PRESENTATION TO THE
NEW BRUNSWICK
COLLEGE OF DENTAL HYGIENISTS

SEXUAL ABUSE BY HEALTH PROFESSIONALS

REQUIRED BEHAVIOURS AND REPORTING OBLIGATIONS

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(Updated from 1998)

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SEXUAL ABUSE BY HEALTH PROFESSIONALS

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Whatever house I enter, there I will go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male, female, of bond, or free[2]

Sexual conduct between [therapists] and patients is unethical, exploitative and harmful. It commonly begins through breaches of appropriate therapeutic boundaries.[3]

I. Boundary violations

Sexual abuse is never about sex. It is always about power, more specifically abuse of power. When a health professional[4] engages in sexual activity with a patient[5], the health professional "violates the boundaries" and commits sexual abuse. Although sex between health professionals and patients is specifically forbidden by the Hippocratic Oath and in various ethics codes of the professions, history is replete with indiscretions between health professionals and patients.

The "therapy session"[6] is the ideal setting for extraordinary intimacy. Patient and therapist are isolated from the world, focused on each other intently, exploring emotions, needs and insecurities. Patients may undergo something called transference, in which they come to see the health professional as something like an all-loving parent they can trust completely. The process can also stir feelings in the health professional. Power is a potent aphrodisiac.

The slippery slope of boundary violations may be ventured upon first, in small inconsequential actions by the health professional such as scheduling a “favoured” patient for the last appointment of the day, extending sessions with the patient beyond the scheduled time, having excessive telephone conversations with the patient, and becoming lax with fees. Violations can involve excessive self-disclosure by the health professional to the patient, which may increase as time goes by until therapy sessions become “rap sessions” or, worse, “therapy” for the therapist. Gifts may be exchanged. The health professional may begin to direct the patient’s work and personal life choices. Sometimes the health professional asks the patient to do household or office duties for him or her. Meetings may be arranged outside the office for lunch or dinner.

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[1] Forbes Roth Basque, Moncton

[2] Hippocratic Oath, 5th century B.C.

[3] *Larry Strasburger, Linda Jorgenson and Pamela Sutherland*, The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope.

[4] The terms “health professional” and “therapist” as used interchangeably in this paper are meant to include all professionals who counsel patients/clients/customers: e.g. psychiatrists, psychologists, social workers, doctors, nurses, pharmacists, dentists, clergy, teachers, lawyers, dental hygienists, etc.

[5] Read also “clients”, “students”, “penitents”, etc.

[6] Used in its broadest sense

Freud warned that therapists should struggle against such "counter transference" and not abuse the patient's longing for love. It is " . . . awfully hard for [health professionals] to walk a straight line when somebody's throwing themselves at them," says William Masters of the Masters and Johnson Institute. But he calls such situations "statutory rape" and likens the balance of power between health professional and patient to the advantage an older man over an underage girl. Health professionals "have to realize that this is part and parcel of working in the field" says Masters. "It's still up to them to protect the patient." Even when health professionals think they are in love, experts say, they are serving their own needs, not the patient's, if they act on their impulses.

The Supreme Court of Canada has written[7]:

> *An ability to "dominate and influence" is not restricted to the student-teacher relationship. Professor Coleman outlines a number of situations which she calls "power of dependency" relationships. Included in these relationships are parent-child, psychotherapist-patient, physician-patient, clergy-penitent, professor-student, attorney-client, and employer-employee. She asserts that "consent" to a sexual relationship in such relationships is inherently suspect. She notes, at pp. 96-7:*
>
> > *The common element in power dependency relationships is an underlying personal or professional association which creates a significant power imbalance between the parties . . . Exploitation occurs when the "powerful" person abuses the position of authority by inducing the "dependent" person into a sexual relationship, thereby causing harm.*[8]

Patient Vulnerability

The following factors contribute to the patient's vulnerability:

a. The nature of the problem;
b. The disclosure of confidential information to the health professional;
c. The patient's idealization of the health professional; and
d. The stress of the reason behind the consultation and the disclosure of personal information.

These four factors lead to the patient's vulnerability and enhance the power imbalance inherent in the health professional-patient relationship. The health professional may be the more powerful party simply because the patient needs the health professional's help. In addition, health

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[7] *Norberg* v. *Wynrib; Women's Legal Education and Action Fund, Intervener* (1992), 92 D.L.R. 449, 463 (S.C.C.)

[8] *Phyllis Coleman, "*Sex in Power Dependency Relationships: Taking Unfair Advantage of the 'Fair' Sex*", 53 Albany L. Rev. 95.*

professionals have access to the systems[9] (symbols of power), are educated and professionally trained, and are licensed to practice, all of which contribute to the health professional's power over the patient.

As they enter the relationship, patients seeking help frequently are pained and vulnerable, hoping and trusting that the health professional will alleviate the problem at hand. They often do not act self-protectively. An immediate power imbalance occurs, the health professional having advantages of education, experience, status, objectivity and authority. This imbalance has caused courts to hold the health professional to the standard of a fiduciary for the patient, requiring the health professional to act with the "utmost good faith" and never take personal advantage of the position of power. This consideration was implicit in Freud's principle of abstinence, requiring the health professional to attend solely to the associations, and by implication interests and needs, of patients, foregoing all personal gratification.

Because of patients' vulnerability and the power imbalance in their relationships with health professionals, patients are susceptible to exploitation. When a health professional sexually assaults a patient, clearly the health professional has acted unethically. Beyond the obligations to avoid conflicts of interest, preserve patient confidences, and maintain objectivity is the duty of all professions to do no harm.

Incidence of Abuse

The incidence of sexual activity between health professionals and patients is unknown. Most studies rely on replies to anonymous questionnaires. Surveys report that between 2.9% and 13% of male health professionals, and up to 5% of female health professionals, admit to having had sexual relationships with their patients. The most authoritative U.S. study found that 65 percent of psychotherapists said they had treated patients who had been sexually involved with previous therapists. Only 8 percent of the patients said they had reported the incidents to authorities.[10]

That reticence reflects a widespread feeling that the professions have looked the other way when it came to sexual contact with patients. Experts estimate that patients file complaints in only 4% of such cases, and relatively few health professionals have been severely disciplined. The professions are perceived to have been more concerned with sweeping the problem under the rug, with enabling people to continue practising.

[9] This includes the medical, educational, legal, pharmaceutical, correctional and social safety net systems

[10] Gartrell, 1986 study on Psychiatrists

Complaint Process

Lodging a complaint can be traumatic. The health professional may claim the patient is hallucinating, exaggerating or misconstruing what went on, and it's usually one's word against the other's. "He was the mentally ill patient and I was the medical professional with the 30-year practice and a long marriage". "I was really the victim in all this. I was innocent," he says. Other excuses include:

a. It did not happen;
b. The patient is a borderline personality disorder;
c. The patient is a liar;
d. This fabrication is part of the patient's illness;
e. The patient threatened to frame me;
f. The patient wanted a sexual relationship, but I refused;
g. It was not a sexual relationship;
h. It was a consensual post-termination sexual relationship;
i. I was going through mid-life crisis (divorce, drugs, depression);
j. It never happened before - this is the first time;
k. I'm going to kill myself.

Because the vast majority of cases involve male health professionals and female patients, sexism may have a role to play in the low number of cases prosecuted against health professionals. Society downplays those types of abuses in which males are the perpetrators. Society has struggled to understand the plight of the patient who becomes a victim of sexual abuse. These relationships have been portrayed as the "normal" evolution of the relationship between two consenting adults.

Experts say it is extremely rare to have someone fabricate a case "out of the blue."

Societal Acceptance

This societal acceptance of clearly unacceptable behaviour is in no small part due to the portrayal of these situations in the popular media. These relationships have become the standard plot line for many films from *The Prince of Tides* to *Basic Instinct*. In Hollywood's eyes, the psychiatric couch is as likely to be a setting for seduction as for therapy. Scriptwriters - usually male - seem unable to resist the fantasy of taking the intimacy of therapy to its forbidden extreme. Put two people in a room, exploring the most vulnerable aspects of their lives, and it must be love! The pattern was established by Alfred Hitchcock's *Spellbound*, when Ingrid Bergman's chilly therapist helps Gregory Peck overcome his amnesia by falling in love with him - thawing out herself in the process. This being 1945 (before sex was invented) they didn't actually *do it*. Today that barrier is long gone.

Consider three movies. In *The Prince of Tides*, Barbra Streisand not only treats her suicidal patient's twin brother, Nick Nolte, but falls in love with him. Sex is part of the cure - hers and his. A female psychiatrist married to a sissy violinist, she needs a "real man," a macho football

coach from the South. Then this real man sweeps her off her feet and she is transformed into a "real woman." A man obviously wrote this plot. Though health professionals cried foul, moviegoers didn't bat an eye.

Even more bizarre is the homicidal, bisexual psychologist (Jeanne Tripplehorn) in *Basic Instinct*, whose affair with her patient Michael Douglas is winked at by her colleagues. At least the shrink played by Richard Gere in *Final Analysis* has an inkling he's getting into ethical hot water when he beds down with his patient's sister. But, how many patient's sisters look like Kim Basinger?

In the movies, almost every woman shrink succumbs to the charms of the man on the couch. See: *The Flame Within* in 1935; *Sex and the Single Girl* (1964); 1983's *Zelig* (therapist Mia Farrow falls for patient Woody Allen); *The Man Who Loved Women* (Julie Andrews falls for Burt Reynolds).[11] Hollywood films, says Susan Fisher, professor of psychiatry at the University of Chicago, *"generally present psychiatrists as unable to completely stay within the boundaries of their roles . . . The problem of therapeutic sexual abuse is, in the Hollywood version, no problem at all."* In real life, the instances of sexual breach of conduct overwhelmingly involve male health professionals and female patients.

Television is no better. When, an American female teacher was convicted and sentenced to jail time for having had sex with one of her grade six (6) students, by whom she became pregnant, the *Saturday Night Live* "news anchor" reported the story and quipped: *"While authorities called her a child molester, her male students voted her the best darn teacher we ever had."* The audience laughed. Society just does not get it! Sexual abuse is not about sex. It is about abuse of power. The same "joke" would not have been made had the sexes of the teacher and the student been any other combination. And yet, the impact of that abuse will likely be just as devastating to that boy as it is to a young girl.

Effect of Abuse

Patients who sleep with their health professionals end up more emotionally scarred than when they began treatment. Sexually abused patients "look very much like incest survivors."[12] Many find it difficult to trust subsequent health professionals, and most blame themselves for the encounter. One U.S. survey found that 11% of patients who had sex with their therapists were hospitalized as a result; 14% attempted suicide and 1% succeeded. According to the author of that survey, "when a therapist engages in sex with a patient, he or she is engaging in a potentially homicidal activity, far more dangerous than getting into a car drunk and driving."[13]

A high percentage of patients who have sexual contact with their health professional are damaged. Injuries included sexual dysfunction, anxiety disorders, depression, increased risk of

[11]Gabbard, co-author of the 1987 book "Psychiatry and the Cinema," produces a long laundry list of examples

[12]Gartrell

[13]Pope

suicide and dissociative behaviour. Sometimes the damage is severe enough to require psychiatric hospitalization. Victims struggle with feelings of guilt, shame, anger, confusion and hatred, an inability to trust and a sense of their own worthlessness. The recognition of harm and the recovery process may take years. Despite the salience of this issue, however, the matter of prevention has been inadequately addressed.

The Response of our Courts

Our Courts have moved, in recent years, toward recognition of the realities of the power imbalance between health professionals and patients.[14] In *Norberg v. Wynrib; Women's Legal Education and Action Fund, Intervener,*[15] a physician prescribed a drug to a patient in exchange for sexual favours. The patient was addicted. Both the trial Court and the British Columbia Court of Appeal felt that while the physician had breached his duty, the action was to be dismissed as:

a. The plaintiff's addiction did not deprive her of her ability to reason and consequently her consent to the sexual acts was voluntary;

b. The patient had suffered no harm as a result of taking the drugs as she was already addicted; and

c. The plaintiff's action was based on her own illegal acts

The Supreme Court of Canada was unanimous in holding that in view of the inequality of power between the parties the plaintiff's dependence on the drug, and the exploitative nature of the relationship, her consent to the sexual acts was not voluntary. Accordingly, the defendant was liable for battery. La Forest J. wrote:

> *As R.F.V. Heuston and R.A. Buckley, eds. Salmond and Heuston on the Law of Torts, 19th ed. (London: Sweet & Maxwell, 1987), at pp. 564-5, put it: "A man cannot be said to be 'willing' unless he is in a position to choose freely; and freedom of choice predicates the absence from his mind of any feeling of constraint interfering with the freedom of his will." A "feeling of constraint" so as to "interfere with the freedom of a person's will" can arise in a number of situations not involving force, threats of force, fraud or incapacity. The concept of consent as it operates in tort law is based on a presumption of individual autonomy and free will. It is presumed that the individual has freedom to consent or not to consent. This presumption, however, is untenable in certain circumstances. A position of relative weakness can, in some circumstances, interfere with the freedom of a person's will. Our notion of consent must, therefore, be modified to appreciate the power relationship between the parties.*[16]

[14] See *W.(B). v. Mellor, 16 A.C.W.S. (3d) 260 sub nom. Weisenger v. Mellor*, B.C.S.C., July 18, 1989, unreported, and *Lyth* v. *Dagg* (1988), 46 C.C.L.T. 25, 10 A.C.W.S. (3d) 345 (B.C.S.C.)

[15] *supra*

[16] at p.457

> *. . . for consent to be genuine, it must be voluntary.*[17]
> *An inequality of bargaining power may arise in a number of ways . . .*
>
> *[A person] may be intellectually weaker by reason of a disease of the mind, economically weaker or simply situationally weaker because of temporary circumstances. Alternatively, the "weakness" may arise out of a special relationship in which trust and confidence has been reposed in the other party. The comparative weakness or special relationship is, in every case, a fact to be proven.*
>
> *As the last sentence of this passage suggests, the circumstances of each case must be examined to determine if there is an overwhelming imbalance of power in the relationship between the parties.*[18]
>
> *Lyth v. Dagg . . . involved a sexual relationship between a teacher and a 15-year-old student . . . Trainor J. . . . considered the following factors:*
>
> > *Sexual abuse is merely one particular way in which one person can assault another. It demands careful examination of the relationship between the parties to appreciate whether both had capacity to consent, understanding the nature and consequences of the conduct, and also* ***whether one of the parties had such a greater amount of power or control over the other as to be in a position to force compliance****. This is an examination to determine whether, in all the circumstances, force was applied by one person to another and whether any consent apparently given was genuine.*
> > *(Emphasis added).*
>
> *Trainor J. concluded that no genuine consent was given to the first sexual contact between the parties. The defendant "dominated and influenced" the plaintiff.*
>
> *The respondent contends that Lyth v. Dagg is distinguishable from the present case in that it involved the sexual exploitation of a child by a teacher. I do not agree. In my view, it was the ability of the defendant to "dominate and influence" the plaintiff that was the important element in the Lyth v. Dagg case.*[19]

In *T.C. v. Scott,*[20] an Ottawa woman who was sexually abused for years by her psychiatrist was awarded, with interest, more than $400,000.

The evidence revealed that the complainant suffered from depression. She had a very troubled relationship with her mother and father. She had been sexually abused by her maternal

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[17] at p.458
[18] at pp.459-460
[19] at pp.462-463
[20] [1977] O.J. No. 2389.

grandfather. She had been raped by a man she dated. The Defendant had known her since she was five or six years old. He was a friend of her parents, and had counselled the family.

When she was about 17, she was admitted to an institute controlled by the defendant for treatment of depression and stress, and was treated by Dr. Scott. There were several suicide attempts over the years. Electroshock therapy and drugs were among the treatments administered during the plaintiff's stays at the clinic.

She testified that the sexual exploitation began in March 1985, when she was an inpatient at the clinic. She was almost 26 at the time. She said the defendant kissed her on the forehead and went on to undo her blouse and kiss her breasts. Sometime later, he took her for a drive and initiated sexual intercourse. No conversation took place at either time; however, the doctor warned his patient not to tell anybody. She testified that she trusted the defendant implicitly, "like her father." She said she never initiated sex with the defendant. She said she needed someone to love her, and that she believed the defendant's statements that he cared for her.

In 1991, the plaintiff ended the relationship after realizing that the defendant was using her and had been lying to her for years. She has been unable to work since then and has been diagnosed with post-traumatic stress disorder, with many debilitating symptoms including headaches, anxiety, panic attacks, chronic pain and sleep disorder. Her future was uncertain.

The trial judge accepted that the sex was usually followed by therapy and that sometimes the sex occurred as soon as she arrived. At that time she advised she was taking medication, namely tranquilizers, librium and sleeping pills. She also acknowledged that the defendant Scott would give her samples of medication.

The Court awarded damages against the defendant for breach of fiduciary duty, breach of trust, sexual assault, aggravated damages for emotional distress and exploitative conduct and punitive damages for the defendant's "reprehensible conduct.

Former Patients

Are affairs with former patients more acceptable? Some health professionals think so, and even some ethics codes hint at some leeway, saying such relationships are "almost always unethical." But purists follow the maxim "once a patient, always a patient." Transference can linger for years after therapy has ended, and the anticipation of a later affair can subvert the therapeutic process. Certainly the majority view in the Supreme Court of Canada in *R. Audet*[21] is that it is up to the professional to establish that the dependency was over.

[21](1996), 175 N.B.R. 81

II. AN ACT RESPECTING HEALTH PROFESSIONALS[22]

The 1996 *Act Respecting Health Professionals*[23] brought into New Brunswick a new standard in the regulatory area regarding boundary violations. The Legislation applied to a number of the Colleges.[24] It was modelled on Ontario's legislation.[25]

The prohibitive behaviour applies to all the professional groups, regardless of their potential interaction with their patients or clients. Thus, "consensual" relationships between a patient and a physician, a nurse, or a dietician, a psychologist are all viewed in the same light. It appears not necessary to show the true nature of the relationship between the parties, insofar as issues of a power imbalance, etc.

The *New Brunswick Dental Hygienists Act* replicates these provisions. Without them, government would never have approved the legislation.

There are four major components to the sexual abuse amendments:
a. A definition of sexual abuse;
b. A requirement for each College to develop measures to prevent sexual abuse by its members;
c. Mandatory reporting of sexual abuse; and
d. Changes to the discipline system to more effectively and sensitively deal with sexual abuse allegations.

Definition of Sexual Abuse

The term "sexual abuse" is favoured over "sexual misconduct." This probably reflects:
a. A desire to convey that the conduct is a breach of trust and a breach of the health professional's fiduciary duty to a patient as well as ethically improper conduct[26]
b. That the scope of sexual abuse is intended to be broader than that of the old sexual impropriety. For example, there were some interpretations of "sexual impropriety" that suggested it did not include words alone[27]

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[22] Chapter 82, S.N.B. 1996

[23] May 1, 1997

[24] Pharmacists, Dispensing Opticians, Denturists, Dietitians, Social Workers, Dentists, Nurses, Medical Laboratory Technologists, Occupational Therapists, Optometrists, Psychologists, Podiatrists, Physiotherapists, Registered Nursing Assistants, Speech-language Pathologists, and Audiologists. The *Medical Act* also has similar provisions.

[25] *Regulated Health Professions Act*.

[26] *Norberg v. Wynrib*, [1992] 2 S.C.R. 224, *Report of the Task Force on Sexual Abuse of Patients* (1991: College of Physicians and Surgeons of Ontario, Toronto) Pp. 78.

[27] *Re College of Physicians and Surgeons of Ontario and Lambert* (1992), 11 O.R. (3d) 545 (Div. Ct.).

The definition is:

> ***36****(2) 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.*
>
> ***36****(3) For the purposes of subsection (2), "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.*

Under this definition, only a patient can be sexually abused. There will remain some difficulty in determining when the dental hygienist-patient relationship ended[28]. Where the dental hygienist-patient relationship has ended but the dental hygienist still has influence over the patient, the conduct may still be inappropriate under other definitions of misconduct. Similarly, sexual misconduct with people who have never been patients can also constitute other forms of professional misconduct.[29]

Dental hygienists who provide sufficient treatment to spouses or lovers to make them patients of the dental hygienist fall within the definition. Virtually any assessment or treatment of a person (except perhaps in an emergency) would make the person a patient of the dental hygienist. This may cause difficulties for dental hygienists in isolated communities where there are few or no options for treatment of the dental hygienist's spouse or lover.

The exception provision ensures that appropriate clinical procedures such as the taking of a sexual history do not constitute sexual abuse. The exception creates an objective test and can be established by expert evidence. However, "touching, behaviour, or remarks of a clinical nature appropriate to the service provided," may not clearly address services delivered in an appropriate manner, but which, in fact, are delivered for a sexual purpose. Thus, a breast examination may be performed ostensibly for a clinical reason, when, in fact, it was not medically necessary for that practitioner to perform such an examination.[30] Nevertheless, such deficiencies may still be addressed by "catch all" provisions against professional misconduct.[31] Conversely, any gratuitous sexual remark to a patient will constitute sexual abuse.

As the definition is contained in the *Act*, it cannot be amended by regulation like most other definitions of professional misconduct. The provision is substantive in nature and likely does not

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[28] *Re College of Physicians and Surgeons of Ontario and V* (1985), 51 O.R. (2d) 549 (Div.Ct.), *Hirt v. College of Physicians and Surgeons of British Columbia* (1986), 34 D.L.R. (4th) 331 (B.C.C.A.).

[29] *Re Cwinn and Law Society of Upper Canada* (198), 28 O.R. (2d) 61 (Div.Ct.), *Re Brand and College of Physicians and Surgeons of Saskatchewan* (1990), 72 D.L.R. (4th) 446 (Sask.C.A.).

[30] *R. V. Cameron*, (1995), 136 Nfld & PEIR 105 (PEICA). An internist performed repeated breast examinations on one patient with a bowel problem and another with headaches.

[31] *Hasan v. College of Physicians and Surgeons of New Brunswick* (1994), 152 NBR (2nd) 230 (C.A.).

apply to conduct occurring prior to proclamation[32]. For conduct occurring prior to proclamation of the *Act*, Colleges/Societies can attempt one or more of the following:

a. Prosecute under the definition of misconduct that existed at the time of the conduct, if any;

b. Prosecute the member for incompetence on the basis that the definition of incompetence does not punish for past misconduct but rather protects the public from future conduct of the member[33] ;

c. Prosecute the member for providing false information on his or her application for registration or renewal of registration forms, if applicable; or

d. Prosecute under the current definitions of sexual abuse on the basis that this is now permitted under the Supreme Court of Canada decision of *Brosseau*[34]

Measures to Prevent and Deal with Sexual Abuse

Colleges must develop a patient relations program which includes measures for preventing or dealing with sexual abuse of patients. The measures must include:

a. Educational requirements for members;
b. Guidelines for the conduct of members with their patients;
c. Provision of information to the public regarding guidelines; and
d. Informing the public as to the complaint procedures under the Act.[35]

The Department of Health's expectations for sexual abuse prevention plans could include:

a. A statement of philosophy to articulate the College/Society's position on sexual abuse;

b. An evaluation of present practices as they relate to sexual abuse, including a review of the complaints and discipline process to evaluate:

   i. How complaints are investigated,
   ii. Communication with complainants,
   iii. Practices during discipline hearings, and
   iv. Collection of data on the receipt of complaints, their types and their ultimate disposition in order to monitor trends and identify problems;

c. Establishing guidelines for professional behaviour and appropriate conduct with patients, covering issues such as:

   i. Who constitute patients or clients,
   ii. The special risks of members of the profession to engage in sexual abuse,
   iii. Maintaining appropriate boundaries,
   iv. What constitutes appropriate and inappropriate behaviour with patients,

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[32] *Re Royal Canadian Mounted Police Act, [1991] 1 F.C. 529 (Fed.C.A.), Edwards v. Ontario College of Certified Social Workers*, an unreported decision of the Ontario Divisional Court released May 25, 1993, *Re Tse and College of Physicians and Surgeons of Ontario* (1979), 23 O.R. (2d) 649 (Div. Ct.), *Re Tse and College of Physicians and Surgeons of Ontario* (1978), 18 O.R. (2d) 546 (Div. Ct.).

[33] *Re Royal Canadian Mounted Police Act*, [1991] 1 F.C. 529 (Fed.C.A.), *Brosseau v. Alberta Securities Commission*, [1989] 1 S.C.R. 301.

[34] *Brosseau v. Alberta Securities Commission*, [1989] 1 S.C.R. 301.

[35] *Dental Hygienists Act*, Section 65.

v. Initiating, maintaining and terminating personal relationships with patients, and
vi. Multicultural aspects of practise;

d. Developing professional education programs, including both continuing education of members and education of candidates for registration, to:
i. Induce an aura of risk as to the real and present danger of slipping into sexually abusive behaviour,
ii. Create an awareness of the consequences of sexually abusing patients,
iii. Sensitize members as to conduct that constitutes sexual abuse and its impact on patients,
iv. Increase knowledge of human sexuality, professional boundaries and appropriate health professional and patient relations,
v. Recognize subtle and indirect disclosure by patients of prior sexual abuse,
vi. Educate health professionals as to how to handle disclosure of prior sexual abuse and how to report it, and
vii. Educate health professionals as to the requirements of the *Act* including statutory definitions, mandatory reporting requirements and penalties;

e. Educating College staff and committee members who have contact with abused patients or investigate or hear allegations of sexual abuse, including:
i. Identifying staff and committee members who have direct contact with the public or abused patients,
ii. Sensitize them to issues of sexual abuse, and
iii. Develop appropriate communication skills;

f. Public education to:
i. Communicate the College's zero tolerance policy, and
ii. Increase public awareness of what constitutes sexual abuse and how to deal with it by an effective communication plan to the public that has contact with the profession; and

g. Reviewing the effect of the sexual abuse provisions and recommending changes, including amendments to the relevant regulations[36].

A report of the College's program must be submitted to the Minister within two years of proclamation of the *Act*, and within 30 days thereafter of a request by the Minister.[37]

Mandatory Reports

This is likely to be the most controversial aspect of the legislation. There are two types of mandatory reports created by the sexual abuse provisions:

a. The general sexual abuse reporting requirement[38]; and
b. Termination reports by those who terminate a relationship with a health professional.[39]

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[36]Presentation of Vahe Kehyayan, Coordinator, Health Professions, Professional Relations Branch, Ministry of Health on Sexual Abuse Prevention Plans to the Joint Meeting of Survivors of Sexual Abuse by Health Care Professionals, Advocates, Regulated Health Professions Governing Bodies and Professional Associations dated October 28, 1993.

[37]*Dental Hygienists Act*, Section 65(4)

[38]*Dental Hygienists Act*, Section 37

Different Types of Mandatory Reports:

Type of Report	Who Must Report	What Must Be Reported	Timing of Report
Sexual abuse – general	All health professionals	sexual abuse	within 21 days of acquiring reasonable grounds to believe the abuse occurred
termination reports	Certain professions who terminate, or intended to terminate, employment, revoke, suspend or impose restrictions on privileges or dissolve a partnership or association of or with a health professional. The amendments to the Psychologists Act does not have this provision.	professional misconduct, incompetence or incapacity	within 30 days of the end of the relationship

Health Professionals Defined

The definition of "health professional" is important:

> "health professional" means a person who provides a service related to
> (*a*) the preservation or improvement of the health of individuals, or
> (*b*) the diagnosis, treatment or care of individuals who are injured, sick, disabled or infirm, and who is regulated under a private Act of the Legislature with respect to the provision of the service and includes a social worker registered under the *New Brunswick Association of Social Workers Act, 1988*.[40]

Not dealt with are reports by health professionals providing therapy to another health professional who has sexually abused a patient.

In addition to the statutory mandatory reports, each College has the power to make regulations designating acts of professional misconduct that must be reported. However, such regulations would only apply to members of the College that passed the regulations and are not binding on members of other Colleges.

General Requirement to Report Sexual Abuse

The truly expansive aspect of this amendment is the requirement that such reporting obligations cross over into other professions. However, beyond that, there are certain aspects which narrow the provisions somewhat. The provision states:

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[39] *Dental Hygienists Act*, Section 38.

[40] *Dental Hygienists Act*, Section 2

> **37**(1) A member who, in the course of practicing the profession, has reasonable grounds to believe that another health professional has sexually abused a patient or client and who fails to file a report in writing in accordance with subsection (4) with the governing body of the health professional within 21 days after the circumstances occur that give rise to the reasonable grounds for the belief commits an act of professional misconduct.

The alleged abuse can only involve a patient or client. Furthermore, the obligation to report only arises where the information is obtained "in the course of practising the profession." Thus, information obtained from another source, however reliable, need not be reported.

The requirement to report sexual abuse applies to all health professionals. The following Checklist for Reporting Sexual Abuse will assist you in determining whether you have a legal obligation to make a mandatory report.

Checklist for Reporting Sexual Abuse

Under the *Act*, sexual abuse must be reported when the answers to all six of the following questions are "yes."

1. **Do you know the name of the alleged abuser?** A report does not have to be made if the reporter does not know the name of the alleged abuser[41]. It is not clear what the reporter's obligation is if the reporter does not know the name of the alleged abuser but likely could find out by, for example, checking the patient's hospital chart.

2. **Is the alleged abuser registered with one of the Colleges of a health profession?** The obligation exists even where the reporter is a member of a different profession from the alleged abuser.[42] If you are uncertain whether the person is registered with a College, you may call the Registrar of the College that regulates the person's health profession.

3. **Was the other person involved a patient of the alleged sexual abuser?** The purpose of the sexual abuse amendments was to deal with sexual abuse of patients and not to pry into the private activities of practitioners.

4. **Did the conduct involve one or more of the following?:**
- **(a) Sexual intercourse or other form of physical sexual relations;**
- **(b) Touching of a sexual nature; or**
- **(c) Behaviour or remarks of a sexual nature?**

[41] *Dental Hygienists Act*, Section 37(2).

[42] Dental Hygienists Act, Section 37(6).

The term "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. Appropriate sexual histories or physical examinations do not constitute sexual abuse.

5. **Was the information of the alleged sexual abuse obtained in the course of practising your profession?** A report must be made whenever the reporter obtains, in the course of practising the profession, reasonable grounds to believe that another health professional has sexually abused a patient.[43] The reporting requirement is not intended to cover information learned through your private life (e.g., at a cocktail party). However, the information may be obtained from any aspect of your professional practice including information from a patient, from your coworkers or staff or from personal observations made during the course of practising your profession (e.g., overheard conversations). The fact that other registered practitioners were present and may have reports on their own does ènot relieve you of your obligation to make your own report.

6. **Does your information constitute "reasonable grounds?"** This question sometimes involves a judgment call. Mere rumour or innuendo (e.g., when someone who barely knows X says "everyone knows that X sleeps with his patients" but can provide no particulars) does not constitute reasonable grounds. However, concrete information from a normally reliable source (e.g., a colleague reports to you that patient Y reported that practitioner X needlessly fondled Y's breasts) would normally constitute reasonable grounds even though you have not spoken to a direct participant to the incident.

Most reports to you from a patient of a specific incident constituting sexual abuse of that patient would constitute reasonable and probable grounds. Questions may arise regarding the threshold for reporting, the "reasonable grounds to believe." It would appear that if a patient's allegation is simply not objectively credible, there is no obligation to report. However, what if, on the other hand, a practitioner who hears such an allegation simply either does not believe, or claims not to believe it? One might contrast the language here with that of other statutes mandating analogous forms of reporting.[44]

One could also note the difficulty in pursuing such a failure to report as a disciplinary matter. A complaint could apparently only come from a complainant who had provided the information to a practitioner and then discovered later that a report had not been made.

Nevertheless, despite these shortcomings, it may well be that this provision has the most direct impact on health professionals. Early experience, in regards to reports about

[43] Dental Hygienists Act, Section 37(1)

[44] "...that reasonably ought to cause the professional person to suspect that a child has been abused..." *Family Services Act*, SNB, c.F-2.2, s.30(3).

"...that reasonably ought to cause the medical practitioner to suspect...", *Motor Vehicle Act*, S.N.B. c.M-17, s.309(1).

physicians, suggests an increased level of "empowerment" on the part of nurses, social workers, and others to bring these matters forward.[45]

Even where there is no obligation to make a mandatory report, Colleges may encourage voluntary reports (e.g., where the reporter can partially identify the sexual abuser).

If the information prompting the report from a health professional came from the reporter's patient, the reporter must attempt to advise the patient of his or her duty to make the report before filing it.[46]

A mandatory report must be made in writing to the Registrar of the College to which the alleged abuser is a member. The report must be filed within 21 days of obtaining the reasonable grounds.[47] The report must contain:

a. The name of the reporter;
b. The name of the alleged abuser;
c. The information the reporter has of the alleged abuse; and
d. The name of the patient, if known and if the patient consents in writing to the inclusion of his or her name in the report.[48]

The reporter can include the name of the alleged victim only if written consent of the patient is given. If the patient is incapable, the patient's representative (e.g., parent or guardian) may give the consent.[49] Presumably, the consent must be an informed consent, requiring the reporter to explain why the consent is sought and the likely results of giving the consent.

The reporter is given immunity from a civil lawsuit for making a mandatory report in good faith.[50] The maker of a voluntary report may also possess a similar immunity under case law[51]

Termination Reports

Termination reports are required by persons having some control over practitioners and who have access to information about the practitioner's practice. In particular, the following people must make termination reports:

a. A person who terminates the employment of a member;
b. A person who revokes, suspends or imposes restrictions on the privileges of a member;

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[45]There also remains some question regarding the retroactive application of this and other provisions. Is there an obligation to report now for behaviour, or even information, which arose prior to these provisions coming into force? *Brosseau v. Alberta Securities Commission* (1989), 93, NR 1 (S.C.C.).

[46]*Dental Hygienists Act*, Section 37(3)

[47]*Dental Hygienists Act*, Section 37(1)

[48]*Dental Hygienists Act*, Section 37(5)

[49]*Dental Hygienists Act*, Section 37(5)

[50]Dental Hygienists Act, Section 37(7)

[51]*Sussman v. Eales* (1985), 1 C.P.C. (2d) 14 (Ont.H.C.), *Carnahan v. Coates* (1990), 47 B.C.L.R. (2d) 127 (S.C.).

c. A person intending to do one of the acts described above but did not do so because the member resigned or voluntarily relinquished his or her privileges;[52] and
d. A person who dissolves a partnership or association with a member.[53]

The employment, privileges, partnership or association must, of course, be for the purpose of offering health services. Patients of the practitioner are exempted from making termination reports.[54]

A termination report must be made where the action or proposed action is made because of conduct of the practitioner that would amount to professional misconduct, incompetence or incapacity. The report must be made within thirty days of the triggering event.

The reporter is given immunity from a civil lawsuit or from retaliation in his or her employment for making a mandatory report in good faith. The maker of a voluntary report may also possess a similar immunity under case law[55].

Handling of Mandatory Reports by the College

Mandatory reports are not complaints[56]. Rather, they constitute information received by the Registrar. Where the identity of the patient is unknown, any action that would notify the alleged abuser of the report may place the patient at risk because the alleged abuser may be able to identify the patient from information contained in a report. The Registrar must maintain the report in confidence until further information arises. Some Colleges have approached the reporter after a period of time has passed and asked the reporter to approach the patient again to see whether he or she is now ready to come forward. Patients, who were reluctant to be identified, are sometimes willing to come forward if they learn there are others who are now making similar allegations.

Access to Decisions of the Discipline Committee

The public is to be given notice of any member whose license has been suspended or revoked.[57]

Reporting by the Licensing Authority

Within two months of the Society's year end, a formal report must go to the Minister of Health regarding complaints received during the calendar year respecting sexual abuse of patients by its members.[58] The report must disclose:

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[52] *Dental Hygienists Act*, Section 38(2).
[53] *Dental Hygienists Act*, Section 38(4).
[54] *Dental Hygienists Act*, Section 38(3).
[55] *Sussman v. Eales, supra.*
[56] 1986 Schwartz Review proposal section 28.01.
[57] *Dental Hygienists Act*, Sub-section 58(2).

a. The number of complaints received during the year;
b. For each complaint:
    i. The date it was received;
    ii. A description of the complaint in general non-identifying terms;
    iii. The decision of the Complaints Committee and the date of the decision;
    iv. If referred to the Discipline Committee, the decision of the Committee, including any penalty imposed, and the date of the decision;
    v. If appealed, the date and outcome of the appeal; and
c. With respect to complaints received in previous years, a report on the status of the complaints if the proceedings above were not completed in the year of the complaint.

III. COMMENT

The Ontario provisions go further in their response to problems of sexual abuse by mandating various financial schemes to provide supportive therapy to victims of sexual abuse by health professionals.[59] Also not dealt with in New Brunswick is the circumstance where sexual abuse is reported to a health professional who is providing therapy to an abusing practitioner.

It will take some time to see the impact of these changes on health professionals. Some licensing authorities will continue to have limited resources which may make implementation difficult. When a licensing authority fails to live up to its mandate to protect the public, and appears to be more responsive to its members than their patients, further scrutiny, and criticism will flow. Having the statutory tools does very little if there is not a willingness to use them.[60]

[58] *Dental Hygienists Act*, Sub-section 65(6).

[59] *Health Professions Procedural Code*, s.85.7.

[60] A recent case in Prince Edward Island is illustrative. A physician was convicted of sexual assault against three patients and incarcerated, (*R. v. Cameron* (1995), 136 Nfld & PEIR 105). His license was revoked by the College, (*Cameron v. College of Physicians and Surgeons of P.E.I.* (1996), 138 Nfld. & PEIR 89). However, a year later he was reinstated. The outcry resulted in a complete overhaul of the *Medical Act* there. (Bill 49, Legislature of Prince Edward Island, 1997).

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