took place. It is important to remember that the standard of proof before the CPSO Committee is proof on a balance of probabilities; this is a *lower* standard of proof than is required at a criminal trial. If the evidence does not meet the standard of proof on a balance of probabilities, it will not satisfy the higher standard of proof in a criminal trial.

The Task Force's emphasis on bridging the gap between regulatory action and criminal action is alarming because it demonstrates that the Task Force is looking at this regulatory issue through a criminal lens. To do so ignores the nuances present in the regulatory disciplinary context that make the issues, process and outcomes vastly different from the criminal sphere. For example, a doctor who *first* engages in a consensual sexual relationship with a woman, and *then* performs cosmetic or plastic surgery on his girlfriend will be found guilty of sexual abuse in the professional sphere[205] and have his licence revoked under the mandatory revocation provision of the *RHPA*.[206] Although this is an act of professional misconduct, it would, rightfully so, not be a criminal offence because the sexual relationship was clearly consensual.

Hence, the Task Force's comparison is faulty; it is incorrect to compare the regulation of health care professionals with the criminal justice system because there are a multitude of acts which are subject to professional discipline but which are not criminal offences. To begin the report with the perspective that all doctors who commit acts of sexual abuse in the context of a

doctor-patient relationship should be subject to criminal reporting and criminal punishments demonstrates a reasonable apprehension bias throughout the Report. This is because the Task Force has demonstrated it has already reached its conclusion that doctors who have allegations of sexual abuse brought against them are guilty of criminal sexual assault. This not only violates the fundamental principle of "innocent until proven guilty", but it demonstrates a lack of understanding of the context in discipline cases which is necessary to create an unbiased report. The Task Force bolsters the basis for its argument for bridging the gap between the regulatory and criminal spheres, on the bottom of page 4 of the report, in enlarged and highlighted font, it reads:

> It's one thing to have the college review and discipline doctors on matters that relate to their profession; however sexual assault is a criminal code violation plain and simple. The CPSO has no more right to interfere with the justice system than a police officer has to remove an appendix.[207]

The error is obvious: the term 'sexual assault' in the *Criminal Code* is not the same as the term 'sexual abuse' in the *RHPA*. As discussed above, the *RHPA* defines 'sexual abuse' without the concept of consent. Thus, under the *RHPA*, a doctor will be found guilty of 'sexual abuse' even where the relationship was consensual (as explained in the *Sliwin* case above). However, sexual assault is only a criminal offence where the relationship was not consensual. Thus, the Report is not comparing analogous acts; sexual abuse in the regulatory context is not the same as sexual assault in criminal law, but the Task Force has based its report on the incorrect assumption that the acts are the same.

Although the Report is not an 'administrative decision' in the traditional sense, it is a Report written by an administrative body appointed by the legislature. The *Baker* test for whether

there is reasonable apprehension of bias in this report is helpful in determining the merits of the report. The *Baker* test for whether there is a reasonable apprehension of bias is:

> What would an informed person, viewing the matter realistically and practically -- and having thought the matter through -- conclude. Would he think that it is more likely than not that [the decision-maker], whether consciously or unconsciously, would not decide fairly.[208]

In applying this standard to the Report, one must consider the following factors. The Task Force has begun its report; a) with the faulty comparison between 'sexual abuse' in the regulatory context and 'sexual assault' in the criminal context, b) in doing so has neglected to consider the nuances that exist in the regulatory disciplinary context, and c) has failed to mention these differences when discussing mandatory police reporting in Chapter 1 of its report. Viewing these factors realistically and practically, it is more likely than not that the Task Force has, whether consciously or unconsciously, not viewed the matter fairly. In conclusion, there is a reasonable apprehension of bias in the report insofar as it assumes that all doctors who have allegations of sexual abuse brought against them in the professional context are both guilty of that sexual abuse under the *RHPA* and are guilty of sexual assault in the criminal context. Consequently, it is concerning that the Minister has integrated many suggestions into Bill 87 from a report that contains a reasonable apprehension of bias.

VI. Conclusion

Bill 87 clearly creates safeguards for patients by legislating more circumstances in which physicians are subject to professional capital punishment. This change is created, however, without additional safeguards for procedural fairness for physicians. Appropriate procedural

fairness is crucial to achieve fairness and provide access to justice. Further, the above analysis demonstrates there is a reasonable apprehension of bias in the Task Force report, and the suggestions from that report are integrated into Bill 87. Based on the reasonable apprehension of bias found in the Task Force report, it is, unfortunately, not surprising that Bill 87 also contains an reasonable apprehension of bias. This reasonable apprehension of bias is found, for example, in the proposed change that the ICRC is empowered to suspend a physician's license without having to wait for the matter to be referred to disciplinary proceedings. The ability to suspend a physician's license at this premature stage in the complaint process demonstrates a reasonable apprehension of bias: the ICRC's decision is based on the uncorroborated allegation that the physician is unfit to practice and the ICRC is therefore justified in suspending the license. This expanded power will begin the disciplinary process from the perspective that the physician is already 'guilty' before he or she has set foot in a disciplinary proceeding and this, undoubtedly, creates a reasonable apprehension of bias. The increased governmental control over the profession coupled with the reasonable apprehension of bias in the Bill creates a serious concern for physicians.

The case study demonstrates that professionals face issues of bias during the disciplinary proceeding. The Law Society in *Sriskanda* said that, a "reasonable apprehension of bias is a matter of procedural fairness and natural justice."[209] It is therefore important to create procedural safeguards to protect physicians from biased decision-making. However, it is naïve to suggest that procedural safeguards can completely eradicate issues of bias; even the seminal case on bias, *Baker*, does not suggest that bias can always be prevented but rather stands for the proposition that bias results in an unfair decision and is appropriately grounds for a decision to be

reviewed.[210] The question, therefore, becomes, if bias is unavoidable, in what way can physicians be afforded greater procedural fairness to counteract the increased governmental interference in the regulation and discipline of the profession under Bill 87? The answer: an enhanced standard of proof in physician discipline cases involving allegations of sexual abuse.

The increased governmental interference under Bill 87 transforms the professional discipline proceeding into something that is more closely aligned with a criminal proceeding than a civil proceeding because the proceeding involves the power of the state to punish an individual. Henceforth, the scope of the legislature's power attracts the standard of proof applied in cases that involve the state versus the individual; proof beyond a reasonable doubt. In other words, the civil standard of proof is not the appropriate standard to use when the discipline of the profession involves the power of the state. Moreover, the standard of proof of a balance of probabilities is problematic in the professional discipline context because the precedent for the application of this standard fails to address the context of professional discipline. As discussed above, the application of *McDougall* to professional discipline cases[211] created the result that the standard of proof before the Discipline Committee at the CPSO is proof on a balance of probabilities. There are, however, serious implications of the application of *McDougall* to cases involving the revocation of a physician's license to practice. First, the court in *McDougall* held that "in civil cases, there is no presumption of innocence"[212] because penalties in civil law (i.e. and order to pay damages) are simply not as severe as the government's ability to rob a person of their freedom. The proposition from *McDougall* that "there is no presumption of innocence" [213] in civil cases contradicts the court's prior decision in *Bernstein*. As discussed above, *Bernstein* stood for the proposition that <u>there is</u> a presumption of innocence of a physician in a discipline

proceeding.[214] As addressed in the above College case study, recent College decisions have demonstrated the need for and application of a presumption of innocence. This supports the argument for a higher standard of proof. [215]

Second, the application of *McDougall* to professional discipline cases created the result that the standard of proof is the civil standard in professional discipline proceedings. The problem with this is twofold. As discussed in the previous paragraph, the decision that a lower standard of proof is acceptable was based on the presumption that the penalty in a civil case is not as severe as the punishment in a criminal case. The revocation of a license to practice, however, is professional capital punishment. Professional capital punishment is a more severe penalty than a civil order to pay damages. Accordingly, the reasoning that a lower standard of proof is appropriate because the penalty in a civil case is not as severe as a criminal punishment is an inappropriate conclusion to make when the professional penalty is a much harsher penalty than a civil order to pay damages.

The third problem is that the disciplinary proceeding is more similar to the procedure in a criminal case than a civil case. The professional is served with 'charges' of misconduct and the finding is 'guilty' or 'not guilty', as in a criminal case. Moreover, counsel acting for the disciplinary tribunal, such as the CPSO, is referred to as Prosecution Counsel. The similarities in procedure between criminal and disciplinary proceedings begs the question of whether the standard of proof beyond a reasonable doubt is needed in the professional discipline context to ensure procedural fairness. While the revocation of a professional license is not as harsh as a criminal punishment, it is arguably more serious than the average civil penalty. If the penalty is harsher in these specific disciplinary proceedings, it seems reasonable to suggest that the

physician is owed a higher degree of fairness which includes the presumption of innocence and a higher standard of proof than the civil standard. These issues are aggravated by Bill 87 which enhances governmental control over the proceedings, a factor which likens the disciplinary process to a criminal trial.

McDougall is therefore not a suitable case to apply when determining the standard of proof in a discipline proceeding involving the revocation of a physician's license to practice. This is because the facts in *McDougall* were unrelated to professional discipline and accordingly the decisions on the issues of presumptions of innocence and standards of proof in *McDougall* ignore the seriousness of a professional discipline proceeding in which a physician stands to lose his or her license to practice. By way of contrast, *Bernstein* involved the revocation of a license to practice medicine. *Bernstein* more appropriately addresses the issues of the standard of proof and the presumption of innocence in a discipline proceeding involving allegations of sexual abuse. The application of an appropriate standard to these discipline proceedings is important to ensure procedural fairness not only under the current regulatory regime but is especially critical if Bill 87 is passed.

In conclusion, Bill 87, if passed, will create more circumstances in which the state can impose professional capital punishment on the physician. This increase in state control over the individual shifts the scope of state involvement and mandatory punishments to more closely align with the criminal sphere than the civil sphere. This shift, coupled the above referenced issues with the *McDougall* precedent, trigger a higher standard of proof, proof beyond a reasonable doubt, in professional discipline cases where the punishment is the revocation of a license to practice.

[1] *Regulated Health Professions Act*, SO 1991, c 18 [*RHPA*].

[2] Bill 87, *An Act to implement health measures and measures relating to seniors by enacting, amending or repealing various statutes*, 2nd Sess, 41st Leg, Ontario, 2016 (first reading 8 December 2016) [Bill 87]

[3] *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817 ¶ 20 [*Baker*]; citing *Cardinal v. Director of Kent Institution,* [1985] 2 SCR 643, at 653.

[4] *Ibid*.

[5] Richard Steinecke, *A Complete Guide to The Regulated Health Professions Act*, (Toronto: Thomson Reuters, 2016) at 10-2 Steinecke]; citing *Mussani v College of Physicians and Suregons of Ontario*, (2003) 226 DLR (4th) 511 (Ont SCJ (Div Ct)), affd 248 DLR (4th) 632 (Ont CA) ¶ 26 [*Mussani*].

[6] *Interim Report of the Task Force on Sexual Abuse of Patients* (Toronto, College of Physicians and Surgeons of Ontario, 1991).

[7] Steinecke, *supra* note 5.

[8] Steinecke, *supra* note 5; citing *Mussani, supra* note 5 ¶ 24-27.

[9] Steinecke, *supra* note 5 at 10-3; citing *Mussani, supra* note 5 ¶ 28.

[10] *Ibid*..

[11] Steinecke*, supra* note 5 at 10-3; citing *Mussani, supra* note 5 ¶ 28. Two other reasons were provided: 1) a physician who has sexually violated a patient has committed an act that has harmed his patient in pursuit of meeting his own needs, and 2) rehabilitation programmes for sexual abusers are not developed to the extent required to ensure that an abuser no longer poses a risk of harm to other patients.

[12] *Regulated Health Professions Amendment Act, 1993,* SO 1993, c 37.

[13] Steinecke, *supra* note 5 at 10-3; citing *Mussani, supra* note 5 ¶ 30.

[14] Steinecke, *supra* note 5 at 10-3; citing *Mussani, supra* note 5 ¶ 31.

[15] Steinecke, *supra* note 5 at 10-3; citing *Mussani, supra* note 5 ¶ 32.

[16] Steinecke, *supra* note 5 at 10-2; citing *Mussani, supra* note 5 ¶ 26.

[17] Steinecke, *supra* note 5 at 10-1.

[18] *Regulated Health Professions Act*, SO 1991, c 18, Schedule 2, (Health Professions Procedural Code) s.1.1 [*Code*].

[19] Steinecke, *supra* note 5 at 1-1.

[20] Steinecke, *supra* note 5 at 1-1.

[21] Robert W. Macaulay & James L.H. Sprague, *Practice and Procedure Before Administrative Tribunals*, (Toronto: Carswell, 2004) vol 2 at 9-1 [Macaulay & Sprague].

[22] Steinecke, *supra* note 5 at 1-2.

[23] Steinecke, *supra* note 5 at 1-2 to 1-3; citing *LaBelle v Law Society of Upper Canada* (2001), 52 OR (3d) 398 (SCJ), affd 56 OR (3d) 413 (CA), leave to appeal to SCC refused 180 OAC 200n

[24] *RHPA* at s.5; see also Steinecke, *supra* note 5 at 1-3.

[25] *RHPA* at ss.5(1), 5.0.1 and 6(7); *Drug and Pharmacies Regulation Act*, RSO 1990, c H4 (renamed from *Health Disciplines Act* by *RHPA*, s.47(2)).

[26] Steinecke, *supra* note 5.

[27] Steinecke, *supra* note 23.

[28] Steinecke, *supra* note 5 at 1-5.

[29] *Ibid*.

[30] Steinecke, *supra* note 23.

[31] *Ibid*.

[32] Bill 87, *An Act to implement health measures and measures relating to seniors by enacting, amending or repealing various statutes*, 2nd Sess, 41st Leg, Ontario, 2016, schedule 4 cl (2.1) (first reading 8 December 2016) [Bill 87].

[33] Bill 87, explanatory note, schedule 4.

[34] *Ibid*.

[35] *Ibid*.

[36] *Ibid*.

[37] *Ibid*.

[38] *Ibid*.

[39] Bill 87, schedule 4, at s.19(2).

[40] Bill 87, schedule 4, at s.19(2)(5).

[41] Bill 87, schedule 4, at s.19(1).

[42] (*Bernstein and College of Physicians and Surgeons of Ontario*, (1977) 15 OR (2d) 447 ¶ 120 [*Bernstein*].

[43] *Ibid*.

[44] *Ibid* ¶ 120.

[45] *Ibid*.

[46] *Ibid.*

[47] *Ibid.*

[48] *Ibid* ¶ 127.

[49] *Ibid* ¶ 127-128.

[50] *FH v McDougall*, 2008 SCC 53 ¶ 27 [*McDougall*].

[51] *Ibid* ¶ 39.

[52] Steinecke, *supra* note 5 at 6:50.40.

[53] *McDougall*, *supra* note 50 ¶ 45.

[54] *Ibid* ¶ 49.

[55] *Ibid* ¶ 40.

[56] *Ibid* ¶ 45-46.

[57] *Ibid*.

[58] *Ibid*.

[59] *Osif v College of Physicians and Surgeons of Nova Scotia*, (2009) 276 NSR (2d) 118 (CA) [*Osif*].

[60] *Ibid* ¶ 198: 'CCFP' is the acronym for the Certification in the College of Family Physicians.

[61] *Ibid* ¶ 112.

[62] *Ibid*.

[63] *Ibid* ¶ 1.

[64] *Ibid* ¶ 112.

[65] *Ibid* ¶ 112, citing *McDougall, supra* note 50 ¶ 40.

[66] *Osif*, *supra* note 59 ¶ 112; citing *McDougall, supra* note 50 ¶ 46.

[67] *Osif*, *supra* note 59 ¶ 112; citing *McDougall, supra* note 50¶ 49.

[68] *Osif*, *supra* note 59 ¶ 117; citing *McDougall*, *supra* note 50¶ 70.

[69] *Baker, supra* note 3.

[70] *Baker, supra* note 3 ¶ 20.

Baker, supra note 3 ¶ 43: The court outlined several factors which are used to determine whether the duty of participatory rights has been satisfied at common law. The factors are as follows; the nature of the decision and the process followed in making that decision, the nature of the statutory scheme and the terms that govern the decision maker, the importance of the decision to the individual, the legitimate expectations of the individual based on what is outlined in the relevant statute, and the choices available to the decision maker at the time of making the decision. The court established that written reasons are not always required of an administrative decision-maker. However, when procedural fairness is at issue, there are three circumstances in which reasons will be required; the decision has important significance to the individual, there is a statutory right of appeal, or there is some "other" circumstance in which "some form of reasons should be required"[71]. This third category clearly opens the door for courts to exercise their discretion on judicial review on grounds of procedural fairness.

[72] *Baker, supra* note 3 ¶ 46.

[73] *Seidman (Re) v College of Physicians and Surgeons of Ontario,* [2013] OCPSD No 20 [*Seidman*].

[74] *XYZ (Re) and the Ontario College of Physicians and Surgeons,* [2013] OCPSD No 27 [*XYZ*].

[75]*Sliwin (Re) v College of Physicians and Surgeons of Ontario,* [2015] OCPSD No 12 [*Sliwin*].

[76] *Seidman*, *supra* note 73.

[77] *Ibid* ¶ 6.

[78] *Ibid* ¶ 7.

[79] *Criminal Code*, RSC 1985, c C-46.

[80] *Seidman, supra* note 73¶ 9.

[81] The *Code* at s. 72(1) and s.72(3)(a).

[82] *Seidman, supra* note 73¶ 10.

[83] *Ibid* ¶ 11.

[84] *Ibid* ¶ 63.

[85] *Ibid* ¶ 17.

[86] *Ibid*.

[87] *Ibid* ¶ 68.

[88] *Ibid* ¶ 69.

[89] *Ibid* ¶ 70.

[90] *Ibid* ¶ 71.

[91] *Ibid*.

[92] *Ibid* ¶ 96.

[93] *Ibid*.

[94] *Ibid* ¶ 164.

[95] *Ibid* ¶ 94.

[96] *Ibid* ¶ 103.

[97] *Ibid* ¶ 110.

[98] *Ibid* ¶ 148.

[99] *Ibid* ¶ 173.

[100] *Ibid* ¶ 223.

[101] *Ibid* ¶ 225.

[102] *XYZ*, *supra* note 74.

[103] *Ibid* ¶ 3-4.

[104] *Ibid* ¶ 8.

[105] *Ibid*.

[106] *Ibid*.

[107] *Ibid* ¶ 54.

[108] *Ibid* ¶ 9.

[109] *Ibid*.

[110] *Ibid* ¶ 56.

[111] *Ibid*.

[112] *Ibid* ¶ 55.

[113] *Ibid*.

[114] *Ibid*.

[115] *Ibid* ¶ 58.

[116] *Ibid* ¶ 8.

[117] *Ibid*.

[118] *Ibid* ¶ 80-81.

[119] *Sliwin, supra* note 75.

[120] *Ibid* ¶ 33-59.

[121] *Ibid* ¶ 6.

[122] *Ibid* ¶ 68.

[123] *Ibid* ¶ 67-69.

[124] *Ibid* ¶ 74.

[125] *Ibid* ¶ 72.

[126] *Ibid* ¶ 75-77.

[127] *Ibid*.

[128] *Ibid* ¶ 80.

[129] *Ibid* ¶ 81.

[130] The *Code* at s.1(3), s.51(5)(2), and s.72(3)(a) ("the mandatory revocation provisions").

[131] *Seidman, supra* note 73 ¶ 21.

[132] *Dunsmuir v New Brunswick*, 2008 SCC 9 [*Dunsmuir*].

[133] *Seidman, supra* note 73¶ 6.

[134] *Bernstein*, *supra* note 42 ¶ 127.

[135] *McDougall*, *supra* note 50 ¶ 42

[136] *Sliwin*, *supra* note 75 ¶ 115.

[137] *Ibid* ¶ 39.

[138] *Ibid*.

[139] *Ibid* ¶ 9.

[140] *Ibid*.

[141] *Ibid* ¶ 55.

[142] One flaw in the comparison is that in sexual abuse cases before the College, part of the inquiry involves determining whether the sexual abuse occurred or whether the activity which occurred falls within the *RHPA* provision for sexual abuse. In cases involving an abuse of a trust account before the LSUC, however, the question of whether the misconduct occurred is often not in dispute: there is often no question that a lawyer has misappropriated the funds or stolen the funds from the trust account. Thus, the issue before the LSUC is not whether the misconduct occurred but instead the issue is in determining the appropriate penalty. There are cases in which the law societies in Canada have dealt with lawyers engaging in sexual relationships with clients. For example, *Law Society of Upper Canada v George Douglas Hunter*, [2007] ONLSHP 27 is comparable to the facts in *Sliwin*. Further, *Adams v Law Society of Alberta*, 2000 ABCA 240 is comparable to the facts in *Seidman*. However, as explained above, this paper will focus on cases that involve and abuse of trust and power in the form of a trust account because, although there are certain egregious cases involving lawyers having sexual relationship with their clients, sexual relationships between lawyers and clients are not expressly prohibited in the same way as they are prohibited between doctors and patients. Stealing money for a trust account, however, is prohibited. Thus, cases involving sexual relationships between lawyers and clients are outside the scope of this paper.

[143] *Law Society of Upper Canada v Rosenthal,* [2011] LSDD No 122 [*Rosenthal*].

[144] *Law Society of Upper Canada v Puskas*, [2013] LSDD No 136 [*Puskas*].

[145] *Society of Upper Canada v Sriskanda*, [2017] LSDD No 8 [*Sriskanda*].

[146] *Rosenthal*, *supra* note 143.

[147] *Ibid* ¶15-22.

[148] *Criminal Code*, *supra* note 79.

[149] *Rosenthal*, *supra* note 143 ¶ 42.

[150] *Ibid* ¶ 43.

[151] *Ibid*.

[152] *Ibid*: [H]e must first provide a medical practitioner's report on his rehabilitation for drug abuse; he must continue counseling and rehabilitation as directed by his physician; he must be supervised by a member of the Law Society for five years; he must attend, as required, all medical treatments as directed by his physician for five years; and he must submit himself to random drug testing for five years.

[153] *Ibid* ¶ 93-94.

[154] *Ibid* ¶ 89.

[155] *Ibid* ¶ 92.

[156] *Ibid* ¶ 94.

[157] *Puskas, supra* note 144.

[158] *Ibid* ¶ 1-5.

[159] *Ibid* ¶ 15.

[160] *Ibid* ¶ 8.

[161] *Ibid* ¶ 12.

[162] *Ibid* ¶ 43.

[163] *Ibid* ¶ 43.

[164] *Ibid*.

[165] *Ibid*.

[166] *Ibid*.

[167] *Ibid* ¶ 16.

[168] *Ibid* ¶ 14.

[169] *Ibid* ¶ 46.

[170] *Ibid*.

[171] *Ibid* ¶ 47; the tribunal made the following orders: (a) the Lawyer shall be suspended from practice for a period of 20 months commencing October 1, 2013 unless another date is agreed upon by the Law Society and the Lawyer; (b) the Lawyer's practice shall be restricted to permanently exclude real estate law; (c) the Lawyer shall not, directly or indirectly, retain the services of Shellee Spinks in any manner associated with his law practice; and (d) the Lawyer shall engage in therapy with a therapist with an addictions specialty, such therapist to be recommended by Dr. Chaimowitz, for psychological counseling and treatment of his alcohol abuse. The Lawyer shall arrange for the therapist to provide quarterly reports to the Director of Professional Regulation confirming his participation in treatment. The Lawyer shall continue such therapy until the therapist provides a report satisfactory to the Director of Professional Regulation, opining that treatment is no longer necessary.

[172] *Sriskanda, supra* note 145.

[173] *Ibid* ¶ 1.

[174] *Ibid* ¶ 4.

[175] *Ibid* ¶ 5.

[176] *Ibid* at 1. The lawyer's appeal was based on: 1) the hearing panel's errors in: assessing the 12 transactions, finding that the Lawyer caused files to be altered, not making credibility findings in a reasonable manner, and admitting certain evidence while failing to allow the Lawyer to obtain production of or to introduce other evidence; 2) the hearing panel's conduct of the hearing giving rise to a reasonable apprehension of bias; 3) ineffective representation from his lawyer during the first part of the hearing; and 4) revocation of licence being a "cruel and unusual punishment," that the presumptive penalty of revocation in all fraud cases was bad in law, and that a penalty of no more than a short term of suspension was justified.

[177] *Ibid* ¶ 82.

[178] *Ibid* ¶ 72*:* the test for reasonable apprehension of bias is "whether an informed person, viewing the matter realistically and practically and having thought the matter through would conclude that the decision-maker would decide fairly or not."

[179] *Ibid.*

[180] *Ibid.*

[181] *Ibid* ¶ 85.

[182] *Ibid* ¶ 83

[183] *Ibid* ¶ 83-85.

[184] *Ibid* ¶ 83.

[185] *Ibid* ¶ 83-85.

[186] *Ibid* ¶ 83.

[187] *Ibid*.

[188] *Ibid* ¶ 85.

[189] *Ibid*.

[190] *Ibid*.

[191] *Puskas*, *supra* note 144 ¶ 45.

[192] *Ibid*.

[193] *Ibid* ¶ 46.

[194] *Ibid* ¶ 43.

[195] *Ibid* ¶ 8.

[196] To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the *Regulated Health Professions Act*, 1991 at 18 [Task Force Report].

To ensure the success of a zero-tolerance policy, the task force recommends removing from the health regulatory colleges the authority to process and adjudicate sexual abuse complaints and instead delegate that authority to a "new, centralized regulatory body and an independent tribunal"[197] called the Ontario safety and Patient Protection Authority (OSAPPA). The task force recommends creating an independent appeal tribunal to review decisions from the OSAPPA. The effect of this recommendation is that the legislature, and not the self-regulating colleges, would have control over the process by which physicians are penalized in cases involving alleged sexual abuse. This is, needless to say, a major shift in power away from what has always been recognized as a self-regulating profession and toward more governmental control.

[198] Macaulay & Sprague, *supra* note 21.

[199] Task Force Report, *supra* note 196 at 3-4.

[200] *Ibid*.

[201] *Ibid*.

[202] *Ibid*.

[203] *Ibid* at 4.

[204] *Ibid* at 6.

[205] *Sliwin, supra* note 75.

[206] The *Code*, *supra* note 131 at s.1(3), s.51(5)(2), and s.72(3)(a).

[207] Task Force Report, *supra* note 196 at 4.

[208] *Baker*, *supra* note 3 ¶ 46.

[209] *Sriskanda*, *supra* note 145 ¶ 22.

[210] *Baker*, *supra* note 3.

[211] *Osif*, *supra* note 59.

[212] *McDougall*, *supra* note 50 ¶ 42.

[213] *McDougall*, *supra* note 50 ¶ 42

[214] *Bernstein, supra* note 42 ¶ 127.

[215] *XYZ*, *supra* note 74.