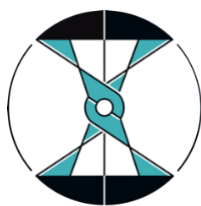


**Independent Review of
Sexual Misconduct Processes at the
College of Physicians and Surgeons of Nova Scotia**

*Prepared for the
College of Physicians and Surgeons of Nova Scotia
June 2019*



CCLISAR

Realizing law's potential to respond to sexualized violence

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Our work would not have been possible without the thoughtful and sincere contributions of patients who had participated as complainants in the College process, and physicians who shared their experiences of being respondents with us. We were also greatly assisted by contributions from the Canadian Medical Protective Association and Doctors Nova Scotia, as well as therapeutic counselling staff from the Avalon Centre.

A special thank you to each of the members of the Expert Advisory Group who donated a whole day of their time to workshop an early draft of the Panel's recommendations. Your valuable insight and contributions informed the final version of the recommendations and the content of this Report.

Littlest but not least, an honourable mention to baby H, who cheerfully attended many meetings and nursed her way through the drafting process.

HOW TO READ THIS REPORT

This report presents the background research, outcomes of stakeholder consultations and final recommendations of the Independent Review Panel, in three parts.

Part One outlines the terms of reference and some background information about the review process and College professional conduct context.

Part Two provides a narrative account of the background information and statutory framework considered by the Independent Review Panel, and the conclusions and recommendations of the Review in a contextualized narrative form.

Part Three sets out the detailed final recommendations of the Independent Review Panel.

PART ONE: BACKGROUND AND INTRODUCTION

Part One provides an overview of the Review terms of reference and process, and background information about the professional regulation of sexual misconduct by physicians in Nova Scotia. This Part is organized into the following sections:

- A. About the Review
- B. The Independent Review Panel
- C. The Review process
- D. What is a “trauma-informed” approach?
- E. Statutory framework and the increase in reports to the College
- F. Past complaints of sexual misconduct at the CPSNS

A. About the Review

The College of Physicians and Surgeons of Nova Scotia (the “College”) has identified “Sexual Boundary Complaints” as a theme for their 2018-2019 strategic plan, along with the objective to “serve the public with processes that are progressive, fair and sensitive to all involved”.

The College engaged the Canadian Centre for Legal Innovation in Sexual Assault Response to conduct an independent review of the College’s policies, practices, and procedures with in cases where a member of the College is alleged to have engaged in sexual misconduct (the “Review”).¹

The [Canadian Centre for Legal Innovation in Sexual Assault Response](#) (“CCLISAR”) is a non-profit, non-partisan organization that seeks to improve the impact of legal processes on the social problem of sexual harm and the experiences of survivors of sexualized violence. CCLISAR’s activities focus on knowledge growth, capacity building and public awareness.

In particular, the Review was mandated to offer recommendations for changes to the College’s professional conduct approach in sexual misconduct cases in order to ensure that they are:

- Responsive to those who report experiences of sexual harm;
- Trauma-informed; and
- Procedurally fair.

The College’s motivation for engaging the Review was to:

- Improve current practices to reduce harm to all parties;
- Reduce barriers to reporting; and
- Increase confidence in the College’s response to sexual misconduct allegations; and
- Inform a substantive review of the College professional standard on sexual misconduct.

¹ Terms of Reference, see [Appendix A](#).

B. The Independent Review Panel

The Independent Review Panel (the “Panel”) was composed of three individuals with relevant experience in legal practice and research involving health systems, sexual assault and professional discipline. The Panel members are:

Nasha Nijhawan, Chair

Nasha has a diverse litigation practice in Halifax, Nova Scotia as a partner at [Nijhawan McMillan Petrunia Barristers](#). Her work includes professional regulation, civil litigation and administrative law. She has experience acting on behalf of sexual assault survivors and advocacy groups, in both civil and criminal contexts. Nasha is a committed equality advocate, with an active *pro bono* practice. In addition to chairing the Panel, Nasha is the primary author of this Report.

Jocelyn Downie

[Jocelyn](#) holds the James S. Palmer Chair in Public Policy and Law at the Schulich School of Law at Dalhousie University. Her research and advocacy work focus on issues at the intersection of health, law, and ethics. Jocelyn is a member of the Board of CCLISAR.

Elaine Craig

[Elaine](#) is an Associate Professor of Law at the Schulich School of Law at Dalhousie University. She has researched and published extensively on sexual assault law in Canada. Elaine is the author of *Putting Trials on Trial: Sexual Assault and the Failure of the Legal Profession* (2018 McGill-Queens) and *Troubling Sex: Towards a Legal Theory of Sexual Integrity* (2012, UBC Press). She has testified before Senate and House of Commons Standing Committees on proposed law reforms to the criminal law of sexual offences and is a regular public commentator on legal responses to sexualized violence. Elaine is the Research Director of CCLISAR.

C. The Review process

The Review was designed as an interactive and consultative process, involving College staff, physicians and patients with direct experience with the College's sexual misconduct process. In accordance with its Terms of Reference, the Review undertook four stages as described below, with the delivery of this report as the final stage.

Stage 1: Document review

In the first stage of this Review, the College provided the Panel with access to all of its internal policy documents and public materials about its professional conduct process. The Panel also received redacted copies of past decisions of the Investigation Panel. One patient complainant permitted the Panel to review her whole "file", providing a snapshot of the way a complaint of sexual misconduct is handled and documented by the College.

The Panel also reviewed jurisprudence and secondary sources relevant to sexual misconduct and administrative disciplinary regimes in the health care context, as well as the statutory frameworks, public materials and reports on past reviews on the treatment of sexual misconduct in the health regulatory context from other provinces.

Stage 2: In-person consultations with relevant stakeholders

Over the course of several weeks, the Panel met with individuals and representatives of groups who have experience with the College professional conduct process, including:

- College staff;
- College legal counsel;
- College Expedited investigation committee members;
- College hearing committee Chair;
- CMPA local and national counsel and representatives;
- Doctors Nova Scotia representatives;
- Therapeutic counsellors who work with sexual assault survivors;
- Patients and health care professionals who had been complainants in sexual misconduct cases; and
- Physicians who had been respondents in sexual misconduct cases.

Invitations to participate were sent by the College to past complainants and respondent physicians.

The majority of participants in the consultation process met with the Panel in person or by telephone. Some participants supplemented their meetings with written correspondence. All

participants in the consultation process were promised that their comments would remain unattributed in this report, and that their identities would be kept confidential by the Panel.

The College offered the Panel unrestricted access to their materials and staff members, within the limits of their confidentiality obligations. The Panel found College staff to be open and candid, with a clear commitment to improving their processes to improve outcomes and reduce harm to all parties. This cooperation from the College and the participation of outside stakeholders, greatly facilitated the Panel's work.

Stage 3: Consultation with an Expert Advisory Group,

The Panel is grateful to an Expert Advisory Group who generously offered a day of their time to offer feedback on the draft recommendations of the Panel.

The members were selected by the College and CCLISAR, and included:

- College professional conduct staff and legal counsel;
- CMPA legal counsel;
- Academic experts on administrative processes responding to sexual assault allegations and trauma-informed interview practices; and
- A local physician with bioethics training.

The Panel incorporated the feedback from the Expert Advisory Group in revisions to its final recommendations to the College, and used it to inform its final report.

Stage 4: Final report including recommendations

This Report represents the final stage of the Panel's work.

D. What is a “trauma-informed” approach?

The Panel has adopted the following definition of “trauma” in its Review:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional or spiritual well-being.²

An experience of sexual misconduct by a physician can be traumatic. The Panel also approached the Review with the understanding that in some cases a complainant in the College sexual misconduct process may have experienced trauma prior to the physician interaction which led to their complaint, and that a history of trauma may have impacted their experience of an interaction with a physician.

As part of its Review, the Panel applied the following understanding of a “trauma-informed” approach to addressing a complaint of sexual misconduct. A trauma-informed approach:

1. Acknowledges that exposure to trauma has an impact on an individual’s behaviours and increases their risk of negative health outcomes;
2. Is capable of recognizing the signs and symptoms of trauma;
3. Adapts policies and procedures to avoid causing re-traumatization by providing a safe environment and promoting choice and collaboration; and
4. Supports coping and resilience.³

The Panel advocates for the use of universal trauma protections in all of the work of the College, not just in response to complaints of sexual misconduct. It should not be necessary for someone to disclose trauma to receive a trauma-informed response.

² Substance Abuse and Mental Health Services Administration, “[SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach](#)”, July 2014, p 11.

³ Adapted from BC Provincial Mental Health and Substance Use Planning Council, “[Trauma-Informed Practice Guide](#)”, May 2013.

E. Statutory framework and the increase in reports to the College

The College regulates 2,628 physicians in Nova Scotia, who together serve a population of approximately 950,000 patients in the province.

The College is governed by the Medical Act (the “Act”) and Medical Practitioners Regulations (the “Regulations”), which set out the College’s professional conduct process.

The Act identifies the purpose and duties of the College, which are primarily to “serve and protect the public interest in the practice of medicine” and secondarily to “preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine” (s. 5(a),(b)). In order to do so, the College is empowered and required to (among other things) establish and promote standards for the practice of medicine (s. 5(c)(iii)).

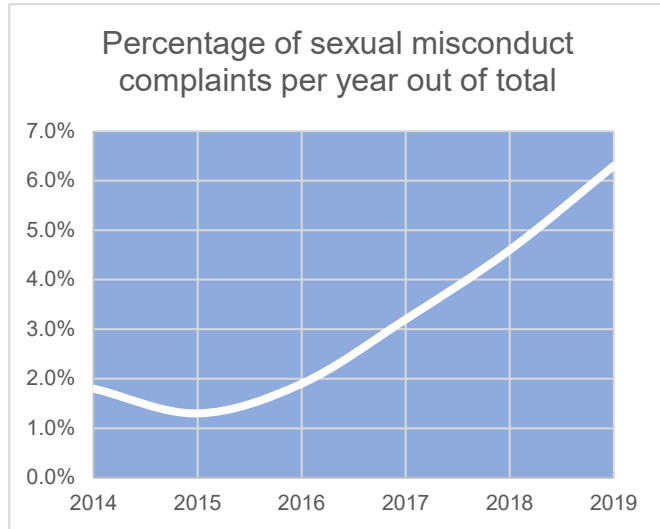
The College is empowered to address “the disciplinary matters of professional misconduct, conduct unbecoming and incompetence” in its professional conduct process (Act, s. 30). The Act defines each of these terms as follows:

- Professional misconduct is “disgraceful, dishonourable or unprofessional” conduct which “may include” a breach of the CMA Code of Ethics, the “accepted standards of the practice of medicine” and “policies approved by Council” (s. 2(aj));
- Conduct unbecoming is “conduct outside the practice of medicine that tends to bring discredit upon the medical profession” (s. 2(f));
- Incompetence is “the lack of competence in the respondent’s care of an individual or delivery of medical services that, having regard to all the circumstances, rendered the respondent unsafe to practice at the time of such care of the individual or delivery of medical services or that renders the respondent unsafe to practice without remedial assistance” (s. 2(r));
- Competence is “the ability to integrate and apply the knowledge, skills, attitude and judgment required to practice safely, ethically and professionally in a designated role and practice setting” (s. 2(d)).

Allegations of sexual misconduct have been considered to be allegations of “professional misconduct” under the Act.

The College reports a steady increase in the number of complaints of alleged sexual misconduct received over the past two years, both as an absolute number and as a percentage of the total number of complaints received.

This increase may be in response to changes in societal norms about reporting incidents of sexual misconduct or increased public awareness and dialogue focused on issues of sexualized violence.



Year	Total complaints	Sexual misconduct complaints	Percentage of the total
2014	219	4	1.8%
2015	236	3	1.3%
2016	205	4	1.9%
2017	220	7	3.2%
2018	259	12	4.6%
2019 to date (5 months)	111	7	6.3%

However, the Panel accepts that reporting rates of sexual misconduct are likely still low relative to complaints about other issues, which is consistent with the under-reporting of sexual misconduct in other legal processes.⁴

⁴ <https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/14842-eng.htm>

F. Past complaints of sexual misconduct at the CPSNS

As part of the Review, the College provided the Panel with redacted copies of 17 decisions issued by the Registrar, investigation committee or hearing committee arising from allegations of sexual misconduct which were received and resolved since 2015. The final outcome of these decisions is set out in the table below.

Decision made by	Outcome	Number of complaints
Registrar	Dismissed	2
	Withdrawn	1
Investigation committee	Dismissed	3
	Dismissed with advice	5
	Informally resolved	1
	Caution issued	2
	Retirement after referral to hearing	1
Hearing committee	Settlement	1
	Finding after hearing	1

The Panel understands that there are currently 13 open complaints of sexual misconduct, filed since 2017, and one complaint was resolved during the final stages of the Review. Information from these cases (nature of allegation or outcome) was not included in materials reviewed by the Panel. The Panel notes, therefore, that the table above does not provide an accurate representation of complaint outcomes since 2015 on the whole. These cases were reviewed by the Panel for illustrative purposes only, and to demonstrate the range of actual outcomes under the current regime.

Of the 17 complaints reviewed by the Panel, four involved allegations of inappropriate comments and 12 alleged sexual touching during a sensitive clinical exam. One additional complaint involved allegations against a physician of sexual harassment and inappropriate touching of other hospital colleagues (not patients).⁵ None of these complaints involved a sexual relationship between a patient and physician.

In addition to the decisions provided by the College in the above-noted date range, there are twelve earlier published decisions of a hearing committee involving a finding of sexual misconduct by a physician, between 1995-2015. For this earlier period, the Panel did not review decisions that were not made public. In other words, the Panel did not review any complaints that were not referred to

⁵ [Re Ezema](#), 2018 CanLII 105365 (NS CPS).

a hearing because they were resolved by the Registrar or an investigation committee. Of these 12 complaints resolved at the hearing committee level:

- One dealt only with applying a sanction for sexual misconduct imposed by another provincial medical college to the physician's Nova Scotia license;⁶
- Two involved a matter also the subject of criminal charges, one of which was not defended before the College;⁷
- Six resolved by settlement agreements or consent to sanctions at the hearing committee;⁸ and
- Three involved a contested hearing (one on sanction only, and two on both misconduct and sanction).⁹

Of the 12 earlier decisions of the hearing committee from 1995-2015 reported publicly, eight related to an inappropriate sexual relationship between a physician and a patient (nearly all of whom were receiving psychotherapy or psychiatric treatment from the respondent physician), and four involved inappropriate sexualized behaviour or touching as part of clinical examinations.

The issues raised in these past decisions of the investigation and hearing committees informed the conclusions of the Panel, and they are discussed in detail in Part Two of this Report.

⁶ [Wozniak \(Re\)](#), 2007 CanLII 82544 (NS CPS)

⁷ [Christie \(Re\)](#), 2001 CanLII 38371 (NS CPS) was not contested; [Ezema \(Re\)](#), *supra*.

⁸ [Wadden \(Re\)](#), 2015 CanLII 105093 (NS CPS); [Oluwole \(Re\)](#), 2012 CanLII 97114 (NS CPS); [Wisniowski \(Re\)](#), 2006 CanLII 81544 (NS CPS); [Sheehy \(Re\)](#), 2006 CanLII 81546 (NS CPS); [Blair \(Re\)](#), 2000 CanLII 28923 (NS CPS); [MacDonald \(Re\)](#), 2000 CanLII 28924 (NS CPS); [Seaman \(Re\)](#), 1996 CanLII 11610 (NS CPS).

⁹ [Dhawan \(Re\)](#), 1997 CanLII 16148 (NS CPS), [Hingley \(Re\)](#), 1999 CanLII 19873 (NS CPS).

PART TWO: OUTCOME OF REVIEW AND CONSULTATIONS

In Part Two of the Report, the Panel outlines the information that emerged from the documentary review and consultation stages of the Review process, and the issues and recommendations identified by the Panel in a contextualized narrative format. This Part does not include the most detailed version of the Panel's recommendations, which follow in Part Three.

This Part is organized into sections that correspond with different stages in the professional discipline process, under the following headings:

Themes emerging from stakeholder consultations with the Panel

The overall themes and perspectives that dominated the Panel's discussions with various stakeholders are included in this section in an effort to provide a richer contextual understanding of the concerns that motivated each group in their feedback. To the extent that the individuals or representatives that the Panel heard from offered specific critiques or suggestions in respect of the College professional conduct process, we have incorporated them into the discussion below.

Patients and patient advocates or supports

Patients and professionals who have worked with sexual assault survivors expressed the view that the professional conduct process must acknowledge and address the significant structural barriers that exist for patients who have experienced sexual misconduct by a physician. These included the significant power imbalance between physicians and their patients, and the manner in which the scarcity of physician access can exacerbate this imbalance in Nova Scotian communities. Patients also expressed apprehension that physicians would use their own health histories (including any history of mental illness) against them, as a means of discrediting a complaint of sexual misconduct.

Patients expressed a need for better communication from the College through the complaints process, and for access to better supports. Patients also expressed a wish to be able to provide input on the potential outcomes of the professional conduct process.

There remains a lack of trust in the College process, and in particular in the likelihood that a complaint will result in a finding of misconduct or in the discipline of a physician. Patient advocates told the Panel that they have heard from patients who do not report because they fear that they will not be believed by the College.

Where patients have experienced sexual harm in their interaction with a physician, the Panel heard they are often motivated to complain in order to protect other patients from similar encounters. In that context, interim restrictions are an important issue, and restrictions that permit physicians to continue to see vulnerable patients do not always seem sufficient from the patient's perspective.

Physicians and physician advocates or supports

Physicians and physician advocates emphasized the devastating personal and professional impact of an allegation of sexual misconduct on a respondent physician, particularly in cases where allegations are ultimately found to be unsubstantiated.

The Panel heard from physicians and their advocates that the College is seen to “assume guilt” instead of “presume innocence” when faced with an allegation of sexual misconduct, and that the onus is on the physician to disprove the complaint. In considering any adaptations to the investigation or hearing protocols in the College’s professional conduct process, the physician perspective acknowledged the need to minimize harm to complainants while expressing concerns about maintaining procedural fairness for respondents throughout the process.

College staff, committee members and the Registrar

It was clear from the Panel’s many consultations with College staff, committee members and the Registrar that the organization is deeply committed to improving their professional conduct process to minimize harm to complainants and to be fair to physician respondents.

College participants recognized the structural barriers inherent in sexual misconduct complaints, including power dynamics between physicians and patients and the scarcity of physicians in many communities. They appear to strive to take special care with complaints of sexual misconduct, in recognition of the particular impact these cases have on both parties.

However, College participants candidly acknowledged their limited training and experience with the unique challenges posed by a complaint of sexual misconduct. In particular, College staff and committee members indicated that they had not received adequate training in order to make them feel comfortable dealing with the issues that arose in sexual misconduct complaints that came before them.

A. Statutory framework and the standard of professional conduct at CPSNS

1. Background and statutory framework

The College has published a document entitled “Professional Standards and Guidelines Regarding Sexual Misconduct in the Physician-Patient Relationship” (the “Standard”). The Standard appears to have been first drafted in September 2000, and was most recently approved by Council of the College in December 2016.¹⁰ An ongoing revision of the Standard by the College was put on hold pending receipt of this Report.

The current Standard is made publicly available on the College website, along with other College publications on clinical standards of practice in the “Standards and Guidelines” section, under the heading “Physician-Patient Relationship”. There is no link directly to the Standard in the College website section on Complaints and Investigations.

The Standard is divided into three sections.

- The Preamble identifies “principles which form the basis” of the Standard;
- Standards identify the following two requirements for “minimum professional and ethical behaviour”:
 - “Physicians must respect professional boundaries in their relationship with patients and must not sexually interact with their patients nor exploit them in any way”; and
 - Physicians who have “reasonable grounds to believe a physician may be guilty of sexual misconduct with a patient” have a duty to report to the College and take specific steps; and
- Guidelines which set out examples of sexual misconduct and precautions to be taken in practice, but are framed as “recommendations endorsed by the College” which it “encourages members to be familiar with and to follow...whenever possible and appropriate”.

The Registrar is empowered by s. 68(7) of the Act to file a complaint against a member if they receive information based on a mandatory report, and can otherwise initiate a complaint on information received from any source.

2. Issues and recommendations

Prohibited sexual misconduct

¹⁰ See [Appendix B](#)

This Review was not mandated to propose specific substantive revisions to the professional standard on sexual misconduct or to the potential disciplinary outcomes in such cases. However, we have identified gaps in the current College process and made some recommendations for consideration by the College in their ongoing review of the substantive standard in sexual misconduct cases.

In the Panel's view, the current Standard does not adequately define or proscribe the range of sexual misconduct violations that fall under the jurisdiction of the College. The Panel recognizes the need for a substantial revision of the Standard, in order to make it useful for (a) patients, to understand the boundaries of appropriate physician conduct; (b) physicians, to have clear direction on sexual boundaries; and (c) investigation and hearing committees, to recognize professional conduct issues that warrant discipline. Accordingly, [the Panel recommends that the College proceed with its plan to revise the existing Standard.](#)

The Panel recommends that **the Standard be renamed** to reflect the prohibition on sexual contact by a physician with a patient using a more plain-language description, i.e. from "Professional Standards and Guidelines Regarding Sexual Misconduct in the Physician-Patient Relationship" to "Sexual Misconduct by Physicians".

The Panel also recommends that the distinction between a "Standard" and a "Guideline" be removed from this policy, so that is clear what the enforceable expectations of the College are with respect to sexual misconduct. The limited usefulness of the current Standard is apparent from the fact that it has never been applied by a hearing committee of the College. None of the investigation committee decisions supplied by the College for review by the Panel included any reference to the Standard in its consideration of an allegation of sexual misconduct.

In *Re Oluwole*, the Standard was found not to apply because it (a) post-dated the alleged misconduct;¹¹ and (b) the committee treated it "simply as an item of evidence, and not as, in effect, a legislated code of conduct". In any event, the "guidelines" section of the Standard was described as a "spectrum" of sexual misconduct, with an escalating scale of severity from voyeurism to sexual acts between a physician and a patient. The committee offered the following comment on the Standard:

...the document's status, as a guideline, or something more, is, in the judgment of the Committee, somewhat unclear. The College states on the first page of the document that "guidelines" are simply recommendations, while compliance with "policies" is mandatory. The front page clearly identifies the document as a "guideline," but page 4 (relied on by Counsel for the College) is entitled "Policy on Sexual Misconduct in the Physician-Patient Relationship" (emphasis added). As the present proceeding involves an agreed disposition

¹¹ *Oluwole (Re)*, supra, para 25.

by the College and the physician, the Committee sees no difficulty arising from any uncertainty as to the actual, or intended, significance of the document (i.e., as a guideline or policy), and the Committee makes no further comment upon it.¹²

Further, in the decision in *Re Wadden*, in which a settlement agreement was approved by a hearing committee after the physician admitted that he “violated the personal physical boundary and the professional boundary between him and a female patient” by conducting an “inappropriate pelvic examination”, no mention of the Standard is made. In fact, the words “sexual boundary” or “sexual misconduct” do not appear in the decision at all.

The Panel recommends that the Standard should specify a non-exhaustive list of the acts or behaviours which constitute disciplinable sexual misconduct, rather than characterize them as “guidelines” which are only “recommendations endorsed by the College” which it “encourages members to be familiar with and to follow...whenever possible and appropriate”. In doing so, the Panel recommends that the College identify and distinguish between different types of sexual misconduct within clinical practice that constitute professional misconduct (for example, sexualized comments, sexual assault, sexual harassment, unnecessary sensitive exams, etc).

The Panel heard from physicians and their advocates that the characterization of an allegation as sexual misconduct or as a sexual boundary violation invites enormous stigma and has a damaging psychological effect on the respondent physician. At the same time, the Panel has noted that experiences of sexual harm to patients is often characterized in the professional conduct process as simply “inappropriate” physician behaviour or a failure to properly communicate (even when a complaint is substantiated)¹³, and it is our view that it is important for deterrence, the affirmation of patients’ experiences, and to encourage reporting that sexual misconduct be named as such when it occurs. The Panel’s recommendation that **a revised Standard for sexual misconduct identify and distinguish between proscribed acts** is aimed in part at avoiding painting all respondents with the same brush.

The College’s existing approach to addressing sexual misconduct appears to view such behaviour only through the lens of “professional misconduct” under the Act. However, the Panel noted a high incidence of complaints that arise from clinical exams that are experienced by patients as sexually inappropriate but described by physicians as strictly clinically indicated. The Panel concludes that there is a gap in physician competence to provide care that is safe to all patients, particularly with respect to sensitive exams. **Accordingly, the Panel recommends that the College consider explicitly incorporating the concept of competence into the Standard on sexual misconduct, by**

¹² *Ibid* at para 26.

¹³ See for example *Wadden (Re)*, *supra*.

identifying competence issues in respect of communication or clinical exams that may give rise to a complaint of sexual misconduct and/or cause sexual harm to a patient.

Finally, in *Re Ezema*, the hearing committee considered allegations of sexual harassment and sexual assault by a physician with respect to three female colleagues in a hospital setting. The Standard was not considered because it did not apply outside of the physician-patient relationship. Instead, the committee had regard to the Professional Standard Regarding Disruptive Behaviour by Physicians, and the prohibition against sexual harassment in the workplace contained in the *Nova Scotia Human Rights Act*.¹⁴ **The Panel recommends that the College consider explicitly incorporating the concept of “conduct unbecoming” into the Standard on sexual misconduct, as it relates to sexual harassment or sexual misconduct outside of a clinical setting but where there is a sufficient nexus to clinical practice.**

The duty to report

Anecdotal evidence heard by the Panel suggests that physicians may not be complying with their duty to report sexual misconduct, which contributes to underreporting and a lack of confidence in the College’s role in responding to allegations of sexual misconduct by physicians. This may be, in part, due to confusion on the part of members regarding the content of the Standard. The Panel also heard that physicians are reluctant to exercise their own judgment as to what constitutes “reasonable grounds to believe a physician may be guilty of sexual misconduct with a patient”, which appears to be a higher standard than other statutory reporting obligations they regularly engage with (i.e. under s. 24 of the *Child and Family Services Act*, the obligation is “reasonable grounds to suspect”).

Accordingly, the Panel recommends that the College take steps to encourage the reporting of any suspicion of sexual misconduct by a physician, including by **changing the reporting obligation in the Standard to “reasonable grounds to suspect”**, and conducting educational outreach about this obligation once the new Standard is in place.

¹⁴ *Re Ezema*, supra, para 31.

B. Training of College staff and committee members

1. Background

Hearing and investigation committee members and College professional conduct staff have received limited training in relation to the unique challenges raised by sexual misconduct complaints, and have not been trained in substantive issues in sexual assault law or how to implement trauma-informed approaches to their work.

2. Issues and recommendations

In order for the College to be able to implement universal trauma precautions in its work, staff must be capable of recognizing the signs and symptoms of trauma, and to identify where trauma may be impacting the behaviours of an individual. Staff should be taught how to adapt the services they provide to the public in a way that is “receptive and supportive of people who have been overwhelmed, are fearful, and have difficulty trusting and self-regulating”.¹⁵

Sexual misconduct allegations are challenging to investigate and adjudicate, and often turn on credibility findings. Myths and stereotypes about women and sexual assault pervade the reasoning of even well-meaning individuals, and can manifest as unconscious bias during the discipline process.

The Panel recommends that the College [require that all College staff, investigators, investigation committee members and hearing committee members who are involved in sexual misconduct complaints receive further training](#) in substantive issues in sexual assault law and to equip them to incorporate universal trauma protections in the College professional conduct process.

In particular, the Panel recommends that **College staff who may be involved in the intake or case-management of sexual misconduct complaints receive training** on:

- Implementing trauma-informed processes;
- Supports or accommodations available to complainants in sexual misconduct cases; and
- Confidentiality requirements for complainants and respondents.

Members of the Expedited investigation committee and any investigators they may engage, and hearing committee members should be trained on:

¹⁵ Nova Scotia Health Authority and IWK Health Centre, “[Trauma-informed approaches](#)” Discussion Guide #1, p 5.

- The neuro-biology of trauma (including the impact of sexual trauma on memory);
- Trauma-informed interview techniques;
- Legal concepts of consent, including the criminal law definition;
- The relationship between gender and race-based myths and stereotypes, implicit bias, and the incidence of sexual assault and sexual harassment; and
- The adverse impact of empirically unfounded and discriminatory myths and stereotypes on fact finding processes in cases involving allegations of sexual misconduct.

Members of the hearing committee should receive further training on the unique evidentiary issues that arise in sexual misconduct cases, including records requests and the relevance standard for admissibility of evidence about the complainant

The Panel recommends that the **College engage subject-matter experts in these areas to conduct the training, and that this training be updated and refreshed every two years.**

No staff or committee member who has not completed this training should be assigned to a sexual misconduct case. A staff member of the College should **maintain records regarding training and ensure that the required training has been completed and updated.**

C. The complaint intake process

a) Background and statutory framework

A complaint may be initiated by any person, or by the Registrar or a committee of the College (Act, s. 36(1)). There is no limitation period or deadline to file a complaint.

General information about the complaints process on the College website is found under the heading “Complaints and Investigations”.

Since January 2019, the College has hired a part-time Public Support Advisor (with a background in social work) to assist complainants in navigating the complaints process and act as a single point of contact on behalf of the College. Any identified complaints of sexual misconduct are now sent to the Public Support Advisor to manage.

It is important to note that an oral disclosure to the College does not constitute a formal complaint, though it may trigger a complaint by the Registrar if sufficient identifying information is provided. A person wishing to file a complaint must do so in writing (this is required by s. 2(e) of the Act), but is not required to use the specific form provided by the College (the website is somewhat confusing on this point). The College will accept any clearly hand-written or typed and signed complaint in paper, but the College requires that all complaints contain:

- Complainant contact information.
- Patient information including date of birth.
- The physician’s name.
- A description of the events that led to the complaint (such as the date and location) and any other information that may help the College in its investigation.
- If possible, complaints should also contain the names of people who witnessed the event or who have other useful information.

The complaint form is available on the College website,¹⁶ and is currently under review by the College. The complaint form includes the question, “Have you brought your concerns to this doctor’s attention?” and a request to, “Provide the full name of any other individual(s) and the details of the information they may have pertaining to your complaint (e.g. other doctor, therapist, chiropractor)”.

¹⁶ See [Appendix C](#).

More information about the complaints process is available on a “Frequently Asked Questions” page on the College’s website.¹⁷ The College offers the following answer to the question, “What should I do if I believe that a physician has engaged in sexual misconduct?”:

People who suspect sexual misconduct by a physician are encouraged to contact the College. The following are examples of sexual misconduct by a physician:

- Sexual contact between a physician and a patient.
- Unnecessary viewing of all or part of a patient’s body by a physician, which may happen if the patient is not permitted to undress in privacy or if the patient is not properly covered when being examined or treated.
- Inappropriate comments about a patient’s sexual orientation by a physician.
- Sexualized comments by a physician, including inappropriate remarks about a patient’s body or clothing.
- Inappropriate and unnecessary requests by a physician for details of a patient’s sexual history.
- Failure by a physician to get permission from a patient before examining private areas of a patient’s body.
- Inappropriate examination of a patient by a physician especially when it involves the breasts, genitals or anus.
- Inappropriate body contact between a physician and a patient, including kissing and hugging of a sexual nature.

These items listed as examples of “sexual misconduct” do not include all of the acts listed in the guidelines section of the Standard, and there are some differences in the language used for the same concepts between the two documents. The Standard is not referenced in the FAQ answer.

¹⁷ See [Appendix D](#).

b) Issues and recommendations

General information about the complaints process

A trauma-informed process is supported by making clear and accessible information about all aspects of a process available to complainants, so that they can make choices about how they would like to engage with the College, before filing a complaint.

The Panel is concerned that the public information available from the College about making a complaint about a physician is not sufficiently accessible to the public in Nova Scotia, with attention to language, literacy and physical barriers. No plain language information is available for complainants which explains the possible procedural and substantive outcomes of the process, supports available from the College, or their rights and any accommodations that might be available to them during the investigation and hearing process.

In addition to these issues, the Panel heard anecdotal evidence from some individuals that the public does not understand well the role of the College in the discipline process, or the purpose of filing a complaint.

Accordingly, the Panel recommends that the College [review their public information materials and revise them to offer a more plain-language explanation of the College's role and the steps of the complaints process, ensuring that they are accessible.](#) Consulting with an **expert in plain language writing**, and **including information in audio/video format** would facilitate the adoption of this recommendation.

The College advised us that they have never received a complaint requiring language interpretation. The Panel is concerned that this is because information about the complaints process is only available in English on the College website, and individuals with other first languages have been deterred from accessing the College. Accordingly, the Panel recommends that **interpretation services be offered by the College, and that the availability of this service be included as part of the information publicly available about the complaints process.**

Filing a complaint about physician sexual misconduct

An individual who wishes to make a complaint about sexual misconduct by a physician must navigate the College's website information about "Standards and Guidelines" and "Complaints and Investigations" in order to determine (a) whether the conduct they are concerned about is prohibited by the College and (b) what will happen if they make a complaint. There is no specialized information (other than the FAQ answer set out above) addressed to complainants who have experienced sexual misconduct.

The Panel is concerned that complainants who have experienced a sexual assault or sexual boundary violation may not feel confident that the process for other types of complaints will be appropriate for their issue. In addition, the public materials relating to the professional conduct process have not been drafted with a trauma-informed approach in mind. Accordingly, [the Panel recommends that the complaint intake process be streamlined and adapted to be more accessible and appropriate to complainants in sexual misconduct cases.](#)

For example, the website recommends that for information regarding filing a complaint, a person can contact the College's Professional Conduct Department by telephone. However, the telephone number provided leads to the general inquiry line and general line voicemail after hours (which are Monday to Friday, 8 am to 4 pm). Based on the volume of calls to be returned and the schedule of the Public Support Advisor, the Panel heard that it is unlikely that a complainant who phones this line will be immediately able to speak to someone. Patient advocates pointed out during the Review that a patient who finds it difficult to contact the College in the first place is unlikely to leave a voicemail, and may not call back. The Panel recommends that the **College offer a separate phone number and voicemail box for complainants who identify that they have a sexual misconduct complaint.**

The College requires a complainant to submit a written complaint by regular mail or fax. In response to a telephone inquiry, a patient will be mailed a complaint form along with a letter which advises them to seek the assistance of third party if they require help filling out the form. The College's website in one place "recommends that complaints not be submitted by email due to the personal nature of the information collected" and in another place states that "complaints cannot be submitted by email". In practice, the Panel was told that current College policy requires staff in the Professional Conduct Department to correspond with complainants in writing only by fax or regular mail. At the time of the Review, the College indicated that it was developing a secure online submission form for complaints on its website.

The Panel is concerned that requiring paper complaints creates a barrier to individuals who are more accustomed to communicating electronically, and/or those who may not have easy access to a

printer or fax machine. The Panel recommends that the **College proceed with its plan to accept written complaints by email or through a secure web-based form.**

The Panel believes that certain aspects of the current form may deter complainants in sexual misconduct cases, or lead them to mistakenly conclude that there are pre-conditions for filing a complaint. For example, the question “Have you brought your concerns to this doctor’s attention?” may be taken to mean that this is a precondition to submitting a complaint. Many complainants would not, for obvious reasons, want raise their concerns with the doctor they believe has engaged in sexual misconduct. In one case, a complainant told the Panel that they believed – based on the form - that they were required to speak to other health care professionals about their complaint before they contacted the College, so that they could answer the question “Provide the full name of any other individual(s) and the details of the information they may have pertaining to your complaint (e.g. other doctor, therapist, chiropractor)”. The Panel recommends that **these questions be removed from the complaint form.**

Further, the requirement that a complaint be filed in writing may pose a barrier to individuals with language, literacy or physical barriers. For example, in one recent investigation committee decision reviewed by the Panel, a third-party physician authored a complaint on behalf of a patient who was unable to read or write. The Panel was informed that in other cases the College has accepted audio- or video-recorded statements by the complainant. The Panel is concerned that an inconsistent or inaccessible approach to complaint intake can lead to unfairness for all parties, while recognizing that it is important to provide certainty to a respondent physician about the case they are to meet. The Panel recommends that the College **use its current capability to record and transcribe calls to develop and adopt a protocol for receiving an oral complaint, in cases of sexual misconduct where this is the preference of the complainant.**

The availability of assistance from the Public Support Advisor is not advertised on the webpage. The Panel recommends that **the Public Support Advisor’s direct contact information and details about the support she is able to provide be posted on a separate page which also includes information about other supports or accommodations available to sexual misconduct complainants.**

College policy does not permit its staff to meet in person with a complainant due to safety concerns. However, there may be cases where a sexual misconduct complainant prefers to meet with the Public Support Advisor in person during the complaint intake process. The Panel recommends that the College **develop a protocol for allowing meetings between complainants and College staff, with regard for the personal safety of staff and the comfort of complainants.**

D. Communications from the College during the professional conduct process

1. Background and statutory framework

Communications with the College

The stress of the complaints process can be exacerbated by the nature, frequency or style of communications from the College for both complainant and respondent. However, where respondent physicians have some experience communicating with the College and a professional obligation to deal with their own regulator, the Panel accepts that complainants are unlikely to be sophisticated in this regard.

The College's current practice is to communicate with both complainants and respondents in writing, by regular mail. On occasion, the Registrar will contact a physician by phone where there is an urgency to the communication, for example where an interim restriction is to be imposed (see **below**). The Panel has reviewed the standard form letters which are routinely sent to physician respondents, and the letter acknowledging a complaint that is sent to a patient.

There are currently no guidelines for informing complainants about the progress or status of a complaint outside of significant process milestones. A complainant will receive a copy of official correspondence about the status of the complaint (i.e. decision letters, notices of hearing) from the College, and may also correspond with College staff by phone.

The confidentiality requirement in the Act

The College advises complainants and respondents about the statutory confidentiality requirement, as part of the College professional conduct process. That requirement, contained in s. 46 of the Act, states:

Confidentiality with respect to complaints

46 (1) All complaints received or under investigation, all information gathered in the course of the professional conduct process and all proceedings and decisions of an investigation committee and a hearing committee that are not open to or available to others in accordance with this Act or the regulations must be kept confidential by any persons who possess such information.

The College includes the text of s. 46(1) on its website, without explanation as to what it means for a complainant or respondent. The Panel reviewed written correspondence between the College and complainants which explained the confidentiality requirement, which simply refers to the Act and advises that the complainant "should not speak publicly about the complaint".

The Panel noted that the manner in which some of the College staff and members of the expedited investigation committee described or explained the confidentiality requirement in the Act revealed some confusion as to the meaning of the statutory provision. For example, some individuals indicated to the Panel their belief that the confidentiality provision precluded complainants from publicly discussing their experiences (as opposed to disclosing knowledge gained from or information about the complaint process). Similarly, the Panel also heard from a complainant who indicated that her understanding was that the confidentiality provision precluded her from speaking with anyone about her experiences.

2. Issues and recommendations

Communication with complainants

The Panel heard that different complainants prefer different methods and frequency of contact from the College, and that some complainants found unexpected contact from the College to be a distressing reminder of their experience. The College should also be aware that safety is a concern for some complainants, who may not be able to receive mail to their house or voicemails on their phone about their complaint. The Panel recommends that the College **take steps to ensure appropriate, timely and accurate communications with complainants**. For example, in order to permit communications with the College to meet the needs of a particular complainant, the Panel recommends that the College **seek early input from complainants about their preferred method and frequency of contact and make a communication plan for staff to follow that is kept on the complaint file.**

The College should use clear, plain language in all communications with complainants, and offer the opportunity to speak with a College staff member by phone or in person to provide an explanation of any major procedural steps in the complaint.

The Panel also recommends that the College **not restrict the use of email in their correspondence with complainants, with the prior consent of the complainant.**

Confidentiality requirements

Communication by College staff to complainants about confidentiality appears to be inconsistent and sometimes suggests that constraints on the complainant are more restrictive than the Act requires, i.e. that they are no longer permitted to speak about their own experience once a complaint is filed. This may be in part due to internal misunderstandings of the requirements under the Act.

The Panel heard from one complainant who felt that they were not able to seek supports during the complaints process because they understood that they were not permitted to disclose their

experience, and that respondent physicians may require clarification about their ability to canvass witnesses or prepare for a hearing. The Panel is also concerned that misinterpretations of s. 46 may result in a suppression of individual complainants' rights to speak about what happened to them.

The Panel recommends that the College **clarify the meaning and limits of the confidentiality requirement under s. 46 of the Act for all parties, and ensure that staff and investigation committee members understand the provision and are trained to explain or troubleshoot these requirements in plain language during their communications with respondents or complainants.** It may be helpful to provide staff and committee members with concrete examples of content that is, and is not, subject to the limits stipulated under section 46.

E. Support for complainants and respondents during the professional conduct process

1. Background

Supports available for complainant and respondent

The Panel heard from both complainants and respondents about the stress of the College complaints process when an allegation of sexual misconduct is raised. For complainants, the Panel recognizes that the College seeks the participation of an individual who may have experienced a traumatic event in a process designed to serve the public interest, and not the personal interest of the complainant. For respondents, the Panel heard that an allegation of sexual misconduct strikes at the core of a physician's self-identity as a healer and care provider, and that the stigma associated with such claims can be extremely damaging both personally and professionally.

Physicians who are faced with a complaint of sexual misconduct can access supports through the Canadian Medical Protective Association (CMPA) including free legal representation during the complaints process. In order to access the services of the CMPA, all physicians in Nova Scotia pay annual dues, a portion of which is reimbursed by public funds through the Nova Scotia Department of Health and Wellness.¹⁸

In addition, Doctors Nova Scotia provides a Professional Support Program which offers confidential peer to peer support for members who are dealing with personal or professional problems, and a Physician Navigator Program which offers confidential peer guidance and moral support to physicians facing investigation by the College. Doctors Nova Scotia is funded by physician annual fees.¹⁹ Each of these programs is designed to reduce the isolation and stress that may be caused by an investigation.²⁰

A physician who receives a complaint from the College is informed of the availability of support and representation from the CMPA and Doctors Nova Scotia in the initial written correspondence from the Registrar.

On the other hand, the only support available to a complainant in the College process is from the Patient Support Advisor who is employed by the College. The Patient Support Advisor's role is to help to guide the complainant through the process, answering questions about what to expect. She is a representative of the College, and not an advocate on behalf of the complainant, and any

¹⁸ Since January 1, 2017, physicians are eligible for a rebate of 90% of any amounts in excess of \$1,750 per year (MSI Physician's Bulletin, July 18, 2017, Vol. LIII, Issue 5).

¹⁹ <https://doctorsns.com/doctors/become-member/categories>

²⁰ <https://doctorsns.com/benefits/support-services>

information provided by the complainant is disclosable to the respondent and may be admissible during the hearing. Owing to the nature of the role, the Patient Support Advisor is “neutral” and unable to provide confidential advice or advocate on behalf of the complainant.

A complainant who wishes to obtain summary legal advice may do so through a pilot program funded by the provincial government, which provides a two-hour legal aid certificate to a limited roster of lawyers who have received specialized training.²¹ As noted, this is a pilot program. The duration of this pilot, or whether it will become a permanent program, is unknown. Funding for legal representation for complainants in the College process is not available through this system.

A sexual misconduct complainant is unlikely to be able to access publicly funded therapeutic counselling in Nova Scotia, due to a scarcity of resources.²² Private counseling fees are approximately \$190/hour, and may be covered to some extent by private health insurance plans or employee assistance programs.²³

Complainants are not currently offered any advocacy or counselling support by the College during the complaints and professional conduct process, but may bring their own supports with them. College counsel is not able to offer legal advice or representation to complainants (though they may advocate a position which aligns with their interests), because of the nature of their role.

Access to alternative care providers

The College acknowledges that filing a complaint will disrupt the physician-patient relationship, but does not offer any assistance to individuals who require alternate care providers during or after a complaint. The College website states:

Complaint investigations can take up to six months and sometimes longer. During an investigation, the College recommends that patients involved in complaints avoid contact with the physician named in the complaint. For this reason, patients should plan to see another physician while the College is investigating their complaint, and perhaps permanently. In rare circumstances, it may be necessary for the physician-patient relationship to continue. You are encouraged to contact the College before doing so.

To find a family physician who is accepting new patients, please call 811 or visit the Need a Family Practice Registry to be added to the provincial waitlist.

²¹ 211 Nova Scotia provides [this service](#) to any participant over the age of 16 who reports experiencing a sexual assault in Nova Scotia.

²² For example, the Avalon Sexual Assault Centre has [closed its waitlist](#) due to an overwhelming demand for services, as of April 2019.

²³ The Association of Psychologists of Nova Scotia sets [recommended fees](#) for psychological services.

Currently, more than 50,000 Nova Scotians are waitlisted for a family doctor, and are without a regular primary care physician.²⁴

2. Issues and recommendations

Legal and therapeutic support for complainants

Patients who complain to the College of sexual misconduct by a physician do so without any hope of personal gain. The professional conduct process serves the public good, and may exact a significant toll on a complainant who is required to participate in an investigation and hearing. The Panel believes that a trauma-informed approach requires that appropriate supports be offered to complainants in order to mitigate the risk of re-traumatization and to support coping and resilience. In doing so, the Panel recognizes that where a complaint of sexual misconduct by a physician arises, a patient may have intersecting vulnerabilities including a history of trauma.

The Panel considered the need for additional logistical, legal or psychological supports for complainants in sexual misconduct cases, and recommends that [the College provide funding for such supports](#).

The complaints process is a complex administrative regime which may not be easy for all complainants to navigate. In cases involving allegations of sexual misconduct, due to a variety of factors, the impact of the process on a complainant is likely to be heightened and the impacts of trauma may impair a complainant's ability to navigate the system. While the Patient Support Advisor can assist complainants, the Panel believes that it is important to offer a complainant access to assistance in understanding the College's process in a completely confidential setting. For this reason, the Panel recommends that **all complainants who file a sexual misconduct complaint be given access to a limited certificate for summary advice from a qualified legal practitioner with experience delivering legal services using a trauma-informed approach.**

In addition, though the complainant is not a party to an investigation or hearing, legal issues impacting their rights (i.e. access to records) may arise during the complaints process. Legal representation on this or other issues may be desirable or necessary for complainants in some cases. Accordingly, the Panel recommends that the College **offer additional funding for legal representation where the College deems it necessary in order to maintain a trauma-informed approach to administering the process.**

The Panel accepts that therapeutic counselling would benefit any patient engaged in the College process who is alleging sexual misconduct by a physician, but that some patients may not be able to

²⁴ The Nova Scotia Health Authority maintains the "[Need a Family Practice Registry](#)", which was [reported to have 55,801 people on it](#) in December 2018.

access such services because of a lack of public resources in Nova Scotia. Given the potential secondary harm of participating as a witness in a sexual misconduct complaint, the Panel recommends that the **College offer funding for a fixed number of hours to every sexual misconduct complainant whose matter is referred to a hearing committee (whether or not a hearing occurs), and to others in need at the discretion of the Registrar.**

The Panel suggests that in appropriate cases, the College may seek costs associated with providing a complainant with funding for legal or therapeutic counselling supports from a respondent physician at the resolution of their matter, as “reasonable costs” of a witness (Regulations, s. 121(1)(g) and (3)). The College may also consider amending the Regulations as necessary to permit such recovery.

Alternative care providers

The Panel acknowledges that it is not within the power or control of the College to find a complainant a new physician in cases where a complaint is made. However, the Panel heard that the fear of losing access to their physician for themselves or family members is a significant deterrent for some complainants, particularly in small communities. This sentiment has also been expressed by complainants in their evidence before College committees in the decisions reviewed by the Panel.

Accordingly, the Panel recommends that the College work with other stakeholders (such as the Nova Scotia Health Authority and Doctors Nova Scotia) to **develop options for alternative care providers in cases where a complaint of sexual misconduct is made.**

F. Screening and investigation of complaints

1. Background and statutory framework

Preliminary screening of complaints by the Registrar

After receiving a formal complaint, the Registrar is empowered to conduct a “preliminary investigation”. Under s. 89 of the Regulations, following a preliminary investigation they must either dismiss, informally resolve or refer the complaint to an investigation committee. The Registrar may also authorize the resignation of the member (which would end the complaint) or provide non-disciplinary “written advice” to the complainant, respondent or any other affected person.

The Registrar’s power to dismiss a complaint without referral to an investigation committee is limited to particular circumstances in the Regulations (s. 89(1)(a)). These circumstances include those cases where the complaint:

- is outside the jurisdiction of the College;
- cannot be substantiated;
- is frivolous or vexatious;
- constitutes an abuse of process; or
- does not allege facts that, if proved, would constitute professional misconduct, conduct unbecoming, incompetence or incapacity, or would merit a caution.

The Panel reviewed two such decision letters from the Registrar involving allegations of sexual misconduct by a physician as part of its review, where the Registrar found that the complaint could not be substantiated.

A complainant who believes that their complaint was unjustly dismissed without referral to an investigation committee can request that the dismissal be reviewed by an independent review committee, whose written decision is final (Regulations, s. 90-93).

The investigation process

Complaints which cannot be resolved by the Registrar are referred to an investigation committee. The statutory role of the investigation committee is to provide “a simple, expeditious process to investigate complaints and screen out those where it concludes there is not sufficient evidence to warrant referral to a full hearing”.²⁵

²⁵ *Patient X v. College of Physicians and Surgeons of Nova Scotia*, 2013 NSSC 165 at para 33.

The College has four regular investigation committees, each composed of four committee members. As required by the Act, a public representative sits on each (s. 32(1)). College staff investigators chair each investigation committee.

As of January 2019, the College has determined that all complaints alleging sexual misconduct that are referred by the Registrar for investigation will be directed to the Expedited investigation committee, instead of being assigned to one of the regular investigation committees. The objective of this new practice is to (a) develop the subject-matter expertise of one committee with respect to sexual misconduct complaints; and (b) allow these complaints to be fast-tracked.

The Regulations provide that an investigation committee may appoint and direct an investigator to investigate the complaint (including by receiving relevant documents and interviewing the complainant and respondent) and submitting a written investigation report to the investigation committee (s. 95-96, see also Act, s. 37).

If authorized by an investigation committee chair, the Registrar, an investigator, or an investigation committee member each have all of the powers, privileges and immunities of a commissioner under the *Public Inquiries Act*, except contempt, arrest and imprisonment (Act, s. 33). This means that during a professional misconduct investigation, they may summon witnesses and compel them to give evidence or produce documents (*Public Inquiries Act*, s. 5).

In addition, the Act confers an investigator with the power to enter the place of a member's practice on reasonable and probable grounds to examine any evidence relevant to the investigation, where approved by the investigation committee chair (Act, s. 38). Finally, an investigator may obtain a search warrant on application to a justice of the peace where they have reasonable and probable grounds that relevant evidence exists at any other place (Act, s. 39), and seize or copy any document or photograph an object (Act, s. 40).

The Regulations also permit an investigation committee to "conduct some or all of the investigation" themselves (s. 96(3)(b)), and this is the College's typical practice. The usual steps in an investigation (including a complaint of sexual misconduct) are:

- A copy of the written complaint is sent to the respondent;
- The respondent submits a written response to the complaint to the investigation committee, including any relevant documents, within a normal timeframe of 30 days;
- The complainant receives a copy of the respondent's written response and is given the chance to comment;
- The respondent has a chance to reply to the complainant's comments; and
- The respondent and complainant appear before the full investigation committee for an interview.

Interviews by the investigation committee are conducted at the College boardroom, with a court reporter and College staff present. A complainant is permitted to bring a support person, and the respondent is usually accompanied by counsel. While one member of the committee usually takes the lead, all of the members are free to ask questions as they see fit.

The rights of a respondent during an investigation are clearly set out in the Act, and include the right to (s. 44):

- Be represented by counsel;
- Disclosure of the complaint, notice of any other matters under investigation and such other information as natural justice requires and as determined by the Registrar; and
- A reasonable opportunity to present a response and make submissions.

The complainant does not have procedural rights (or standing) as a party during the investigation process, notwithstanding that their complaint may be finally dismissed at this stage.²⁶

At any stage, the investigation committee is free to dismiss a complaint on the same bases as were available to the Registrar as outline above (s. 98(1)), namely because it:

- Is outside the jurisdiction of the College;
- Cannot be substantiated;
- Is frivolous or vexatious;
- Constitutes an abuse of process; or
- Does not allege facts that, if proved, would constitute professional misconduct, conduct unbecoming, incompetence or incapacity, or would merit a caution.

After receiving all of the evidence in the manner outlined above, the investigation committee is required to consider if there is “sufficient evidence that, if proven would constitute...professional misconduct” and “warrants imposing a licensing sanction” (s. 99(5)(f)). If the investigation committee finds that there is such “sufficient evidence”, it must either issue a consensual reprimand with or without conditions on the respondents’ license, or refer the matter for a hearing (Regulations, s. 99(7)).

A “licensing sanction” is defined in the Act as including the following penalties: (a) the imposition of conditions or restrictions on a license; (b) a consensual reprimand; (c) a reprimand; (d) a suspension of a licence; and (d) a revocation of a licence or registration (s. 2(z)).

If the investigation committee finds that there is not sufficient evidence that, if proven would constitute professional misconduct, it may dispose of the complaint by dismissal, non-disciplinary advice, informal resolution or issuing a caution to the respondent physician (Regulations, s. 99(5)(a)-

²⁶ *Patient X*, supra at para 57-58.

(d)). Resignation of a member is an informal resolution specifically contemplated by the Regulations (s. 7(h)).

A “caution” is defined in the Regulations as “a warning from the investigation committee that a person may have breached the standards of professional ethics or practice in circumstances that are not determined under the Regulations to warrant a licensing sanction” (s. 2). Cautions are disclosed on a physician’s Certificate of Professional Conduct (CPC) for a period of three years, and will be disclosed in the event of a physician application for licensure in other jurisdictions. A caution remains permanently on the records of the College, and can be referenced in the event of any future complaints against a physician.

The decision of the investigation committee is communicated by letter to both the respondent and complainant.

2. Issues and recommendations

The Panel was told by physicians that the College should not accept unmeritorious complaints, or that such complaints should not be referred to an investigation committee. This sentiment likely arises from the fact that complaints that are referred for investigation are often found by the committee to be not substantiated at that level, and physicians feel that the investigation process was unnecessarily onerous for them. The Panel is satisfied that the Regulations provide an appropriate basis for the early dismissal of complaints by the Registrar, and that complaints are being appropriately referred for investigation (i.e. that complaints are not being referred when they could have otherwise been resolved earlier by dismissal under s. 8g(1)(a) of the Regulations).

The Panel heard from both physicians and complainants that interviews by a full investigation committee are intimidating or seem overly adversarial. The Panel heard that complainants facing four questioners without representation may feel uncomfortable telling their story, or may conclude that the College has a bias in favour of physicians. The physical setting of the interviews (i.e. at a large boardroom table), may contribute to a complainant’s feelings of intimidation. On the other hand, physicians feel that investigation committee members favour the complainants in their interview styles. There is a perception that interviews of respondents are conducted more “like cross-examinations” than are interviews of complainants. The Panel heard from complainants who experienced the interview similarly. The Panel received and reviewed a recording of one interview of a complainant that could at some points be fairly characterized as adversarial on the part of the questioning committee member, if not confrontational, in tone and content.

The Panel is also concerned that investigations conducted in this manner may not be sufficiently thorough, given the serious nature of the allegations. investigation committee members lack training and expertise in conducting interviews, which impacts the quality of the fact-finding process

and can cause harm to those being interviewed. Accordingly, the Panel recommends [changes to the investigation process as it relates to sexual misconduct complaints](#).

The Panel recommends that the College employ the process provided under s. 96 of the Regulations and **use a single investigator to conduct sexual misconduct investigations and provide a report to the investigation committee upon which to base its decision**. The College should consider engaging external investigators with training in conducting investigations into complaints of sexual misconduct, at least until such time as staff can be appropriately trained.

The Panel also wishes to highlight the importance of **ensuring that the investigator in charge of sexual misconduct complaints is properly trained in employing a trauma-informed approach which incorporates an understanding of the effects of trauma on memory**, and that they **offer a complainant accommodations in order to ensure a safe environment**.

In addition, the Panel has concerns that investigation committees have not been consistent in determining whether “there is sufficient evidence that, if proven, would constitute...professional misconduct...and warrants imposing a licensing sanction”. In particular, the Panel reviewed decisions of the investigation committee in which:

- The investigation committee applied the test as “whether there is a reasonable prospect of proving the allegations on a balance of probabilities” or whether there was sufficient “reasonable evidence”;
- The investigation committee declined to refer to hearing where they were presented with “two very different versions of events” and indicated it had no reason to doubt the credibility of either party, or was “unable to prefer one version of events over the other with respect to the clinical encounter”; or
- A complainant’s evidence was discounted because “it is difficult to develop objective evidence regarding largely subjective matters – in this case, the emotional response of the complainant”, or that there was “no evidence to support an inappropriate examination” because there were no independent witnesses to the event.

Accordingly, the Panel recommends that **the College provide written guidelines to investigation committees (and ongoing training on these guidelines) on how to apply the legal standard of “sufficient evidence if proven” for referral to a hearing, with specific attention to what to do in cases in which credibility is a central issue**.

The College’s decision to assign all complaints of sexual misconduct to an expedited investigation committee has merit to the extent that it seeks to ensure there is no delay in the response to a serious allegation, and in capacity building of a single group of decision-makers to address the same kind of issues. However, the Panel heard that expedited timelines may not afford physicians with sufficient time to prepare a response. In cases where the College does not identify an ongoing public risk, or

any public risk has been mitigated by interim restrictions, the timeline should not be expedited. The Panel recommends that **expedited timelines for investigations only be imposed if there is a need to do so in order to protect the public interest or the integrity of the investigation process.**

G. Interim measures

1. Background and statutory framework

The College has the power under s. 45(1) of the *Medical Act* to suspend the license of or impose interim restrictions or conditions on the practice of a physician who has been accused of professional misconduct if there are “reasonable and probable grounds to believe that (a) a member is exposing or is likely to expose the public, patients, the medical profession or the member to harm or injury; and (b) intervention is required prior to the disposition of the matter by the investigation committee or hearing committee” (“interim measures”).

The College has imposed interim restrictions in seven of the 26 sexual misconduct complaints filed since 2017 (or 27%), out of which one physician who received an interim suspension was the subject of two complaints. These complaints remain ongoing, and so no further information about them is included in this Report. In three additional cases filed since 2017 (or 12%), physicians agreed to an undertaking restricting their practice. Of the seven complaints filed in 2015 and 2016, the Panel reviewed three earlier cases where the investigation committee imposed an interim measure.

The most common interim measures involve restricting practice with patient populations deemed to be at risk, requiring the presence of a chaperone in clinical exams, and posting a sign advising of any restrictions, or suspension pending the outcome of an investigation or hearing.

Where a decision has been made to impose an interim measure, the Act requires that the member receive written notice with reasons for the decision, “forthwith” (s. 45(2)). Within 30 days, the member then has the right to request a meeting with the investigation committee and to appear before the committee with counsel, have disclosure of the complaint and any other document before the committee, and to present a response and make submissions (Act, s. 45(5)). The College advised that in some cases, the complainant will appear before the investigation committee on the merits of the complaint within the 30 day window, and the interim measure may be resolved or changed based on the physician’s substantive response to the complaint.

In a case where interim measures are imposed, the investigation committee is required to “proceed in as timely a manner as possible to conclude its investigation and make a decision respecting the further disposition of the matter” (Act, s. 45(6)(b)).

The College also has a process for negotiating an undertaking from a physician to voluntarily restrict their practice during the investigation of a complaint.

2. Issues and recommendations

The Panel heard concerns about interim measures from physicians and their advocates. Interim measures impact physician practice without warning, increase stress and stigma, may cause fear and discomfort among the other patients, and limit access to medical care in a resource-limited sector. Further, these restrictions are sometimes impractical in particular practice environments, for example where another health care provider is not available as a chaperone. Accordingly, the Panel recommends that the College [review the current practice around interim measures in order to mitigate the personal and professional impact of an allegation of sexual misconduct on a respondent physician at the early stages, always prioritizing the public interest.](#)

Patients and their advocates emphasized the importance of interim measures in cases where an allegation of sexual misconduct has been made. The Panel heard that often patients who have experienced sexual harm are motivated to complain to the College out of a concern for other patients and a sincere belief that the doctor will repeat their behaviour. In such cases, complainants seek assurances that a physician have restrictions placed on their practice until the matter is finally resolved.

The Panel is cognizant that the College must balance their statutory object of the protection of the public with the rights of the physician not to be restricted from practice except in accordance with the Act.

In order to provide further clarity and manage the expectations of both complainants and respondents about when to expect the imposition of interim restrictions after an allegation of sexual misconduct, the Panel recommends that the College **develop and publish guidelines for the use of undertakings and interim measures which outline the possible restrictions that the College will consider imposing, and in what circumstances.**

The Panel notes that there are divided opinions about the appropriateness and efficacy of chaperones as an interim restriction for physicians facing allegations of sexual misconduct.²⁷ A detailed analysis of this issue is beyond the scope of this Review.

The CMPA provided the Panel with reference to jurisprudence from Ontario, based on similar statutory language to the Act, that requires (a) an evidentiary foundation for the imposition of an interim restriction, and (b) that the conditions imposed must be the least restrictive order possible to protect the public.²⁸ No such judicial interpretation is available in Nova Scotia at present.

²⁷ In particular, the Australian Health Practitioner Regulation Agency (AHPRA) has adopted the recommendations of a comprehensive report it commissioned, to abandon the use of chaperones as an interim restriction except in exceptional cases, in favour of gender-based or wholesale prohibitions on patient contact or on suspensions from practice (Paterson, Ron. "Independent review of the use of chaperones to protect patients in Australia", February 2017, <https://nhpopc.gov.au/chaperone-review/>).

²⁸ *Fingerote v. The College of Physicians and Surgeons of Ontario*, 2018 ONSC 5131 (Div Ct).

However, the Panel does recommend that the College **review current practices to ensure that available restrictions are designed to achieve the goal of public protection with the least possible impact on the practice of a physician, including by constructively alerting the public of the existence of an allegation, and that the investigation committee clearly outline the evidentiary basis for their imposition of an interim restriction.**

The urgent imposition of an interim restriction (or request for an undertaking) may also be the first notice of a complaint from the College for a physician who is otherwise unaware that an allegation has been made. Accordingly, a physician will likely not yet have had CMPA counsel assigned, which is a process the Panel understands can take several days. In order to mitigate the risk that a physician who is called by the Registrar about an interim measure or undertaking will feel compelled to offer an explanation for their behaviour before consulting with counsel, the Panel recommends that **the College and CMPA arrange for duty counsel to be available to assist on urgent matters, and act as a point of first contact for the Registrar.** The Panel acknowledges that this suggestion is outside of the unilateral control of the College. The Panel believes that it is in the best interests of both parties for the respondent physician to have the immediate assistance of counsel, so that **an undertaking that meets the requirements of the College can be negotiated where possible.**

H. Resolution of substantiated complaints without a hearing

1. Background and statutory framework

The statutory scheme provides for many options for the alternative resolutions of complaints, aside from disposition by a hearing committee.

As noted above, before a complaint is referred to a hearing, the Registrar or investigation committee is empowered to informally resolve complaints (Regulations, s. 89(1)(b), 99(5)(c)), which resolution may include the voluntary resignation of a member (Regulations, s. 7(h)). However, a complaint may only be withdrawn where the Registrar and the complainant agree (Act, s. 36(2)).

The Registrar or investigation committee may also provide “non-disciplinary” written advice to any person affected by the complaint, including the respondent and complainant (Regulations, s. 89(2), 99(5)(b)). In the decisions reviewed by the Panel, investigation committees frequently provided advice to physicians in dismissed complaints.

If the matter is referred to a hearing, an investigation committee may direct the Registrar to attempt to negotiate a settlement agreement on behalf of the College (Regulations, s. 99(7)(b)). Where the Registrar and respondent agree on terms of settlement, the settlement agreement must be considered by the investigation committee, who may recommend that the hearing committee accept it, if it satisfies the following conditions (Regulations, s. 102(1),(2)):

- The public is protected;
- The conduct or its causes can be, or have been, successfully remedied or treated, and the respondent is likely to successfully pursue any remediation or treatment required;
- The content of the proposed settlement agreement provides sufficient facts and admissions to support the agreed disposition; and
- Settlement is in the best interests of the public and the profession.

If the proposed settlement does not satisfy the above-noted conditions, the investigation committee may recommend appropriate changes to the agreement, or refer the matter for a hearing (Regulations, s. 103(3)).

Among the cases reviewed by the Panel, settlement agreements often involved mandatory training or education, in addition to psychological assessment and/or treatment for a physician before they can return to practice.²⁹ However, none of the cases reviewed by the Panel which resulted in the informal resolution or settlement of a complaint of sexual misconduct involved any form of requirement for an apology or acknowledgment of harm by the physician to the complainant.

²⁹ See for example, *Seaman (Re)*, *Blair (Re)*, *Sheehy (Re)*, *Wisniowski (Re)*, supra.

The Act contains a definition of “mediation”, as “any form of dispute resolution” (s. 2(aa)). However, neither of these terms appear anywhere else in the Act or Regulations. In any event, there does not appear to be any clear guideline or policy at the College for the role of the complainant in cases which end in an informal resolution or settlement agreement.

Finally, a respondent who admits or does not contest the allegations set out in a complaint or decision of the investigation committee to refer a matter to hearing on the basis of “sufficient evidence”, may submit a proposed consent revocation agreement for approval by the hearing committee. The hearing committee is then required to consider whether to accept the proposed agreement, and provide written reasons (Regulations, s. 105(1)-(4)).

2. Issues and recommendations

The Panel heard concerns that alternative resolution pathways available under the Act and Regulations may be under-utilized. In particular, the Panel considered the potential to more effectively use the College’s power to resolve a complaint by informal resolution in cases of sexual misconduct.

The Panel heard that physicians perceive that the College does not adequately consider available alternate resolution options, even where appropriate.

The Panel noted an antagonistic institutional relationship between the CMPA and the College, which may be an ongoing barrier to the informal resolution of individual complaints, to the detriment of all participants.

The Panel recommends that the College [adopt a complainant-led approach to identifying cases that may be appropriate for information resolution.](#)

The Panel believes that instituting a complainant-led approach to alternative resolution of complaints may actually serve to increase reporting. In cases where a complainant wishes to address the behaviour of a physician but does not wish to either participate in an investigation and hearing process, or impose such a process on their doctor, they may otherwise be reluctant to initiate a process in which they have little control. Accordingly, the Panel recommends that the College **include a question on the complaint form that offers the complainant the opportunity to share their desired outcome in the professional conduct process at the outset, including their willingness to participate in an informal resolution process.** The availability of informal resolution of complaints should be included in the information provided on the College webpage for sexual assault complaints.

The Panel also recommends that **the potential for informal resolution be canvassed by the investigator in all sexual misconduct cases, where the College deems that it would be in the public interest to do so.**

Such an approach may include the option of a restorative process but, given that the use of restorative approaches in cases of sexualized violence has been challenged,³⁰ this should only be at the request of the complainant. In any event, any informal resolution process which involves an interaction between the complainant and physician should be facilitated by a trained professional with experience in trauma-informed approaches to alternative dispute resolution.

The Panel recognizes that there are many reasons why the College may consider it in the interests of public protection to accept a settlement agreement or agree to permit a physician to retire, including problems of proof. However, anecdotal evidence suggests that complainants may not always agree with such outcomes, and may perceive settlement as protecting the physician rather than the public. The Panel recommends that **in all cases where the College determines that it is appropriate to enter into an informal resolution or settlement with the respondent, the wishes of the complainant are canvassed and considered.** Of course, the Panel recognizes that the College's ultimate obligation is to protect the public.

In making this recommendation, the Panel is not suggesting that the College treat the complainant as a party to the complaint, or that the College should refrain from exercising its own discretion to refuse informal resolutions where it is not appropriate because of the nature of the allegations, particular vulnerabilities of the complainant, or for any other reason. Accordingly, the Panel recommends that the College **develop internal guidelines with respect to their exercise of discretion to resolve a complaint by informal resolution, to guide the Registrar and investigation committees** and to identify situations where the College would or would not be satisfied to make an informal resolution available to a member.

The Panel also heard that complainants whose allegations are dismissed by an investigation committee do not feel that their concerns were heard or that the complaint outcome was adequately explained to them. Where an allegation of sexual misconduct is dismissed, no acknowledgement is made of the experience of sexual harm by the complainant.

Patients whose complaints have been dismissed do not have the opportunity to have a substantive discussion with the College about why their complaint was not sustained, or to correct any miscommunication that may have arisen within the patient-physician relationship. Accordingly, the Panel suggests that the Registrar employ their power to provide "advice" to the complainant to **offer**

³⁰ For example, there has been a moratorium in place for referrals of criminal matters to the [Nova Scotia Restorative Justice Program](#) for intimate partner violence and sexual offences since 2000.

the opportunity to have the outcome explained to them and to discuss any outstanding concerns with the Registrar or his designate about their complaint or the College's process. For example, in some cases, it may be appropriate for the College to engage an independent physician with relevant expertise to explain a clinical exam in which a patient experienced sexual harm.

I. Hearings

1. Background and statutory framework

The College hearing committee holds five or six hearing per year, on average, including for the approval of settlement agreements between the College and a physician. However, the College has rarely held hearings in sexual misconduct matters.

Based on the Panel's review of published decisions, in the past 25 years there appear to have only been: one contested hearing about an allegation of sexual misconduct in a patient relationship,³¹ one uncontested hearing about an allegation of sexual misconduct in a patient relationship (where there was also a related criminal matter),³² and one contested hearing involving an allegation of sexual harassment and sexual assault of hospital colleagues.³³ There was also one contested sentencing hearing, where the misconduct was admitted.³⁴

Other hearing committee decisions involving allegations of sexual misconduct involve matters dealt with by settlement agreement or on consent (including all allegations of impermissible sexual relationships between a physician and patient).³⁵

Committee members are therefore unlikely to have direct experience in dealing with common evidentiary issues in sexual misconduct cases, and likely will be reliant on the submissions of counsel in identifying and resolving issues. Past decisions of the hearing committee offer limited guidance to the parties.

The Act requires the College to establish a pool of hearing committee members, including a Chair and Vice-Chair, which is separate from the investigation committee members. Members of the hearing pool are medical practitioners and public representatives. The current Chair of the hearing pool is an experienced lawyer, though this is not a statutory requirement (Act, s. 47).

When a hearing is required in a professional misconduct matter, the Chair of the hearing pool appoints a hearing committee with at least five members, a majority of which must be medical practitioners (Act, s. 48).

If authorized by a hearing committee chair, the Registrar, a hearing committee, or a hearing committee member each have all of the powers, privileges and immunities of a commissioner under

³¹ *Dhawan (Re)*, supra.

³² *Christie (Re)*, supra (hearing was held but uncontested).

³³ *Ezema (Re)*, supra.

³⁴ *Hingley (Re)*, supra.

³⁵ See for example *Oluwole (Re)*, *Wisniowski (Re)*, *Sheehy (Re)*, *Blair (Re)*, *MacDonald (Re)*, *Seaman (Re)*, supra.

the *Public Inquiries Act*, except contempt, arrest and imprisonment orders (Act, s. 52). This means that during a hearing, they may summon witnesses and compel them to give evidence or produce documents (*Public Inquiries Act*, s. 5). A member is a compellable witness at a hearing (Act, s. 53(6)).

There are no written rules for the conduct of a hearing, though the hearing committee is empowered to determine additional rules of procedure not in the Regulations (s. 110(2)). This power must be exercised consistently with the provisions of s. 53 of the Act, which include the procedural rights of respondents to:

- Natural justice;
- Advance disclosure of any evidence relied upon by the opposing party;
- Representation by counsel;
- Know all evidence considered by the hearing committee;
- Present evidence and make submissions, including the right to cross-examine witnesses; and
- Receive written reasons within a reasonable time.

Complainants are not permitted to participate as a party at a hearing (Regulations, s. 110(1)).

The Regulations provide for the option of excluding the public from the whole or a part of a hearing at the request of a party, and the hearing committee has broad discretion to impose any restriction on publication or broadcasting of any information disclosed in the hearing (Regulations, s. 109). The power to impose a publication ban is also contained in s. 53(5) of the Act.

Based on the Panel's review of past cases, the College regularly requests protection for complainants against the publication of identifying information under s. 109 of the Regulations and s. 53(5) of the Act. The hearing committee regularly uses pseudonyms in the place of patient names when it publishes cases, and issues publication bans on their identifying information.³⁶ In *Re Dhawan*, the hearing committee closed the hearings while complainants were giving their evidence.

However, in *Re Ezema*, the College's request for a publication ban on the names of three witnesses who alleged sexual misconduct at the request of the College was opposed by the respondent physician.³⁷ Each of the witnesses was required to testify in support of the request for a publication ban, as to the potential harm that could be caused in the absence of a ban.³⁸

When granting the parties' requests for publication bans, the committee noted the importance of open hearings in maintaining public confidence in the College's enforcement of physician standards

³⁶ See for example *Oluwole (Re)*, *Wisniowski (Re)*, *Sheehy (Re)*, *Blair (Re)*, *MacDonald (Re)*, supra.

³⁷ *Ezema (Re)*, at para 18.

³⁸ *Ibid* at para

of conduct,³⁹ and the evidence of potential embarrassment and distress to the witnesses.⁴⁰ However, the balancing exercise identified by the committee was of “the interests of these three witnesses with Dr. Ezema’s interests,” rather than the public interest.⁴¹ In this instance, the committee found that there would be no “harm or unfairness” to the respondent physician by the proposed publication ban, and it would “likely be embarrassing” to the witnesses “living and working in a small town”.⁴² Once the publication ban was granted for the College witnesses, the respondent physician requested and was granted a publication ban on the identity of witnesses testifying on his behalf, unopposed by the College.⁴³

2. Issues and recommendations

The Panel recommends that the [College take steps to minimize harm to complainants during the hearing process](#). In order to achieve this objective and provide clarity to participants in advance of a hearing, the Panel recommends that certain **protections be incorporated into a written policy by the hearing committee**, pursuant to their power under s. 110(2) of the Regulations.

The Panel is of the view that there should be a **presumption that the hearing committee will issue a publication ban to protect against publication of identifying information about a sexual misconduct complainant or witness testifying with respect to sexual misconduct allegations, in all cases unless the complainant or witness requests otherwise**. In particular, the committee should avoid requiring complainants to testify in order to establish an evidentiary basis for a publication ban, as in *Re Ezema*.

In addition to publication bans on the identity of the complainant, the Panel recommends that **the hearing committee should consider in all hearings of sexual misconduct complaints whether to close or partially close the hearing, or to impose restrictions on the publication of medical or other sensitive information**. The complainant should be permitted to make submissions on this question.

The Panel also considered the issue of compelling unwilling witnesses to testify regarding their alleged experiences of sexual misconduct. One of the three witnesses in *Re Ezema* (a co-worker who alleged an incident of sexual harassment) was compelled to testify against her wishes. According to the hearing committee this witness appeared “to be particularly vulnerable. She had to be

³⁹ Ibid at para 10.

⁴⁰ Ibid at para 15-17.

⁴¹ Ibid at para 20.

⁴² Ibid at para 19.

⁴³ Ibid at para 21.

compelled to attend the hearing by subpoena. She was quite emotional. She testified that the subject matter of the charges were embarrassing to her..."⁴⁴

The Panel is of the view that complaining witnesses in sexual misconduct cases should only be compelled to testify against their wishes if the College believes that the risk to the public presented if they do not testify outweighs the potential harm caused to them by forcing them to appear. **The Panel recommends that the College develop and publish a guideline for when the College will exercise its subpoena power in respect of a complaining witness in a sexual misconduct case.** This information should be available to potential complainants to promote choice, in keeping with a trauma-informed approach.

The Panel canvassed the issue of testimonial aids during consultations. No objections to offering complainants these types of accommodations were raised by any Review participants. The Panel recommends that **the hearing committee should inform the complaining witnesses of the availability of accommodations during the hearing process.**

The Panel recommends that a **self-represented respondent should not be permitted to cross-examine the complainant in person.** In such cases, the College should appoint counsel for the purpose of cross-examination.

The issue of obtaining access to or relying on a complainant's third-party records, particularly psychiatric records, was raised by different individuals several times during the consultations. College staff indicated that, while not frequent, they do receive requests of this nature in some cases. The Panel was not provided with any examples of these requests nor specific information regarding their frequency.

The College does not currently have an established policy for responding to such requests at the investigation or hearing stages. Nor does the College have a policy regarding the purposes for which a respondent physician may rely on a complainant's records in his or her possession to mount their defence.

Research in other jurisdictions, such as Ontario, has documented the way in which discipline committee processes continue to permit reliance by respondent physicians on a complainant's personal records to pathologize and discredit the complainant - to question the stability and credibility of the complainant on the basis of stereotypical assumptions about gender, women, and sexualized violence.⁴⁵

⁴⁴ *Ezema (Re)*, supra at para 15.

⁴⁵ Sanda Rogers, "Zero tolerance Some of the Time? Doctors and Sexual Abuse in Ontario" in Elizabeth Sheey, ed, *Sexual Assault in Canada: Law, Legal Practice and Women's Activism* (Ottawa: University of Ottawa Press, 2012)

The Panel recommends that the **College develop a process for obtaining records and guidelines regarding the purposes for which a complainant's records can be used (whether in the possession of the respondent physician or not)**. Given the complexity of this issue, and the ongoing misuse of evidence of this nature in both regulatory proceedings in other jurisdictions and criminal proceedings the Panel recommends that this process be developed in consultation with experts in sexual assault law, on the basis of principles derived from the criminal protections for complainants in sexual assault proceedings.

In addition, the Panel recommends that **the College establish a guideline which identifies impermissible myths and stereotypes which may not be relied upon in demonstrating relevance in questioning complainants** (such as the stereotype that an individual who has alleged an experience of sexual misconduct in the past is by virtue of that allegation less credible).

Finally, the Panel recommends that **a complainant be permitted to provide a victim impact statement to the hearing committee, in cases where a complaint is substantiated or the committee is required to consider a settlement agreement between the College and respondent physician**. There should be no cross-examination on the statement.

451. See also Lise Gotell, "The Ideal Victim, the Hysterical Complainant and the Disclosure of Confidential Records: A Case Study of the Implications of the Charter for Sexual Assault Law" (2002) 40 Osgoode Hall LJ 251.

J. Disclosure of complaints outcomes or aggregated data

1. Background and statutory framework

The College's 2017 Annual Report includes annualized statistics for all complaints, but does not specify how many relate to sexual misconduct. The Annual Report includes the College's own observation that "there has been a marked increase in complaints involving sexual impropriety."

The public must be notified when a complaint is referred by the investigation committee to a hearing, and when a hearing is scheduled (Regulations, s. 100(2)(a) and 108; Act s. 49).

The Regulations (s. 118) require that the Registrar must publish either a full decision or a decision summary of:

- Any consensual licensing sanction (reprimand with or without conditions) imposed by an investigation panel (s. 100(1));
- Any decision by a hearing committee to accept a settlement agreement or consent revocation agreement; and
- Any decision by a hearing committee which resulted in a licensing sanction (Act, s. 55(1)(b)).

Where the Registrar elects to publish a decision summary instead of the full decision of a committee, the Regulations require the summary to include certain basic information, sufficient to identify the member and any admissions or findings of discipline (s. 119). Decisions must be published on the College website and in a "Professional Conduct Digest" maintained by the College and made available to the public (Regulations, s. 118(1)). Where the Registrar considers it necessary, broader publication or disclosure of the decision can be made, including to other regulatory bodies, employers, health authorities or other individuals or entities.

In addition to the obligation to send a decision to the respondent and complainant, an investigation committee may send some or all of their decision "to other such persons as the committee determines" (Act, s. 43(2)).

The obligation to publish a decision or decision summary can be limited by the imposition of a publication ban by either the investigation committee (Act, s. 43(3)) or hearing committee (Act, s. 53(5)).

Decisions of the Registrar or investigation committees which do not result in referral to a hearing (i.e. dismissal, caution, informal resolution), remain confidential.

The College currently maintains a database for information about the complaints process, but it is not being used to track statistical information (including demographic information) about sexual misconduct complaints or repeated incidents of complaints or inquiries about the same physician.

Accordingly, the College does not have a comprehensive data set to allow for the analysis of trends over time in relation to sexual misconduct violations, including the nature and seriousness of allegations, demographic data on complainants or respondent physicians, or disciplinary outcomes. The College also does not have a method of tracking patterns of inappropriate sexual behaviour by physicians which does not necessarily result in a complaint but may indicate a risk to the public.

2. **Issues and recommendations**

The Panel recognizes that public reporting is essential for public trust. The College reports an increase in sexual misconduct inquiries/complaints in recent years. However, it remains likely that sexual misconduct violations remain significantly under-reported, given the incidence of under-reporting of sexual assault and harassment in the general population.

The College has expressed a concern that public disclosure of the statistics about sexual misconduct cases might negatively impact reporting because the majority of complaints about sexual misconduct have been dismissed and this might lead complainants to believe there is no point in filing a complaint. Nonetheless, the Panel recommends that the College [gather, maintain, analyze and publish information on sexual misconduct complaints to improve public accountability and provide data for future improvements to the process.](#)

One reason to do so is in order to identify gaps in complainant populations or any over-representation in physician populations (both of which could inform outreach or educational initiatives by the College).

In addition to **maintaining a database of aggregated anonymized data about the complaints process and collecting and publishing qualitative records of complaint characteristics and outcomes**, the Panel recommends that the College **offer an optional evaluation form for all participants in the professional conduct process (complainants, respondents, witnesses, committee members) after each complaint** in order to receive feedback, and develop further evidence-based reforms to the process. The Panel recommends that the College **use this optional form to track demographic data about complainants and respondents in sexual misconduct violation cases**, including age, gender identity, sexual orientation, first language, race/ethnicity and education level.

PART THREE: FINAL RECOMMENDATIONS

The following recommendations of the Panel are set out in detail in sections in this Part:

1. Use the ongoing review of the College standard on sexual misconduct to improve clarity for physicians and the public concerning prohibited physician conduct, and capture other physician conduct which can cause harm to a patient;
2. Require specialized, ongoing training for College staff and committee members involved in sexual misconduct complaints;
3. Improve public understanding of the role of the College and its complaints process;
4. Reduce barriers to reporting by making the complaints intake process more accessible and appropriate to complainants in sexual misconduct cases;
5. Ensure appropriate, timely, and accurate communications between the College and complainants;
6. Offer access to legal advice and counselling support to complainants in sexual misconduct cases;
7. Use a single investigator trained in trauma-informed interview techniques to conduct sexual misconduct investigations;
8. Take steps to mitigate the personal and professional impact of interim measures on a respondent physician, taking into account the public interest;
9. Adopt a complainant-led approach to the informal resolution of sexual misconduct complaints;
10. Minimize harm to complainants during the hearing process by offering adaptations and accommodations; and
11. Gather, maintain, analyze and publish information and data on sexual misconduct complaints for public accountability and to inform further improvements.

1. Revise the existing College standard on sexual boundaries

- a) Rename the standard to remove the reference to the “Physician-Patient Relationship”, i.e. “Sexual Misconduct by Physicians”.
- b) Specify the acts or behaviours which constitute disciplinable conduct in the standards, rather than just by providing examples in the guidelines.
- c) Distinguish between physician behaviour which constitutes professional misconduct, conduct unbecoming and incompetence.
 - i. Identify and distinguish between different types of sexual misconduct within clinical practice which constitute professional misconduct under the standard, including by providing specific examples;
 - ii. Identify competence issues which could give rise to an allegation of sexual misconduct, and how the College will address them through the professional conduct process (e.g., a failure to adequately explain or seek consent for touching during a sensitive clinical examination or procedure);
 - iii. Identify the circumstances in which behaviour outside of clinical practice will constitute disciplinable sexual misconduct as conduct unbecoming (e.g. workplace sexual harassment, or in the case of criminal conviction for sexual assault).
- d) Modify the reporting obligation on physicians to change the “reasonable grounds to believe” requirement to “reasonable grounds to suspect”. Require reporting of any suspicion of sexual misconduct by a physician.

2. Require specialized training for College staff and committee members involved in sexual misconduct complaints
 - a) Provide mandatory training to all College staff who may be involved in the complaint intake and case management process on:
 - i. Implementing trauma-informed approaches;
 - ii. Supports or accommodations available to complainants in sexual misconduct cases; and
 - iii. Confidentiality requirements for complainants and respondents.
 - b) Provide mandatory training to all Expedited investigation committee members, investigators and hearing committee members on:
 - i. The neuro-biology of trauma and the relationship between memory formation and sexual trauma;
 - ii. Trauma-informed interview techniques;
 - iii. Legal concepts of consent, including the criminal law definition;
 - iv. The relationship between gender and race-based myths and stereotypes, implicit bias, and the incidence of sexual assault and sexual harassment; and
 - v. The adverse impact of empirically unfounded and discriminatory myths and stereotypes on fact finding processes in cases involving allegations of sexual misconduct.
 - c) Provide mandatory training to all members of the hearing committee on the unique evidentiary issues that arise in sexual misconduct cases, including records requests and the relevance standard for admissibility of evidence about the complainant;
 - d) Ensure that all training is provided by experts in the relevant area/s and require that it be completed before any of the individuals identified above are permitted to perform their role in a complaint process. Require that this training be updated and refreshed every two years.
 - e) Assign a member of the College staff the role of maintaining records regarding training and ensuring that the required training has been completed and updated.

3. Improve public understanding of the College and complaints process

- a) Use or consult with a plain language expert in preparing all public materials about the College complaints process.
- b) Make comprehensive information available (in printed form and on the College website) about the College's professional conduct process, which:
 - i. Uses accessible language (and visual aids, including video) to describe the professional conduct process in detail, including the possible procedural and substantive outcomes of the process;
 - ii. Includes clear information about the College's role in the discipline of physicians and the complaints process; and
 - iii. Offers access to translation and/or interpretation services for the complaints process, written in commonly spoken languages (i.e. French, Mi'kmaq, Arabic).
- c) Make information about the College's complaints process available to be displayed by hospitals and doctor's offices in an accessible, plain language format.

4. Make the complaints intake process more accessible and appropriate to complainants in sexual misconduct cases
 - a) Stream public inquiries which self-identify as relating to a complaint of sexual misconduct from the general complaints process to reduce barriers to reporting:
 - i. Create a separate webpage on the College's website to provide information about complaints of sexual misconduct as distinct from general complaints.
 - ii. Offer a separate phone number and voicemail box for self-identified sexual misconduct complaints, with a message that indicates when the Public Support Advisor will be available to take their call in-person if they do not wish to leave a voicemail.
 - iii. Include information about the Public Support Advisor's role, including her email address, on the website and indicate that initial contact by a sexual misconduct complainant can be made through email to the Public Support Advisor, or through a secure web-based form.
 - b) Prepare an alternative or supplemental information package for sexual misconduct complaints which identifies in plain language:
 - i. What happens once information suggesting sexual misconduct by a physician is received by the College, including what may occur in the event that the complainant does not wish to be identified or participate in a formal process; and
 - ii. Additional supports and accommodations available for complainants in such cases, including at a hearing, and how they can be accessed.
 - c) Offer a separate complaint form for sexual misconduct complaints (but allow such complaints to also be submitted on the general complaint form). The sexual misconduct complaint form should include questions about:
 - i. How a complainant wishes to communicate with the College, and how the College can safely contact the complainant; and
 - o What the complainant's desired outcome of the complaint process is, including whether they are interested in an informal resolution of the complaint if the College deems it to be appropriate.
 - d) Revise the general complaint form to avoid questions which could be taken to imply that there are pre-conditions to filing a complaint (e.g., "have you brought your concerns to this

doctor's attention?"). The College should collect this information at a later stage in the process, if necessary.

- e) Use or consult with a plain language expert on the creation of the specific sexual misconduct complaint form and on the revisions to the general complaint form.
- f) Where a complainant prefers not to or is not able to submit a written complaint, receive complaints by recorded phone calls or recorded interviews, appended to a signed complaint form which indicates explicitly that the complainant adopts their recorded statement as the substance of their complaint. Ensure that it is clear on the website that a complaint can be submitted in this way.
- g) Develop a safety protocol which allows for College staff to meet in person with a complainant at the intake stage of the process, if the complainant requests an in-person meeting.

5. Ensure appropriate, timely, and accurate communications between the College and complainants
 - a) Require College staff to seek the preferred method (e.g., phone calls, letters, emails etc) and frequency of communication with complainants, and then make a communication plan in the file. Provide updates on the status of their complaint according to the plan. Do not restrict the use of email in official correspondence with complainants, if they prefer to use email.
 - b) Use clear, plain language in written correspondence with complainants, and offer the chance for complainants to speak to the Public Support Advisor if they have questions about the correspondence they receive.
 - c) Clarify the meaning and limits of the confidentiality requirement under s. 46 of the *Medical Act* for both doctors (e.g., it does not preclude one from canvassing witnesses, preparing for hearing) and complainants (e.g., it does not preclude one from seeking assistance or counselling, speaking about own experiences). Ensure that staff is able to explain these requirements in plain language in their communication with complainants and respondent physicians.

6. Offer legal and counselling support to complainants in sexual misconduct cases

- a) Provide all complainants with access to funding for independent legal advice and representation.
 - i. Funding for legal services should be offered on a certificate model which provides every complainant with access to a fixed number of hours of legal services, with additional funding for legal services to be available only if deemed necessary by the College; and
 - ii. Maintain a roster of qualified and interested lawyers who can offer competent legal services to complainants and who are willing to accept certificates on the College's terms. Require lawyers on this roster to confirm that they are competent in sexual assault law and have made themselves familiar with the College's disciplinary process.
- b) Provide access to a fixed number of hours of funded therapeutic counselling to all complainants whose sexual misconduct complaints are referred to a hearing committee (whether or not a hearing occurs), and to others at the discretion of the Registrar.
- c) Ensure that complainants are provided with a clear explanation of the current role of the Public Support Advisor as a neutral navigator in assisting the complainant during the complaints process at the College (i.e. not as an advocate, and not in a confidential capacity).
- d) Work with other stakeholders to provide assistance to complainants who make an allegation of sexual misconduct against their physician in gaining access to an alternate health care provider.

7. Use a single trauma-informed investigator to conduct sexual misconduct investigations

- a) Employ the process provided under s. 96 of the Regulations and have a single investigator appointed to conduct the investigation:
 - a. Develop a small pool of qualified sexual assault investigators to be engaged as an investigator in all complaints of sexual misconduct, and use external investigators where appropriate. This investigator should have legal training, familiarity with a medical context, and demonstrated experience conducting trauma-informed investigations relating to sexual misconduct.
 - b. Permit the investigation committee to instruct the investigator on areas of questioning of interest to the Committee prior to the interviews.
 - c. Require the investigator to audio and/or video record all interviews for the benefit of the investigation committee.
 - d. Require the investigator to complete an investigation report for consideration by the investigation committee. The report should outline investigative steps undertaken and summarize and conduct a limited weighing of the evidence relevant to the allegation.
 - e. Allow the investigation committee to require the investigator to conduct supplementary interviews after it reviews the investigation report.
 - f. Offer the complainant the opportunity to appear before the investigation committee prior to their decision, but do not require them to do so.
 - g. Offer the respondent the opportunity to make submissions to the investigation committee on the investigation report prior to their decision.
- b) Commit to investigation guidelines which ensure a trauma-informed process. The investigator should offer accommodations to a complainant to make the investigation process more trauma-informed, including the location and timing of interviews, the availability of supports, and the nature of the questioning.
- c) Develop written guidelines for the investigation committee on how to apply the legal standard of “sufficient evidence if proven” for referral to a hearing, with specific attention to the question of how to address cases in which credibility is a central issue.
- d) Only impose an expedited timeline for the investigation if there is a need to do so in order to protect the public interest or the integrity of the process. However, the College’s approach

in every case should recognize that a trauma-informed approach to responding to complaints of sexual misconduct requires that unnecessary delays be avoided and that each stage of the process occur in a timely manner.

8. Review the principles and practices behind the use of interim measures:

- a) Develop guidelines for the use of undertakings and interim measures which outline the possible restrictions that the College will consider imposing or agreeing to and in what circumstances:
 - i. Review current practices to ensure available restrictions are designed to achieve the goal of public protection with the least possible impact on the practice of a respondent physician.
 - ii. Consider whether interim restrictions which will provide constructive notice of the existence of a sexual misconduct complaint (i.e. signs) are appropriate or necessary, given the potential harm to the respondent physician and public confidence.
 - iii. Make these guidelines available on the College website along with other professional conduct process materials for the benefit of complainants and respondents.
- b) Provide respondent physicians with a meaningful opportunity to negotiate an undertaking which achieves the College's objective before seeking to impose an interim measure under s. 45 of the *Medical Act*.
- c) Seek the early involvement of CMPA counsel in all cases involving interim restrictions or undertakings, where possible. Work with the CMPA to develop a protocol to streamline this process.
- d) Require the investigation committee to provide a clear written articulation to respondent physicians explaining the connection between the particular interim measure imposed and the goal of public protection.

9. Adopt a complainant-led approach to the informal resolution of sexual misconduct complaints
- a) Include a question on the complaint form that offers the complainant the opportunity to share their desired outcome from the professional conduct process, including their interest or willingness to participate in an informal or alternative dispute resolution process.
 - b) Empower the investigator to canvass the willingness of the complainant and respondent physician to participate in an informal resolution of the complaint prior to the completion of an investigation report, if the College deems that it would be in the public interest to do so.
 - c) Establish written guidelines for use by the Registrar and investigation committee with respect to the exercise of discretion to resolve a sexual misconduct complaint without a hearing.
 - d) Canvass and consider the wishes of the complainant in all decisions to resolve a complaint by an alternative means, including informal resolution or settlement.
 - e) In cases where a complaint is dismissed by the investigation committee, offer the complainant the opportunity to discuss any outstanding questions or concerns about the outcome of their complaint, with the Registrar or their designate in order to promote public confidence in the professional conduct process.

10. Minimize harm to complainants during the hearing process

- a) Develop a guideline for when complainants or other witnesses will be subpoenaed by the College against their wishes to testify at a hearing (i.e., only when the College has established necessity, and balanced the harm to the witness and the public interest). Such cases should be extremely rare.
- b) Impose publication bans on the identity of the complainant or any witnesses alleging sexual misconduct unless the complainant or witness specifically requests otherwise.
- c) As a standard preliminary matter in each case involving a sexual misconduct complaint, require that the hearing committee consider the question of whether: (a) the hearing should be closed or partially closed in order to protect the privacy of the complainant; and (b) whether to impose restrictions on the publication or broadcasting of evidence about the complainant which would unduly infringe upon their privacy, with particular attention to the use of social media to broadcast evidence from a hearing in real time.
 - a. Provide the complainant with the opportunity to make submissions on these questions, by themselves, with the assistance of counsel for the College, or through their own counsel.
 - b. Require that the hearing committee provide reasons in each case in which a hearing is not closed when requested by any party.
- d) Require that the hearing committee inform the complainant or any other witness, of the availability of accommodations during the hearing process including screens, the presence of a support person, the use of support animals, and the ability to testify by video from another location in each case involving a sexual misconduct complaint. The hearing committee should consider any objections by the respondent physician on the basis of procedural fairness in deciding whether to grant the request of a complainant or witness for the use of such accommodations. Require that the hearing committee provide reasons in each case in which a complainant's request for accommodations of this nature is not granted.
- e) Develop written guidelines for the assessment of relevance in questioning complainants, including by identifying impermissible myths and stereotypes which may not be used to ground a claim of relevance. These guidelines should be premised on principles derived from the criminal protections for complainants in sexual assault proceedings.
- f) Develop a process for the exercise of the investigation committee or hearing committee's power to order the production of complainant records and the purpose for which a complainant's private records (whether in the possession of the respondent physician or not) can be used, in consultation with experts in sexual assault law.

- g) Do not permit cross-examination of a complainant by a self-represented respondent. The College should appoint counsel for the purpose of cross-examining a complainant in such instances.
- h) Allow complainants to present victim impact statements orally or in writing to the hearing committee, where a complaint is substantiated or a settlement agreement is being considered. Do not permit cross-examination on a victim impact statement.
- i) Create a written procedural guide for the hearing committee reflecting all of the above.

11. Gather, maintain, analyze and publish information on sexual misconduct complaints for public accountability and improvement

- a) Optimize the use of the College's database technology to allow for aggregated anonymized data collection.
- b) Continue to track inquiries received by the College about a sexual misconduct violation which do not result in the filing of a complaint. Develop a database function to identify when multiple disclosures have been made about the same physician that do not result in a formal complaint.
- c) Track the incidence of complaints that include an allegation of a sexual misconduct violation.
- d) Track the progress of complaints through the professional conduct process, and note outcomes at each stage.
- e) Compare data about sexual misconduct inquiries and complaints over time and with other jurisdictions, where possible.
- f) Publish reports about the incidence and outcomes of sexual misconduct complaints.
- g) Offer an optional evaluation form for all participants in the professional conduct process (complainants, respondents, witnesses, committee members) after each complaint in order to receive feedback, and engage in evidence-based reforms to the process. Use this optional form to track demographic data about complainants and respondents in sexual misconduct violation cases, including age, gender identity, sexual orientation, first language, race/ethnicity and education level.

APPENDIX A

Independent Review of the College of Physicians and Surgeons of Nova Scotia's Policies, Practices, and Procedures for Responding to Allegations of Sexual Misconduct by Physicians

TERMS OF REFERENCE

Mandate:

The College of Physicians and Surgeons of Nova Scotia (the College) will engage the Canadian Centre for Legal Innovation in Sexual Assault Response (CCLISAR) to conduct a review of the College's policies, practices and procedures in response to allegations that a member of the College has engaged in sexual misconduct.

Scope of Review:

This review will assess the operation of the College's policies, practices, and procedures in order to ensure that the College has effective and defensible practices and procedures that are: responsive to those who report experiences of sexual harm; trauma-informed; and procedurally fair.

The review will result in a Final Report highlighting any recommendations for improvement and identifying any follow-up issues. This document will be public.

Description of the Review Process:

The review process will involve four stages.

Stage 1. An Independent Review Panel (IRP) will conduct a document review of the College's relevant policies and procedures as well as any other documentation and materials provided by the College or requested by the IRP. This stage of the review will also include a review of other provincial/territorial Colleges' policies on sexual misconduct and relevant secondary literature and reports.

Stage 2. The IRP will conduct in-person consultations with relevant stakeholders over the course of a three days in March 2019 in Halifax, Nova Scotia. The focus of these consultations will be on the College's processes and practices for responding to allegations of sexual misconduct against a member of the College. The IRP will meet and consult with any individual or organization identified by either the College or the IRP who are likely to provide information relevant to the scope of this review. This could include meetings with members of the College's staff (especially the individuals responsible for receiving complaints and doing intake), physicians and laypeople who have served on investigatory or adjudicative panels for the College, representatives from organizations such as the Canadian Medical Protective Association, or the College's legal counsel.

These consultations should also include meetings with individuals who have experience with the College's process (or part of it) as either a complainant or respondent. The College will take

reasonable steps to identify individuals of this description and forward a letter from the IRP inviting them to participate.

The College will manage the scheduling and coordination of the in-person consultation meetings.

Any comments, observations, or insights offered during these consultations or in writing will remain unattributed in CCLISAR's report. The IRP's notes, emails received through the IRP's designated email account, and internal correspondence between members of the IRP will not be produced to the College or made public.

Stage 3. A draft of the Final Report will be circulated to an Expert Advisory Group (EAG). This group will meet in Halifax, NS at the Schulich School of Law for a one-day workshop to discuss and provide feedback on this document and to offer any suggestions for revisions before the Report is finalized.

Stage 4. The Chair of the IRP will revise and, with the IRP, finalize the Report and will then present the Final Report to the College in May, 2019.

Composition of the Independent Review Panel:

The Independent Review Panel will be comprised of three individuals external to and independent from the College. The Chair of the IRP will be a practicing lawyer with expertise in gender-based harm and professional discipline related complaints processes. The remaining members of the IRP will include legal academics with expertise in legal responses to sexualized violence, trauma informed investigative and adjudicative models and/or the legal regulation of health professionals.

Composition of the Expert Advisory Group:

The Expert Advisory Group (EAG) will have up to nine members. Members of this group will have relevant experience in professional discipline complaints processes and/or legal processes for responding to sexualized violence (e.g. adjudication or investigation) and/or expertise regarding issues of gender-based harm. The Chair of the IRP will also chair the EAG and the other two members of the IRP will be a part of the EAG.

Up to three members of the EAG will be selected by the College (preferably this will include a member of the College's administration team who is familiar with organization's policies and practices; and a legal practitioner who has experience with this type of process either as counsel to the College or through CMPA defence work).

Up to three further members of the EAG will be selected by the Research Director of CCLISAR. Members selected by the Research Director of CCLISAR will be academics with relevant expertise who are external to and independent from the College.

This group will provide advice to the IRP on the Report and its recommendations.

Proposed Timeline for the Review:

- January 2019: Finalize terms of reference/contract
Begin review of documents provided by the College
Compile list of relevant stakeholders for consultations (in consultation with the College)
- February 2019: Complete preliminary review of the College documents and materials
Conduct review of background materials (reports from other colleges' processes/review of policies at other colleges/secondary literature)
Schedule consultations (in collaboration with the College)
- March 2019: IRP – Conduct consultations/interviews
Draft Report with recommendations
- April 2019: Circulate interim draft to Expert Advisory Group
Hold Expert Advisory Group Workshop
- May 2019: Revise report in light of EAG Workshop
Finalize Report and present to the College

APPENDIX B



Professional Standards and Guidelines Regarding Sexual Misconduct in the Physician-Patient Relationship

This document is a physician **standard** and **guidelines** approved by the Council of the College of Physicians and Surgeons of Nova Scotia.

A **standard** reflects the minimum professional and ethical behavior, conduct or practice expected by the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are required to be familiar with and comply with the College standards.

Guidelines contain recommendations endorsed by the College of Physicians and Surgeons of Nova Scotia. The College encourages its members to be familiar with and to follow its guidelines whenever possible and appropriate.

Preamble

Exploitation of a patient is professional misconduct. Sexualized behaviour with a patient is exploitation. Sexualized behaviour with a former patient may be exploitation.

This standard reflects ethical responsibilities of physicians set out in the [Canadian Medical Association's Code of Ethics](#). In particular, the following sections of the Code are reflected:

1. Consider first the well-being of the patient.
2. Practice the profession of medicine in a manner that treats patients with dignity and as a person worthy of respect.
13. Do not exploit patients for personal advantage.

The following principles which form the basis of this professional standard are:

- (a) Trust is the basis of the patient-physician relationship;
- (b) The patient is considered to be the vulnerable individual in the professional relationship;
- (c) Power imbalance exists in the patient-physician relationship;

- (d) Transference may develop as a result of the power imbalance;
- (e) Sexualized behaviour in the patient-physician relationship is never acceptable;
- (f) A breach of sexual boundaries has potential for significant harm to the patient;
- (g) The physician cannot provide objective care when a sexualized relationship exists;
- (h) The onus is always on the physician to maintain professional boundaries with a patient and not to exploit the patient in any way; and
- (i) The nature of a fiduciary relationship makes a consensual sexual relationship between physician and patient impossible.

A “sexual boundary” violation describes a range of behaviours in which professional boundaries are crossed when sexual actions are allowed to enter into a physician-patient relationship.

Any finding of a sexual boundary violation by a physician within a physician-patient relationship will result in a disciplinary sanction. Physicians should be mindful that terminating the physician-patient relationship does not eliminate the possibility of a sexual boundary violation.

Professional Standards

1) Standards in a Physician-Patient Relationship

- a) Physicians must respect professional boundaries in their interactions with their patients and must not sexually interact with their patients nor exploit them in any way.

2) Duty to Report

- a) If a physician has reasonable grounds to believe that another physician may be guilty of sexual misconduct with a patient, the physician must notify the College of Physicians and Surgeons of Nova Scotia and immediately do the following:
 - (i) Inform the patient that all physicians have a duty to notify the College of Physicians and Surgeons about alleged sexual misconduct by other physicians;
 - (ii) Inform the patient that he or she may make a written complaint to the College;
 - (iii) With the consent of the patient, the physician will provide the name of the patient and the physician involved to the College; and
 - (iv) If the patient withholds consent to be named, the physician is limited to notifying the College of the alleged incident and the name of the physician involved.

Guidelines

The following guidelines assist in meeting the professional standards.

1) Professional Misconduct

Professional misconduct in the physician-patient relationship includes, *but is not limited to* the following:

- a) Voyeurism as may be expressed by inappropriate disrobing or draping practices that reflect a lack of respect for the patient's privacy;
- b) Inappropriate comments about or to the patient, including making sexual comments about the patient's body or clothing;
- c) Inappropriate comments about the patient's sexual orientation or gender identification;
- d) Making comments about the patient's potential sexual performance during an examination or consultation, except when the examination or consultation is for the purpose of addressing issues of sexual function or dysfunction, and the comments are relevant to the management of that patient's problem;
- e) Requesting details of sexual history or sexual preference in any situation when this is inappropriate;
- f) Initiation by the physician of inappropriate conversation regarding the sexual problems, preferences or fantasies of the physician or patient;
- g) Failure to obtain permission to perform an examination of breasts, genitals, or anus;
- h) Examination of breasts, genitals, or anus when not clinically indicated or performed in a non-standard manner;
- i) Performing a pelvic examination, anal-rectal examination, or examination of external genitalia without wearing gloves;
- j) Inappropriate body contact, including hugging of a sexual nature and kissing;
- k) Touching or massaging breasts, genitals or anus, or any other sexualized body part for any purpose other than appropriate physical examination or treatment; and
- l) Physician-patient sex, whether consented to or initiated by the patient, and any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Such activities may include, but are not limited to, the physician encouraging the patient to masturbate in the physician's presence, masturbation by the physician of himself or herself or the patient, and contact between the mouth, genitals, or anus of the physician and the mouth, genitals, or anus of the patient.

2) Precautions in Practice

Consideration should be given to the following:

a) Patient Undressing:

- (i) A physician should provide complete privacy for a patient to undress and to dress;
- (ii) A patient should be provided with an adequate gown or drape; and
- (iii) The physician should not assist with removing or replacing the patient's clothing, unless the patient is having difficulty and consents to such assistance.

b) Communications:

- (i) A physician should be careful to ensure that any remarks or questions that are asked cannot be construed as demeaning, seductive or sexual in nature; and
- (ii) When sensitive subjects, such as sexual matters, have to be discussed, the physician should explain why the questions have to be asked, so that the intention cannot be misconstrued.

c) Documenting Sexualized Behaviour:

- (i) Physicians should document any sexualized behaviour by the patient.

d) Undue Touching:

- (i) Hugging and kissing a patient is considered high risk behaviour that can be misinterpreted. Any touching that is not part of the physical examination must be of a type that cannot be misconstrued.

e) Cultural Preferences:

- (i) A physician should be aware and be mindful of the particular cultural preferences in the diverse patient population.

f) Attendants

- (i) Although attendants are not mandatory, a physician should carefully consider whether an attendant would contribute to an individual patient's feeling of comfort and security. Also, an attendant may protect the physician from unfounded allegations. If a patient asks to have an appropriate support person in the room, that request must be honoured. Signage indicating that an attendant is available or a printed policy regarding the provision of attendants is a good practice.

g) Dual Roles:

- (i) Physicians should not use a patient as a confidante or for personal support, invite the patient to accompany them to social events, discuss the physician's sex life or relationships or engage in other similar behavior that is outside of the physician-patient relationship.

h) Non-sexual boundaries:

- (i) A physician should avoid crossing non-sexual boundaries such as self-disclosure of personal information, as these may accumulate and take the physician down the "slippery slope" into the realm of sexual misconduct.

i) Unusual Office Practices:

- (i) A physician should not ask the patient to come in at odd hours, or to meet at his or her home or some other unusual place.

Resources

Physicians in situations of uncertainty are encouraged to contact the Canadian Medical Protection Association, the College of Physicians and Surgeons of Nova Scotia or Doctors Nova Scotia.

Canadian Medical Protective Association
[Recognizing boundary issues, 2014](#)

Acknowledgements

In developing this standard, the College incorporated information provided in the policies of the Colleges of Physicians and Surgeons of Alberta, British Columbia and Ontario.

Document History

Approved by the Council of the College of Physicians and Surgeons of Nova Scotia: **December 9, 2016**

This document was reviewed and approved with minor changes by the Council of the College of Physicians and Surgeons of Nova Scotia: **September 29, 2000, March 10, 2006, December 10, 2010**

Approximate date of next review: **2019**

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APPENDIX C

The College of Physicians & Surgeons of Nova Scotia

As the licensing and governing body for physicians in the province of Nova Scotia, the College takes your complaint seriously and will investigate it. Often the complaints process takes several months depending on the complexity of the complaint. If you are complaining about more than one physician, please complete a separate form for each. Additional forms may be obtained by calling 902 422 5823 or toll free at 1 877 282 7767, or you may photocopy this form.

The Complaints Process:

To begin an investigation into your complaint please

- **Complete this form (one form per physician)**
- **Forward the completed forms to the College's Investigations Department**

If you have any questions or require assistance to complete this form, please contact the Professional Conduct Department, at 902 422 5823 or toll free at 1 877 282 7767.

1. Patient information

Ms/Mrs/Mr/Dr _____	Address _____
Last Name _____	_____
Given Name _____	_____
Birth Date _____	Tel. Home _____
Health Card # _____	Tel. Work _____

2. Person making the complaint:

Same as Above (#1)

OR

Relationship to patient _____	Address _____
Ms/Mrs/Mr/Dr _____	_____
Last Name _____	_____
Given Name _____	Tel. Home _____
	Tel. Work _____

3. Print full name of the doctor complained about along with his/her address and telephone number.

Physician Name	Address	Telephone Number

4. How long have you been a patient of this doctor? _____

**5. Have you brought your concerns to this doctor's attention? Yes ___ No ___
Please explain.**

6. Provide the full name of any other individual(s) and the details of the information they may have pertaining to your complaint (e.g., other doctor, therapist, chiropractor).

Name	Address	Information details

7. Provide full names of hospitals and dates you attended, related to your complaint, if applicable.

Name of Hospital	City	Date(s) attended

8. Provide a clear description of the complaint you have about the doctor. Please explain in your own words an account of the incident in question. (Attach additional pages if necessary)
Please print or type your complaint.

I wish to lodge a formal complaint about Dr. (...)

Signature

Date

Please attach any relevant information that will assist our inquiry into this complaint.

COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA
Suite 5005 - 7071 Bayers Road
Halifax, NS B3L 2C2

Telephone: 902 422 5823
Toll free: 1 877 282 7767
Fax: 902 422 5271

APPENDIX D

Frequently Asked Questions

Collapse All

What is the College of Physicians and Surgeons of Nova Scotia and what does it do?

The College is the body that licenses and regulates the province's physicians under the [Medical Act](#).

What can I do if I am concerned about a physician or a physician's practice?

If you feel you cannot talk to your physician or the issue is not resolved, you can call the College's Professional Conduct Department for assistance at 902-422-5823 (toll-free in 1-877-282-7767). By contacting the College you are not automatically filing a complaint against your physician.

What are my rights as a patient?

Patients have the right to:

- Be treated with respect;
- Expect confidentiality be maintained within the circle of care, unless their physician explains why it has to be broken;
- Refuse an examination or treatment;
- Withdraw consent without obligation or harassment;
- Expect their physician not to take physical, emotional, sexual or financial advantage of them;
- Be kept informed, if possible, of major delays in obtaining consultations or treatments;
- Receive appropriate referrals;
- Request a second opinion;
- Be listened to carefully and supportively regarding their concerns; and
- Have another person present during examinations.

When should people make complaints about physicians?

The College investigates any complaint regarding the conduct, actions, competence, or capacity of a physician. Anytime an individual has concerns in this regard, a complaint to the College may be warranted.

The College views the conduct of a physician through the lens of the [Professional Standards and Guidelines](#) approved by the College's Council. Physicians must comply with all College standards and are recommended to follow all College guidelines. Physicians are expected to stay current with these documents.

If you believe your physician is not practising professionally, you are encouraged to review the standards as outlined in the College's [Professional Standards and Guidelines](#). You may also wish to review the [Canadian Medical Association's Code of Ethics](#).

Who can make a complaint?

Complaints about physicians can come from anyone, including patients, patients' families, other physicians, and other agencies. A person who files a written complaint with the College is known as a "complainant."

Can I complain for someone else?

Yes. With the patient's consent, or consent of the patient's legally authorized representative (example: legal guardian), a complaint can be filed.

When you file a complaint on behalf of someone, this is referred to as a *First-Party Complaint*. You must meet one of the following requirements:

- obtain the patient's signed written consent (as long as the patient has the mental capacity to consent), or;
- obtain a copy of a personal directive (a personal directive gives you permission to make personal decisions on behalf of an individual that has lost the mental capacity to make such decisions), or;
- be appointed a representative under the [Adult Capacity and Decision-making Act](#) – the College will require a copy of the Court's [representation order](#).

A First-Party Complaint can be filed on behalf of a deceased person by the Executor of the estate. Please note the College will request a copy of the Will, and may require the Will to be authenticated.

If no Will is available, please contact the [Professional Conduct Department](#).

What if the documentation required by the College is not available? Can I still file a complaint on behalf of someone else?

Yes. When the necessary documentation is not available a complaint can be filed on behalf of someone else. This is referred to as a *Third-Party Complaint*.

In such cases, the party filing the complaint is not able to receive any confidential information related to the complaint.

As directed by the [Medical Act](#), all information received by the College from the complainant during the course of the investigation is copied to the physician against whom the complaint is filed.

All disciplinary decisions are [published](#) on the College's website.

How do I make a complaint?

- [Complaint Forms](#)
- [Complaint Process](#)

While a complaint form is recommended, complaints can also be filed without a form if they are typed or clearly printed by hand. All complaints must be submitted in writing and signed by the

complainant. The College recommends that complaints not be submitted by email due to the personal nature of the information collected.

Complaints must contain:

- Complainant contact information.
- Patient information including date of birth.
- The physician's name.
- A description of the events that led to the complaint (such as the date and location) and any other information that may help the College in its investigation.
- If possible, complaints should also contain the names of people who witnessed the event or who have other useful information.

In order to proceed with a complaint investigation, the "Authorization and Consent to Release Information" on page 1 of the Complaint Form must be signed. Please note, this is not required for complaints made by the patient, only for complaints that involve care of someone else.

How does the College deal with complaints?

When the College receives a written complaint about a physician:

- All complaints are subject to a preliminary review by Investigations staff.
- Complaints are triaged by the Director of Professional Conduct. Any issue that involves public safety is reviewed immediately by the Registrar.
- The complaint is sent to the physician, who in most cases has 30 days to respond.
- Complaints of a more serious nature are processed on an expedited basis, and the physician is typically given seven days to respond.
- The complaint and response are reviewed by Professional Conduct staff and the Registrar as part of the preliminary investigation.
- Any additional medical records, documents or statement which would be helpful are requested.

Physicians may sometimes need more than 30 days to respond to a complaint. If this happens, the Professional Conduct Department may grant an extension to the physician in order to prepare and submit a written response.

Once a preliminary investigation is conducted and the findings reviewed by the Registrar, the Registrar then can:

- Dismiss a complaint.
- Refer the matter to the investigations committee.
- Authorize the resignation of physician – with consent.
- Refer a physician for capacity assessment – with consent.

Is there a time limit to file a complaint?

There is no time limit to file a complaint, but the College recommends that complaints be submitted as soon as possible. The earlier a complaint is received, the sooner any possible risks

to the public can be addressed. If a complaint is received long after an event, it may be more difficult to obtain medical records or other information necessary to investigate the complaint.

Who will review the complaint?

You receive a letter from the College acknowledging receipt of your complaint. The Professional Conduct Department staff conducts a preliminary investigations ensuring that all required documentation is submitted. The Registrar then reviews the complaint. The matter may then be reviewed by an investigation committee, and potentially a hearing pool.

How are complaints investigated?

Your complaint undergoes a preliminary investigation by the Registrar, in accordance with the *Medical Act*. The preliminary investigation will include the gathering of information to determine the appropriate means to resolve this matter. Complaints can be resolved in many ways. In the event this matter is resolved as a result of this stage, you will be provided with a letter explaining the decision or outlining next steps.

If a matter is referred to an investigation committee, the investigation committee may appoint an investigator to conduct or to further an investigation.

When investigating a complaint, an investigator may do any of the following:

1. Request additional written or oral explanation from the complainant, the respondent or a third party.
2. Request an interview of the complainant, the physician or a third party.
3. Investigate any matter relating to the respondent that arises in the course of the investigation in addition to the complaint that may constitute any of the following:
 - Professional misconduct.
 - Conduct unbecoming the profession.
 - Incompetence.
 - Incapacity.

A respondent (physician) may submit any information relevant to the complaint to an investigator, including medical information or patient records.

When an investigator has completed their investigation, they must prepare a summary of the investigation and provide a copy of the investigation summary to the investigation committee.

Investigation committees are composed of physicians and members of the public, trained for this purpose. At any time during an investigation, if the committee believes there is concern for public safety and intervention is required prior to final decision of the matter, the committee may direct the Registrar to suspend the physician's licence to practice, impose restrictions or conditions on the practice or suspend the ability of the physician to obtain a licence if not currently licensed.

The investigation committee cannot impose disciplinary sanctions against a physician without his/her consent but may provide advice for improvement or Caution the physician (warning). If the physician does not consent (agree to the discipline), the matter would be referred for formal adjudication by a Hearing Committee.

Hearing Committee

In cases where there is evidence of professional misconduct, incompetence or conduct unbecoming, the investigation committee may refer the complaint to a Hearing Committee. At this point, the College becomes the formal complainant and charges are filed against the physician. The hearing process is similar to a trial, with sworn evidence and legal submissions by a prosecutor acting for the College and a lawyer representing the physician. Complainants may be called to testify as witnesses. In some cases, the matter may be resolved with a settlement agreement. Hearing committee decisions can range from dismissal of the complaint to removal of the physician from practice.

Appeal Process

The *Medical Act* allows a complainant to appeal the dismissal of their complaint by the Registrar through an Independent Review Committee (IRC). A request for appeal must be submitted in writing within 30 days of the date of the dismissal. The IRC may uphold the dismissal, conduct its own investigation, or refer the matter to an investigation Committee. The decision of the IRC is final.

If I file a complaint with the College, am I expected to appear before the Investigations Committee?

The complainant may be asked to meet with the investigation committee reviewing the complaint if committee members require additional information or clarification of the complaint. If so, the complainant may be accompanied by a friend, a family member or some other support person. The physician will not be present if the committee wishes to meet with the complainant.

Does making a complaint cost anything?

There is no fee for filing a complaint.

How long does the complaint process take?

The College makes every effort to resolve complaints as quickly as possible. While the length of the process can vary, most complaints are resolved within six months.

If I file a complaint, should I plan on seeing another physician?

Complaint investigations can take up to six months and sometimes longer. During an investigation, the College recommends that patients involved in complaints avoid contact with the physician named in the complaint. For this reason, patients should plan to see another physician while the College is investigating their complaint, and perhaps permanently. In rare circumstances, it may be necessary for the physician-patient relationship to continue. You are encouraged to contact the College before doing so.

How do I find a physician who is accepting new patients?

To find a family physician who is accepting new patients, please call 811 or visit the [Need a Family Practice Registry](#) to be added to the provincial waitlist.

What should I do if I believe that a physician has engaged in sexual misconduct?

People who suspect sexual misconduct by a physician are encouraged to contact the College. The following are examples of sexual misconduct by a physician:

- Sexual contact between a physician and a patient.
- Unnecessary viewing of all or part of a patient's body by a physician, which may happen if the patient is not permitted to undress in privacy or if the patient is not properly covered when being examined or treated.
- Inappropriate comments about a patient's sexual orientation by a physician.
- Sexualized comments by a physician, including inappropriate remarks about a patient's body or clothing.
- Inappropriate and unnecessary requests by a physician for details of a patient's sexual history.
- Failure by a physician to get permission from a patient before examining private areas of a patient's body.
- Inappropriate examination of a patient by a physician especially when it involves the breasts, genitals or anus.
- Inappropriate body contact between a physician and a patient, including kissing and hugging of a sexual nature.

What are the possible outcomes of complaints?

Dismissal of Complaint:

- Dismissed by Registrar
- Dismissed by investigation committee

Caution. A warning from an investigation committee that a person may have breached the standards of professional ethics or practice in circumstances that are not determined under the regulations to warrant a licensing sanction.

Reprimand (Consensual). A *disciplinary sanction against a physician with the consent of the Physician*, as a result of a finding of professional misconduct, incompetence or conduct unbecoming and *approved by an investigation committee*. This may include permanent conditions or restrictions on the physician's practice or prescribing, repayment of costs to the College, and/or a requirement to undergo additional training.

Reprimand. A disciplinary sanction *imposed against a physician* as a result of a finding of professional misconduct, incompetence or conduct unbecoming. This may be reached through a settlement agreement between the physician and a hearing committee, or imposed by a Hearing committee. This may include permanent conditions or restrictions on the physician's practice or prescribing, repayment of costs to the College, and/or a requirement to undergo additional training.

Sanctions may include the following:

Licence Suspension. The physician remains licensed however is not permitted to practice temporarily. The physician may be required to complete additional training or undergo assessment prior to privileges being reinstated.

Licence Restrictions and Conditions. Limitations put on a physician's practice or prescribing. This may come about with agreement between the physician and an investigation committee, or may be part of a reprimand and imposed by a hearing committee.

Revocation. The physician's licence to practice has been revoked, either by a hearing committee or with consent of the physician.

Are the things I say and write to the College kept confidential?

The College takes great care to ensure that complaint information is kept confidential. Staff and investigation committee members are bound by confidentiality agreements and information in the College's possession is strictly protected by a number of security measures. The College also asks complainants and physicians to avoid speaking publicly about a complaint while it is under investigation.

All complaints received or under investigation, all information gathered in the course of the professional conduct process and all proceedings and decisions of an investigation committee and a hearing committee that are not open to or available to others in accordance with the [Medical Act](#) or the regulations must be kept confidential by any persons who possess such information.

Meetings of investigation committees are not open to the public and their decisions (with the exception of consensual reprimands) are not made public. Proceedings before hearing committees are usually open to the public, except in cases where sensitive information is involved. Decisions of hearing committees are published, but in some cases, publication bans may be imposed on portions of the evidence and the decision. Hearing committee decisions do not ordinarily identify patient names.

During the course of an investigation, it may be necessary for College staff to obtain a copy of a patient's medical records to assist the committee in its investigation. If this is the case, a copy of the records is usually given to the complainant and to the physician in question. If the complainant is not the patient involved in the complaint, this person will not receive a copy of the records, unless the appropriate consent has been provided.

Does the College award financial compensation?

No, the College does not award financial compensation. People seeking financial compensation should seek legal advice.