

COURT OF APPEAL FOR ONTARIO

ARMSTRONG, BLAIR and JURIAN SZ JJ.A.

B E T W E E N:

DR. ANIL MUSSANI	)	W. Neils Ortved, Jonathan Lisus, and
	)	Christopher A. Wayland, for the
Appellant	)	appellant, Dr. Mussani
)	
- and -	)	Paul Schabas, Lisa Brownstone, and
	)	Vicki White, for the respondent, College
COLLEGE OF PHYSICANS AND	)	of Physician and Surgeons of Ontario
SURGEONS OF ONTARIO)	
	)	Sean Hanley for the Intervenor, Attorney
Respondent	)	General of Ontario
)	
- and -	)	Christopher D. Bredt, for the Intervenor,
	)	The Ontario Medical Association
)	
THE ONTARIO MEDICAL	)	Elizabeth J. McIntyre, for the Intervenor,
ASSOCIATION, ATTORNEY	)	Ontario Nurses' Association
GENERAL OF ONTARIO, ONTARIO)	
NURSES' ASSOCIATION and)	
COLLEGE OF NURSES OF ONTARIO	)	Linda Rothstein and Robert A. Centa,
	)	for the Intervenor, The College of
Intervenors	)	Nurses of Ontario
)	
	)	Heard: June 24, 2004

On appeal from a decision of the Divisional Court, dated May 20, 2003 (reported at (2003), 64 O.R. (3d) 641.

R.A. BLAIR J.A.:

In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slave.

The Hippocratic Oath¹

¹ From the Hippocratic Oath: *Dorland's Illustrated Medical Dictionary*, 27th ed. (Philadelphia: Saunders, 1988) at 768.

OVERVIEW

[1] From ancient times the notion of sexual relations between a doctor and patient has been considered fundamentally improper. Even the Hippocratic Oath recognized the problem. But the prohibition of such relations has not prevented human nature from unfolding in predictable fashion. The problem persists in present-day society.

[2] In 1993, the Ontario Legislature – with all party approval – enacted a zero tolerance/mandatory revocation scheme governing discipline for sexual intercourse and other specified sexual acts between health professionals and their patients, in an attempt to deal with the issue. It did so in response to the high profile *Final Report of the Task Force on Sexual Abuse of Patients*², and following widespread consultation amongst the province’s twenty-one regulated health professions.

[3] This appeal concerns the constitutionality of the mandatory revocation scheme, which forms a part of the *Health Professions Procedural Code* (“the Code”)³. These provisions require the mandatory revocation of a health professional’s licence to practise where the health professional is found by the relevant discipline committee to have engaged in certain specified acts of sexual conduct with a patient. In such circumstances the health professional cannot apply for reinstatement for a period of five years.

[4] The appellant, Dr. Mussani, engaged in a sexual relationship with his patient, A.K., between early 1992 and October 1994. He was found guilty of sexual abuse and, in accordance with the mandatory revocation provisions of the Code, his certificate of registration was revoked. His appeal to the Divisional Court was dismissed. He appeals further to this Court, seeking:

a) a declaration that sections 1(3), 1(4), 51(5), and 72(3) of the Code (“the Mandatory Revocation Provisions”) violate sections 7 and 12 of the *Canadian Charter of Rights and Freedoms*, that they cannot be justified under s. 1 of the Charter, and therefore that they are of no force and effect; and,

b) an order setting aside the judgment of the Divisional Court and the Orders of the Discipline Committee of the College of Physicians and Surgeons of Ontario dated December 3, 1998 (to the extent that it contains a conviction for “sexual abuse”) and December 14, 1999, and substituting the penalty of

² College of Physicians and Surgeons of Ontario, Task Force on Sexual Abuse of Patients, Final Report of the Task Force on Sexual Abuse of Patients (Toronto: College of Physicians and Surgeons of Ontario, 1991).

³ The Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

reprimand for the penalty of revocation ordered by the Discipline Committee.

[5] The Ontario Medical Association (“OMA”) and the Ontario Nurses’ Association (“ONA”), who were granted intervenor status, support the appellant. The OMA raises the additional argument that the Mandatory Revocation Provisions also violate s. 2(d) of the Charter.

[6] The Attorney General of Ontario and the College of Nurses of Ontario (“the College of Nurses”) were also granted intervenor status. They support the position of the respondent, the College of Physicians and Surgeons of Ontario (“the College”).

[7] For the reasons that follow, I would dismiss the appeal.

FACTS

[8] Dr. Mussani began treating A.K. as her family physician in 1985. She was then a 23-year old undergraduate student studying physiotherapy. He saw her a few times a year until 1990, and much more frequently between 1990 and the end of 1994.

[9] During their doctor-patient sessions A.K. confided in Dr. Mussani about difficulties in her marriage, and Dr. Mussani provided both counselling and psychotherapy to her, beginning in 1990. He billed OHIP for these services. His medical records contained frequent notes regarding discussions of marital discord and family dysfunction. In 1990, he referred her to a psychiatrist whose notes – which were in Dr. Mussani’s records – also indicated that her marriage was unhappy, her sexual relationship with her husband unsatisfactory, and her self-confidence and self-esteem were wanting. In July 1991, A.K. told Dr. Mussani she “would like to see a marriage counsellor”, but none was recommended or consulted. Dr. Mussani’s records show that he treated A.K. ninety times during 1990 and 1991 for counselling, psychotherapy and physical ailments. In January 1992, he referred her to a specialist for contraceptive advice. His notes indicate that in February 1992, she was “at a loss re: what to do” about her marital difficulties.

[10] A.K. obtained her Bachelor of Science degree in physiotherapy in 1987. She worked with university teaching hospitals for a time and then in private practice in a physiotherapy clinic. At one point – in December 1991 – she became Dr. Mussani’s employee for a period of time, as part of a Workers’ Compensation Board programme.

[11] Over the years, Dr. Mussani and his wife and A.K. and her husband became friends. They began to socialize with one another. In December 1991, they vacationed together in Florida. During the month prior to that vacation, Dr. Mussani had seen A.K.

seven times for counselling and psychotherapy, primarily to discuss her marital discord. Shortly after their return from vacation, the two began to meet for coffee, and soon their relationship evolved into a sexual affair.

[12] The affair lasted from spring 1992 until October 1994. On the surface, at least, the relationship between Dr. Mussani and A.K. appears to have been consensual, between two adult professionals. They professed their love for each other and even discussed marriage.

[13] The treatments continued – including the counselling and psychotherapy sessions – while the sexual relationship was ongoing. There were several billings to OHIP for after hours special visits for counselling. In 1992, Dr. Mussani treated A.K. thirty-five times; in 1993, twenty-nine times; and in 1994, twenty times. The Discipline Committee found no evidence that Dr. Mussani ever attempted to terminate the doctor-patient relationship.

[14] In the summer of 1994, A.K. became pregnant. She did not know whether Dr. Mussani or her husband was the father. Dr. Mussani referred her to an obstetrician for an abortion but did not refer her to anyone in advance for counselling. She had the abortion.

[15] In October 1994, A.K. terminated the relationship.

[16] There was conflicting expert evidence about the nature of the relationship between A.K. and Dr. Mussani, including testimony as to the extent of his boundary violations and as to whether the relationship was exploitive and subject to power imbalances. The Discipline Committee resolved this evidence by finding that Dr. Mussani had “clearly betrayed his patient’s faith in him by engaging in a prolonged sexual relationship with her”, that his conduct was “totally unacceptable” and “a disgrace to the profession”, and that his conduct brought “embarrassment and shame to himself, to his colleagues, and to all members of the profession”. The penalty was mandatory revocation of his certificate of registration. However, the Discipline Committee concluded that revocation was the appropriate sanction even if it had not been mandated by the Code.

[17] During the affair, Dr. Mussani became A.K.’s physiotherapy patient. Her practice, as well as his, is governed by the Code and the *Regulated Health Professions Act*. The appellant relies on this as an indication of the maturity and sophistication of the complainant and as a measure of the professional power balance between them.

[18] Dr. Mussani has also been disciplined for unwanted touching of another female patient. This misconduct occurred during the time that his affair with A.K. was ongoing.

LEGISLATIVE FACT EVIDENCE

[19] The zero tolerance/mandatory revocation regime has a history. It was enacted following the Final Report of the Task Force, which had been established by the College to make recommendations concerning what was then recognized to be an ineffective response by the College and the Courts to the problem of sexual abuse of patients by doctors. The Report was released in November 1991.

[20] The Task Force recommended a policy of zero tolerance together with the mandatory revocation of a doctor's licence as the appropriate means of dealing with the problem of sexual abuse of patients. In formulating its recommendations, it consulted with patients, doctors, advocacy groups, and institutions such as the College. During six months of hearings it received 303 detailed reports of sexual abuse. It reviewed a number of studies that had examined incidents of sexual abuse by physicians, including a Canadian survey, which found that 8% of Ontario women reported sexual harassment or abuse by doctors. The Task Force found ample evidence that sexual abuse by physicians was a serious societal problem.

[21] Its recommendations for zero tolerance and mandatory revocation were founded upon a number of important findings and factors. Principal amongst these were the following:

- a) the general vulnerability of patients in such relationships;
- b) the power imbalance that almost invariably exists in favour of the practitioner, thus facilitating easy invasion of the patient's sexual boundaries;
- c) the privileged position of doctors in society, based on their education, status and access to resources;
- d) the breach of trust entailed in such conduct by physicians;
- e) the serious, long-term injury to the victim, both physical and emotional, that results from sexual abuse, including the harmful effects on future care caused by the victim's inability to place her trust in other doctors and caregivers;
- f) the fact that sexual abuse tarnishes public trust in the entire profession;
- g) the results of an historical review by the Task Force of sanctioning decisions by the College's Discipline Committee

and the Divisional Court, which demonstrated a leniency that reflected “a profound non-appreciation of the harm done to victims”; and,

h) the significant risk of recidivism by abusers, enhanced by the ineffectiveness of rehabilitation measures and previous restrictions on doctors’ practices in providing protection against the re-occurrence of abuse.⁴

[22] The Task Force recommended that the penalty for “sexual violation” of a patient – i.e., any physical sexual conduct – be mandatory revocation of licence for five years. It acknowledged this was severe, but stated the sanction was justified based on the foregoing considerations and the members’ conclusion that doctors should be held to the highest standard of conduct and accountability in this area.

[23] In December 1991, an all-party resolution in the Legislature approved the findings and major recommendations of the Task Force, including the recommendation of a mandatory revocation scheme. A year later, on November 25, 1992, the Minister of Health introduced Bill 100, amending the *Regulated Health Professions Act* to implement the recommendations. It proposed the imposition of the mandatory revocation of licence in a somewhat narrower range of situations than envisaged by the Task Force. Instead of revocation for all forms of sexual touching except kissing, as was recommended, Bill 100 provided for the mandatory penalty only in cases of sexual intercourse and what the parties refer to as the “frank” forms of physical sexual relations listed in s. 51(5) of the Code, which are set out below.

[24] Bill 100 was the subject of wide spread consultation amongst the health professions. Healthcare professional organizations, on the whole, supported the zero tolerance approach to sexual abuse of a patient by a health professional, although there were some concerns expressed regarding what type of conduct should be included in the term “sexual abuse” and what the remedy should be.

[25] Amongst the submissions made on Bill 100 to the Standing Committee of the Legislature on Social Development were those of the Ad Hoc Coalition of Regulated Health Care Associations, the OMA and the Registered Nurses’ Association of Ontario (the “RNAO”), the Ontario Psychiatric Association, the Respiratory Therapy Society, and the Ontario Dental Association. None opposed zero tolerance of sexual abuse in their profession.

⁴ The Task Force on Sexual Abuse of Patients, *Final Report*, (Toronto: The Task Force, 1991) at 15, 16, 24, 92 and 97. See also the Reasons of the Divisional Court (reported as *Mussani v. College of Physicians and Surgeons of Ontario* (2003), 64 O.R. (3d) 641) at para. 26.

[26] The Ad Hoc Coalition represented fifteen different health care associations from fourteen of the regulated health professions (including the OMA). The Coalition took the position “that all instances of sexual relations between practitioner and patient are unethical and that because of the power imbalance in the relationship between practitioner and patient, consent by the patient will rarely be genuine”. It agreed that “[t]he multi-faceted vulnerabilities of the patient create an enormous power differential, raising questions about the ability [of the patient] to give or withhold informed consent to participate in [sexual relations].”⁵

[27] In a separate presentation, the OMA itself submitted that “sexual abuse of patients is absolutely unacceptable and must not be tolerated, and [the OMA] therefore subscribes to the principle of ‘zero tolerance’ in the belief that sexually abusive physicians not only threaten the well-being of patients, but also impugn the reputation of the entire profession”.⁶ In addition, the OMA supported the Government’s proposed amendments to s. 51 of the Code “as they pertain to subsection 51(5), paragraph 2, subparagraphs i, ii, iii, iv and v” (these provisions are set out below),⁷ and there does not seem to be any dispute that “sexual abuse” should encompass acts of sexual intercourse or physical sexual acts such as those listed in that subsection.⁸ On penalty, however, the OMA took the position that the period of time for which a doctor’s licence was to be revoked or suspended should vary depending upon the circumstances of the case and the severity of the offence.

[28] In its comments to the Standing Committee, the RNAO stated:

Bill 100 is commendable in its forthright approach towards stemming the problem of sexual abuse. It’s a long-overdue piece of legislation which sets an appropriate standard of conduct for all health care providers in the province. It should serve as a deterrent to professionals who might otherwise abuse the privileged position of intimacy that being a health care provider allows.⁹

[29] The amendments to the Code became effective on December 31, 1993. It was during this period of high profile discussion concerning the amendments to the Code and

⁵ Submission of the Ad Hoc Coalition of Regulated Health Care Associations on Bill 100, at 17-18.

⁶ Submission of the on Bill 100 Ontario Medical Association to the Standing Committee on Social Development 100 at 1.

⁷ Ibid, at. 15.

⁸ Ibid, at 8 and 22

⁹ Legislative Assembly of Ontario, Standing Committee on Social Development, *Official Report of Debates (Hansard)*, Third Session, 35th Parliament (30 November 1993) at s-612 to s-614. The RNAO is the professional association representing over 20,000 registered nurses in Ontario.

the introduction of the zero tolerance/mandatory revocation scheme that the affair between Dr. Mussani and A.K. took place.

ANALYSIS

The Relevant Provisions of the Code

[30] The relevant provisions of the *Health Professions Procedural Code* are as follows:

1(3) In this Code,

“sexual abuse” of a patient by a member means,

(a) sexual intercourse or other forms of physical sexual relations between the member and the patient,

(b) touching, of a sexual nature, of the patient by the member, or

(c) behaviour or remarks of a sexual nature by the member towards the patient.

1(4) For the purposes of subsection (3),

“sexual nature” does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided.

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

51(5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.

2. Revoke the member’s certificate of registration if the sexual abuse consisted of, or included, any of the following,

i. sexual intercourse,

- ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
- iii. masturbation of the member by, or in the presence of, the patient,
- iv. masturbation of the patient by the member,
- v. encouragement of the patient by the member to masturbate in the presence of the member. [underlining added]

72(1) A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed.

(3) An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,

- (a) five years after the revocation; or
- (b) six months after a previous application under subsection (1).

73(5.1) A panel may not make an order directing that the Registrar issue a new certificate of registration to an applicant whose certificate had been revoked for sexual abuse of a patient unless the prescribed conditions are met.

The Issues

[31] It is important to consider precisely what the focus of the inquiry on this appeal is and what it is not.

[32] What is at issue on this appeal is the constitutionality of *the mandatory revocation* of a health professional's certificate of registration *for a minimum period of five years* in circumstances where the health professional and a patient engage in sexual intercourse or in one of the other frank sexual acts described in s. 51(5) para. 2 of the Code. Does *mandatory revocation* violate the s. 7 liberty or security of the person interests of the health professional? If so, is the health professional deprived of those rights in accordance with the principles of fundamental justice? Does *mandatory revocation* constitute cruel and unusual punishment or treatment, and therefore violate the health

professional's s. 12 rights? Does it contravene the s. 2(d) right to freedom of association? If there are violations of ss. 7, 12, or 2(d), can the Mandatory Revocation Provisions be saved by s. 1 of the Charter?

[33] What is not at issue on this appeal, however, is

- a) whether there is a general s. 7 “liberty” right to choose a consensual sexual partner; or,
- b) whether, if there is such a right, a limitation prohibiting health professionals from engaging in consensual sexual relations with their patients, deprives them of their liberty right in accordance with the principles of fundamental justice.

[34] Although much was said about these latter two points in argument, all parties to this proceeding agree that government may limit the rights of health professionals in the public interest, and that a zero tolerance policy prohibiting sexual relations between a health professional and his or her patient is both acceptable and desirable.

[35] In addition to the foregoing questions, two preliminary points were raised. They are:

- a) whether ss. 7 and 12 of the Charter apply at all in the context of professional disciplinary proceedings, as opposed to “criminal” or “quasi-criminal” proceedings; and, even if they do,
- b) whether the Mandatory Revocation Provisions invoke only the sort of economic interests – in this case, the right to practise a profession – that do not attract Charter protection.

[36] I shall deal with the preliminary points first.

The Preliminary Points

Application of ss. 7 and 12 to Discipline Proceedings

[37] The Supreme Court of Canada has said that s. 7 of the Charter “is not confined to the penal context”, and “can extend beyond the sphere of criminal law, at least where there is ‘state action which directly engages the justice system and its administration’”: *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307 at paras. 45-46.

[38] Whether s. 12 can apply to discipline proceedings respecting a health professional depends, to some extent, on whether those proceedings are characterized as “quasi-criminal”

or “administrative” in nature. I shall deal with this issue when I deal with the s. 12 argument later in these reasons.

No Constitutional Right to Practise a Profession

[39] The essence of what Dr. Mussani is seeking to protect is not the right to choose a consensual sexual partner from amongst his patients, but rather the right to engage in the economic activity of his choice. Despite his efforts to contextualize and to characterize his claim otherwise, he is trying to protect the right to practise his profession. The Charter does not protect such a right, however.

[40] It is self-evident that the revocation of a health professional’s certificate of registration is a serious – even a draconian – measure. Nonetheless, all serious disciplinary measures, even draconian ones, are not prohibited by the Charter. For instance, the courts have held that the removal of a driver’s licence, no matter the economic hardship it may cause, is not a violation of the liberty interest under s. 7 because it does not interfere with a fundamental right: see *Horsefield v. Ontario (Registrar of Motor Vehicles)* (1999), 44 O.R. (3d) 73 (C.A.); *Condo v. Ontario (Registrar of Motor Vehicles)* (1999), 123 O.A.C. 111 (Div. Ct.).

[41] The weight of authority is that there is no constitutional right to practise a profession unfettered by the applicable rules and standards which regulate that profession: see *Reference re Criminal Code, Sections 193 and 195.1(1)(c)*, [1990] 1 S.C.R. 1123 at 1179, per Lamer J. (prostitution); *Siemans v. Manitoba (Attorney General)*, [2003] 1 S.C.R. 6 at 31 (operating video lottery terminals); *Biscotti v. Ontario Securities Commission* (1990), 74 O.R. (2d) 119 (Div. Ct.), aff’d (1991), 1 O.R. (3d) 409 (C.A.), leave to appeal to S.C.C. refused, [1991] 1 S.C.R. vi (securities broker); *Belhumeur v. Barreau du Québec (Comité de Discipline)* (1988), 54 D.L.R. (4th) 105 at 116 (Que. C.A.) (practice of law); *School District No. 39 (Vancouver) v. British Columbia Teachers’ Federation* (2003), 224 D.L.R. (4th) 63 at paras. 201-206 (B.C.C.A.) (teacher); *Walker v. Prince Edward Island* (1993), 107 D.L.R. (4th) 69 at 77-78 (P.E.I.S.C. A.D.), aff’d [1995] 2 S.C.R. 407 (public accounting); *Assn. of Professional Engineers of Ontario v. Karmash*, [1998] O.J. No. 2161 (Div. Ct.) (QL) (engineer); *Cosyns v. Canada (Attorney General)* (1992), 7 O.R. (3d) 641 at 652-654 (Div. Ct.) (tobacco farmer challenging taxation of tobacco products); *Charbonneau v. College of Physicians & Surgeons of Ontario* (1985), 52 O.R. (2d) 552 at 560-561 (H.C.J.) (physician).

[42] There are some older authorities that suggest the contrary: see, for example, *Wilson v. B.C. Medical Commission* (1988), 53 D.L.R. (4th) 171 at 184-185, 192-193 (B.C.C.A.); *Khaliq-Khareemi (Re)* (1989), 57 D.L.R. (4th) 505 at 511 (N.S.S.C. A.D.); and *Re Branigan and Yukon Medical Council* (1986), 26 D.L.R. (4th) 268 at 277-78 (Y.T.S.C.). However, these decisions all pre-date the more recent pronouncement of the

Supreme Court of Canada in *Reference re Criminal Code, Sections 193 and 195.1(1)(c)* (at 1179) and that court's affirmation of the decision of the Prince Edward Island Court of Appeal in *Walker*. The decision of the Nova Scotia Court of Appeal in *Khaliq-Khareemi* followed the British Columbia Court of Appeal in *Wilson*; but *Wilson* has not been followed in other provinces. Moreover, the British Columbia Court of Appeal itself has implicitly overruled *Wilson* in its more recent judgment in *School District No. 39 (Vancouver) v. British Columbia Teachers' Federation, supra*.

[43] I am satisfied, therefore, that there is no constitutionally protected right to practise a profession, and that the mandatory revocation of a health professional's certificate of registration in substance infringes an economic interest of the sort that is not protected by the Charter. This conclusion is in my view sufficient to dispose of this case. In the event that I am in error, however, and because of the importance of the Charter arguments to the twenty-one different health professions governed by the Code in Ontario, I propose nonetheless to deal with the parties' submissions respecting ss. 7, 12, and 2(d) of the Charter.

Section 7

[44] Section 7 of the Charter states:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[45] An analysis of this provision involves a two-step process. First, it must be determined whether there has been a deprivation of the right to life, liberty or security of the person. Secondly, the person seeking to establish the violation must establish that the deprivation of the right is not "in accordance with the principles of fundamental justice". I note the onus is on the person seeking to establish the violation.

[46] The appellant submits the Mandatory Revocation Provisions violate his "liberty" interest under section 7 because they interfere with his right to make fundamental personal life choices, unimpeded by state action: see *Blencoe v. British Columbia (Human Rights Commission), supra*; *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844; *R. v. Malmö-Levine*, [2003] 3 S.C.R. 571; *Hitzig v. Canada*, [2003] O.J. No. 3873 at paras. 92-93 and 101-102 (C.A.) (QL). He contends they infringe his "security of the person" because of the state-imposed psychological stress that results from mandatory revocation proceedings: see *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46 at para. 59.

[47] I agree with the Divisional Court that these arguments cannot succeed.

Security of the Person

[48] I shall deal with security of the person first.

[49] In my view, the s. 7 guarantee of security of the person is not engaged in the circumstances of this case. It is clear that the right to security of the person can extend to serious state-imposed psychological stress: see *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, at para. 59, and *Blencoe*, at paras. 56-57. However, the psychological stress must be “serious”, it must be “state-imposed”, and not all forms of state interference or state-caused psychological prejudice will constitute s. 7 violations. See *R. v. Transport Robert (1973) Ltée* (2003), 68 O.R. (3d) 51 at 58 (C.A.).

[50] Here, the argument is that the stigma of being disciplined by the College for sexual abuse of a patient, the publicity associated with such a proceeding, the loss of privacy and disruption to the doctor’s personal and emotional life, and the mandatory revocation of the doctor’s certificate of registration, result in psychological stress that interferes with the doctor’s right to security of person. I do not agree.

[51] As already noted, the appellant accepts that the Code properly prohibits a health professional from having sexual relations with a current patient. The appellant is licensed to practise in a regulated profession. A certain amount of stress, anxiety and stigma inevitably arises in the context of disciplinary proceedings relating to sexual abuse allegations. Just as the personal trauma arising from delays in being investigated in human rights proceedings did not attract the protection of s. 7 in *Blencoe*, however, the difficulties experienced by a health professional who is disciplined for sexual abuse of a patient by the loss of his or her certificate of registration do not deprive the doctor of his or her security of the person. As Bastarache J. noted in *Blencoe*, “[t]here is no constitutional right or freedom against such stigma protected by the s. 7 rights to ‘liberty’ or ‘security of the person’” (para. 96).

The “Liberty” Interest

[52] What of the “liberty” interest, then?

[53] The appellant and his supporting intervenors argue that the Mandatory Revocation Provisions “interfere with the intensely personal decision as to whether to enter into an intimate relationship with another person” on a consensual basis and in circumstances that are not exploitative or predatory in nature¹⁰. As I have already pointed out, however, this is not the issue on the appeal.

¹⁰ See Appellant’s factum, at 18.

[54] While the argument that the liberty interest guarantees a general right to choose one's consensual sex partner, on fundamental life choice grounds, is an intriguing one, and may find some support in the jurisprudence,¹¹ it need not be decided in the circumstances of this case. The parties and intervenors all concede that sexual relations between a health professional and his or her patient are unacceptable. In the context of a regulated health profession, then, the liberty interest cannot extend to the point of protecting a doctor's right to decide to have sex with a current patient. There is no valid liberty interest, in that sense. Indeed, the appellant acknowledges as much. He concedes that in the many instances where an intimate relationship between a health professional and a patient is inherently exploitative, "any 'liberty' interest held by the health professional to enter into such a non-consensual relationship may not be a 'legitimate' interest with which s. 7 is concerned".¹²

[55] However, the appellant and his intervenor supporters contend that there are *some* cases where there is in fact no power imbalance between the health professional and the patient; there are *some* cases where the relationship is in fact not exploitive; there are some cases where consent to the impugned sexual conduct is in fact genuine. They submit that such situations do not call for the ultimate sanction of revocation. Two arguments flow from this contention.

[56] The first is that the Mandatory Revocation Provisions compel health professionals to choose between terminating a professional relationship with a patient or entering into what can be a consensual, non-exploitive sexual relationship with that patient. The Provisions therefore interfere with the health professional's "liberty" interest in making fundamental life-style decisions. In this respect, the appellant and his intervenor supporters rely upon the decision of the Nova Scotia Supreme Court in *Fancy v. Shepherd, supra*. In that case, legislation that required a spouse to forfeit his or her spousal support if the spouse remarried, was ruled unconstitutional. Chief Justice Glube found a violation of the security of the person interest, not the liberty interest. At para. 32 she said:

The decision to marry or cohabit is a fundamental right and by forcing a person to choose to not marry or cohabit because she will lose her maintenance, denies her the right to freely choose who [*sic*] she will live with. Psychological anxiety is generated violating the security of the person. Many activities have an economic component to them. In this case the violated right to security is the right to enter into a

¹¹ See, for example, *A.B. v. The College of Physicians & Surgeons of Prince Edward Island*, [2001] P.E.I.J. No. 89 at paras. 34-35 (S.C.T.D.) (QL); *Fancy v. Shepherd* (1997), 164 N.S.R. (2d) 274 at 281-282 (S.C.); *Lawrence v. Texas*, 539 U.S. 558 (2003); *National Coalition for Gay and Lesbian Equality v. Minister of Justice*, [1998] 12 B. Const. L.R. 1517; *Dudgeon v. United Kingdom* (1981), 4 Eur. Ct. H.R. 149; *Toonen v. Australia*, Communication No. 488/1992 (Mar. 31, 1994), United Nations Human Rights Committee.

¹² Appellant's factum, at para. 79.

conjugal relationship without fear of losing support. Although there is an economic component that is secondary, I find this section violates the person's personal right to security.

[57] I do not think *Fancy v. Shepherd* assists the appellant. It precedes *Blencoe*, but in any event does not parallel this case. Central to its conclusion was the right to choose freely with whom the claimant would live. The right to marry or cohabit is quite different, however, from any claim to a right by a health professional to have even a consensual, non-exploitive sexual relationship with a patient – which everyone connected with the case acknowledges is unacceptable. The only dispute is over the appropriate sanction for such conduct. The s. 7 liberty interest is not infringed by the choice required, in these circumstances.

[58] The second argument is the following. There is admittedly a range of conduct properly captured by the Mandatory Revocation Provisions without violating s. 7, namely those situations where there are power imbalances, potential exploitation and a lack of real consent. But there is another range of situations where there may be no power imbalance, no exploitation, and actual consent – albeit a small sub-set of the whole of this type of conduct. Capturing those situations by mandatory revocation does violate a legitimate liberty or security interest. Therefore, the argument goes, the Mandatory Revocation Provisions as a whole are unconstitutional: see *R. v. Heywood*, [1994] 3 S.C.R. 761.

[59] I do not accept this argument. However, I will deal with it more fully in the portion of these reasons addressing “overbreadth” and the principles of fundamental justice because it relates more to those issues than to the questions of “liberty” or “security of the person” in themselves.

[60] For the reasons I have just outlined I find that the Mandatory Revocation Provisions do not deprive the appellant of his right to “life, liberty and security of the person”. If necessary, however, I would also dismiss the s. 7 claim on the basis that the Provisions are in accordance with the principles of fundamental justice. I turn to that issue now.

The Principles of Fundamental Justice

[61] The appellant and his intervenor supporters generally acknowledge that the State has an interest in limiting the right of health professionals to engage in sexual relations with their patients. But they argue that the Mandatory Revocation Provisions deprive health professionals of their s. 7 rights to liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice.

Vagueness

[62] In this regard, they say first that the Mandatory Revocation Provisions are impermissibly vague, because they do not define who a patient is, or, more particularly, they do not define when the doctor-patient relationship terminates.

[63] I do not agree. There is a high threshold for meeting this criterion. A provision is unconstitutionally vague where it sets a standard that is not intelligible, that cannot provide the basis for coherent judicial interpretation, and that is not capable of guiding legal debate: *Canadian Foundation for Children, Youth and the Law v. Canada*, [2004] 1 S.C.R. 76 at paras. 15-17; *R. v. Nova Scotia Pharmaceutical Society*, [1992] 2 S.C.R. 606 at 639-649; *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927 at 983. In short, unconstitutional vagueness stems from language that is so imprecise neither the individual concerned nor the agency enforcing the provision can determine whether the conduct in question is prohibited or not.

[64] That is not the case here. Doctors know who their patients are, by and large. While there may be difficulties in some individual circumstances in determining when a health professional-patient relationship has terminated or begun, an examination of various disciplinary and Court decisions demonstrates that such situations are capable of resolution: see the authorities referred to at para. 83 of the judgment below, including *Boodoosingh v. College of Physicians and Surgeons of Ontario* (1990), 73 O.R. (2d) 478 (Div. Ct.), aff'd (1993), 12 O.R. (3d) 707 (C.A.), leave to appeal to the S.C.C. refused, [1993] 4 S.C.R. v.

[65] Moreover, I observe in passing that the Ad Hoc Coalition of Regulated Health Care Associations itself was of the view that the question of defining when a patient ceases to be a patient – although a difficult issue – was “not amenable to addressing through legislation or regulation”. It recommended that each College develop its own clear guidelines as to when a person ceases to be, or becomes a patient for purposes of the legislation, but did not seem concerned that the proposed legislation lacked such a definition.¹³

[66] In brief, I agree with the remarks of Then J., at para. 84 of the Divisional Court judgment:

Thus, the appellant’s argument that the word “patient” is unconstitutionally vague is not supportable. To the extent that “patienthood” is not obvious in a given circumstance, it is a factual inquiry that is subject to interpretation by the

¹³ Submission of the Ad Hoc Coalition of Regulated Health Care Associations on Bill 100 to the Standing Committee on Social Development, at 18-19.

tribunals and the courts. There is nothing about the impugned provisions that prevents a court or tribunal from giving sensible meaning to their terms.

[67] The argument that the Mandatory Revocation Provisions are unconstitutionally vague, fails.

Overbreadth

[68] The appellant and his supporting intervenors submit the Mandatory Revocation Provisions are overly broad in two ways. First, they apply a “one-size-fits-all” approach to sanction regardless of the facts, regardless of the nature and quality of the impugned relationship (i.e., there may be cases where there is genuine consent, no power imbalance, and no exploitation), and regardless of the nature of the medical treatment being provided. Secondly, they apply across the board to all health professions with no regard to the differences in power imbalance considerations as between the professions and without an evidentiary base establishing the need for a zero tolerance/mandatory revocation regime in any profession other than medicine.

[69] In *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486 at 503, Lamer J. affirmed that “the principles of fundamental justice are to be found in the basic tenets of the legal system”. Legislation is said to breach the principles of fundamental justice where it “infringes life, liberty or security of the person in a manner that is unnecessarily broad, going beyond what is needed to accomplish the governmental objective”: *R. v. Heywood*, *supra*, at para. 52, per Cory J. Reviewing legislation for overbreadth involves balancing the interests of the State against those of the individual and calls for a certain amount of deference to what the legislature has done. As Cory J. noted in *Heywood*, at para. 51:

In analyzing a statutory provision to determine if it is overbroad, a measure of deference must be paid to the means selected by the legislature. While the courts have a constitutional duty to ensure that legislation conforms with the *Charter*, legislatures must have the power to make policy choices. A court should not interfere with legislation merely because a judge might have chosen a different means of accomplishing the objective if he or she had been the legislator.

[70] In my view, state protection against sexual abuse and sexual exploitation in general is a basic tenet of our legal system. State protection against sexual abuse and sexual exploitation by health practitioners of patients reflects that basic tenet.

[71] The ultimate purpose of the sexual abuse provisions in the Code is “to eradicate the sexual abuse of patients by members” (s. 1.1). In more general terms, the objective of the legislative scheme is to ensure that discipline for serious forms of sexual abuse signals the serious harm that such abuse causes the patient as well as the breach of trust committed by the health professional and the harm such misconduct causes to the profession itself. The goals are to encourage the reporting of sexual abuse by patients and to enforce the principle of zero tolerance by deterring future abuse and by dealing with the significant risk of recidivism through the removal of the offender from the practice for a minimum period of time. These are legitimate state concerns, mirroring fundamental values underlying our legal system, including the protection and enhancement of human dignity and integrity.

Overbreadth: The “One-Size-Fits-All” Argument

[72] There are admitted problems with zero tolerance/mandatory penalty regimes. They are rigid. They can lead to results in individual cases that are harsh, extreme, and even arguably unjust. They deprive the body imposing the penalty of any discretion to tailor the result to meet the requirements of the circumstances. In particular, they deprive the reviewing body of any flexibility in responding to situations where there may be genuine consent to a relationship between mature adults, and no power imbalance or exploitation on the part of the health professional.

[73] However, the Mandatory Revocation Provisions were enacted in response to a recognized and growing problem of sexual abuse in the medical profession. Indeed, they were enacted specifically to rectify a situation where discretionary sanctioning on the part of professional disciplinary committees and the courts had been found to be wanting. They must be considered in the context of a general power imbalance between a doctor and patient that can lead to easy exploitation of the relationship by the doctor at the risk of considerable harm to a vulnerable patient: see *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 at 246, 255 and 259-260, per La Forest J. (citing the Task Force Report). In addition, they must be considered in the context of a regulated profession. The Legislature acted upon the recommendations of a Task Force that had carefully examined the difficulty, and after consulting broadly with health professionals in relation to Bill 100. A health professional need only say “no” to either the sexual or the professional relationship.

[74] As noted above, the Legislature is entitled to deference with respect to the remedies it chose.

Hypotheticals

[75] The appellant and his intervenor supporters rely on a number of “hypotheticals” to buttress their arguments respecting overbreadth. The Supreme Court of Canada has

sanctioned the use of reasonable hypotheses as a means of assessing whether impugned legislation has overshoot legislative objectives, both in considering whether a legislative provision contravenes the principles of fundamental justice under s. 7 (see, for example, *R. v. Heywood*, *supra*, at para. 62) and in considering whether punishment or treatment is cruel and unusual under s. 12 (see *R. v. Smith*, [1987] 1 S.C.R. 1045 at 1078, per Lamer J.).¹⁴

[76] The appellant and his supporting intervenors acknowledge that generally there are power imbalances and risks of exploitation in practitioner-patient relationships. They submit, however, that there *may* be situations where there is genuine consent on the part of the patient, no power imbalance and no exploitation. As examples of this point they put forward three actual cases where intimate relations between a health professional and a patient have commenced during or shortly after treatment and blossomed into perfectly consensual, long-term, harmonious, marital relationships: see *College of Physiotherapists of Ontario v. Melunsky*, [1999] O.J. No. 148 (Div. Ct.), (QL) affirming the Decision of the Discipline Committee of the College of Physiotherapists of Ontario, dated March 24, 1998; *N. v. College of Physicians and Surgeons of British Columbia* (1997), 143 D.L.R. (4th) 463 (B.C.C.A.); and *A.B. v. The College of Physicians & Surgeons of Prince Edward Island*, *supra*. They also rely on *R. v. Boodoosingh*, *supra*.

[77] In addition, they suggest a number of other possible situations where they say the Mandatory Revocation Provisions would apply, but where they submit it makes no sense, from a Charter perspective, that they should. For instance, what of the case where a health professional treats his or her spouse (e.g., a doctor prescribing a drug, or a physiotherapist providing treatment for an athletic injury)? Or what if a health professional administers emergency treatment to a spouse at the scene of an accident? Or what of the health professional who engages in sexual abuse but has a treatable mental illness or addiction from which he or she can be successfully rehabilitated?

[78] Since the Mandatory Revocation Provisions might catch all of these situations, as well as those where there is an admitted power imbalance, and strip the reviewing body of any discretion with respect to the sanction imposed, the appellant and his supporting intervenors argue they are unconstitutionally overbroad. As I mentioned earlier in these Reasons at paragraph 59, I do not accept this argument either.

[79] The fact that an intimate sexual relationship which began during treatment may blossom into a truly loving one but still lead to revocation of a health professional's certificate of registration, does not necessarily make the Mandatory Revocation Provisions unconstitutionally broad, in the sense that they overshoot the legislative objectives. The health professional need only terminate the treatment relationship to avoid the problem. The issue is whether the means chosen by the Legislature –

¹⁴ Thus, this portion of these Reasons also applies to the s. 12 analysis which comes later.

mandatory revocation of the certificate of registration – are overly broad *in relation to the purpose of the legislation*.¹⁵ If they are not, the Legislature has the right to make difficult policy decisions that may, in rare cases, override what might otherwise be considered permissible conduct. I do not read *R. v. Heywood* as mandating a contrary decision. The Supreme Court merely decided that the impugned legislation in that case went too far.

[80] Here, the means chosen to meet the legislative objectives – i.e., the revocation of the health professional’s certificate of registration in the case of the frank sexual acts listed in s. 51(5) para. 2 of the Code – do not go too far, in my opinion. They are not overly broad. Mandatory revocation in such circumstances (a) signals the seriousness with which the sexual abuse of patients is to be taken, (b) underscores the gravity of the breach of trust involved, (c) emphasizes the considerable impact of the practitioner’s failure to meet his or her responsibility towards maintaining the integrity of the profession, and (d) responds to the need to protect the public from the risk of recidivism by removing the practitioner from the practice for a minimum period of time. The importance of responding to these objectives is not contested.

[81] The decisions in *Melunsky, A.B., N., and Boodoosingh* do not assist the appellant, either as precedents or as hypotheticals. In terms of precedents, the Discipline Committee in *Melunsky* was wrong in its approach to s. 12 of the Charter – see the succeeding portion of these reasons – and the Divisional Court did not deal with the Charter issues at all, but rather approached the appeal as a matter of sanction only. *Boodoosingh* pre-dates the enactment of the Mandatory Revocation Provisions, and may well be an example of the type of sanction disposition the Legislature decided needed to be altered with the enactment of the Code amendments. *A.B.*, and *N.* were decided under different statutory regimes. In terms of hypotheticals, those cases – and the other hypotheticals relied on – do not constitute “imaginable circumstances which could commonly arise with a degree of generality appropriate to the particular offence”: *R. v. Morrissey*, [2000] 2 S.C.R. 90 at para. 50; *R. v. Goltz*, [1991] 3 S.C.R. 485 at 515-516 [emphasis added].

[82] For all of these reasons, I am satisfied that the Mandatory Revocation Provisions are not overly broad from a constitutional perspective, even though the relatively rare case of a genuinely consensual relationship may be caught by them and even though they eliminate the defence of genuine consent for the purposes of the penalty imposed.

Overbreadth: Application to All Health Professions

[83] The appellant and his intervenor supporters also submit, however, that the Mandatory Revocation Provisions are too broad because of their application to all twenty-one health professions in Ontario, without regard to the differences between the

¹⁵ *R. v. Heywood*, *supra*, at para. 49.

professions, and in particular, without regard to the differences in power imbalance considerations as between the different health professions. Where sexual relations are concerned, mandatory revocation applies equally to the chiropodist who removes a bunion from a patient's foot as it does to the health professional who provides psychiatric or psychotherapy treatment. In this way, they overshoot any legitimate legislative objectives, say the appellant and his supporting intervenors.

[84] I would not give effect to this argument.

[85] While the Mandatory Revocation Provisions may have had their genesis in the Report of the Task Force, which focused on the practice of medicine, Bill 100 was the subject of widespread input from the various health professions. As pointed out in paragraphs 24-28 above –and notwithstanding the differences between the professions – there was solid support for the zero tolerance principle of the legislation and for the objective of eradicating the problem of sexual abuse by health professionals of their patients. This is reflected in the statutory purpose of the legislation as articulated in section 1.1 of the Code cited above. All of these professional relationships are characterized in some fashion by the opportunity to capitalize on practitioner-patient dynamics for the purpose of invading the patient's sexual boundaries, if the practitioner is so minded.

Section 12 of the Charter

[86] Section 12 of the Charter states:

12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

[87] The appellant and its supporting intervenors argue that this provision applies to professional disciplinary proceedings; that the Mandatory Revocation Provisions constitute punishment or treatment, within the meaning of s. 12; and that the punishment or treatment is cruel or unusual. They contend the Provisions are therefore of no force and effect.

[88] Then J. gave very thorough and complete reasons in rejecting these submissions. I am in substantial agreement with those reasons, and adopt them. I would only add the following.

Does s. 12 Apply to Professional Discipline Hearings?

[89] As Then J. noted, there is no judicial precedent for the application of s. 12 in the professional discipline context. The decision of this Court in *Henderson v. College of Physicians and Surgeons of Ontario* (2003), 65 O.R. (3d) 146, was released two weeks

after the decision of the Divisional Court in this case. The appellant and his supporting intervenors rely on *Henderson* for the proposition that professional discipline proceedings are quasi-criminal in nature and therefore attract the protection of s. 12.

[90] *Henderson* was not a constitutional case, however. The issue before the Court was whether or not the College could amend a notice of hearing to add additional complaints after the hearing had commenced. It was a procedural matter, and for reasons of procedural fairness the Court concluded that under the Code and the *Statutory Powers Procedure Act*, the College could not amend the notice in such a fashion at that late stage. Given the serious potential consequences of such a proceeding – including the potential loss of licence to practise – the Court concluded that the professional “is entitled to have his or her professional regulator strictly adhere to the express provisions of its legislative mandate” (para. 27). In that context the court observed, in *obiter dicta*, that “[i]ndeed, more than one case has referred to professional discipline proceedings as quasi-criminal in nature”. The court was not required to, and did not consider the characterization of such proceedings for constitutional/Charter purposes, however. In my view, the decision in *Henderson* does not affect the Divisional Court’s decision in these proceedings.

[91] Other authorities indicate that professional disciplinary hearings are not criminal or quasi-criminal in nature because – despite their potentially serious sanctions – they do not result in true penal consequences. Rather, they are administrative and regulatory in nature, designed to maintain discipline, professional integrity and professional standards and to regulate conduct within the profession in question. See *R. v. Wigglesworth*, [1987] 2 S.C.R. 541 at 559-561; *Brosseau v. Alberta Securities Commission*, [1989] 1 S.C.R. 301 at 313-314; *Adams v. Law Society (Alberta)*, [2000] A.J. No. 1031 at paras. 6, 7 and 11 (C.A.); *Latulippe v. College des Médecins*, [1998] A.Q. No. 1866 (Que. C.A.) (QL); *Re Stevens v. Law Society of Upper Canada* (1979), 55 O.R. (2d) 405 (Div. Ct.); *Warnes v. College of Physicians and Surgeons of Ontario*, [1992] O.J. No. 3748 (Div. Ct.) (QL); *Belhumeur v. Barreau du Québec (Comité de Discipline)*, *supra*.

[92] Cases that have referred to discipline proceedings as quasi-criminal in nature, apart from *Henderson*, include the following: *Piller and Association of Ontario Land Surveyors*, [2002] O.J. No. 2343 at para. 59 (C.A.) (QL), Cronk J.A., concurring; *College of Physicians and Surgeons of Ontario v. Boodoosingh*, *supra*; *Re Matheson and College of Nurses of Ontario* (1980), 27 O.R. (2d) 632 at 634-635 (Div. Ct.); and *Re Stoangi and Law Society of Upper Canada* (1978), 22 O.R. (2d) 274 at 277 (H.C.J.). None of these cases was a constitutional case.

[93] It is not necessary to determine this issue for the purposes of this appeal, however.

[94] Assuming that s. 12 is engaged in these circumstances, I agree with the conclusion of the Divisional Court that the Mandatory Revocation Provisions do not constitute

“punishment” or “treatment”, as those words have been interpreted and applied in the context of s. 12. Further, if they do, the punishment or treatment is not cruel and unusual; it is neither so excessive as to outrage standards of decency, nor grossly disproportionate to what is appropriate in the circumstances: *R. v. Smith, supra*, at 1072-1073. “The standard under s. 12 is stringent, demanding and highly deferential to legislative choices” (Reasons of the Divisional Court, para. 144).

Punishment or Treatment

[95] As Then J. held, the Mandatory Revocation Provisions do not constitute “punishment” in the context of s. 12 because they do not give rise to “true penal consequences”, such as “imprisonment or a fine which by its magnitude would appear to be imposed for the purpose of redressing the wrong done to society at large rather than to the maintenance of internal discipline within the limited sphere of activity”: *R. v. Wigglesworth, supra*, at para. 24, per Wilson J. The \$35,000 fine that can be imposed under the Mandatory Revocation Provisions, but was not in this case, is not of sufficient magnitude to meet this threshold, in my view.

[96] Nor do the Mandatory Revocation Provisions constitute “treatment”. In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 609, Sopinka J. observed that “[t]he degree to which ‘treatment’ in s. 12 may apply outside the context of penalties imposed to ensure the application and enforcement of the law has not been definitively determined by [the Supreme Court of Canada]”. He noted the examples given by Lamer J. in *Smith* of “treatment” (as opposed to “punishment”) that would be contrary to s. 12, namely, lobotomisation of dangerous offenders and the castration of sexual offenders. He also referred to his own statement in *Chiarelli v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 711 at 735, that deportation might constitute “treatment” even though it was not penal in nature. These examples are quite different than the mandatory revocation of a professional licence, in my opinion. The Mandatory Revocation Provisions do not constitute “treatment” within the meaning of s. 12.

Cruel and Unusual

[97] Nor is the effect of the Mandatory Revocation Provisions – if indeed they do constitute punishment or treatment – “cruel and unusual”. The revocation of a health professional’s certificate for having engaged in the frank sexual acts listed in s. 51(5) para. 2 of the Code – including sexual intercourse – is not a penalty that is grossly disproportionate to the misconduct in question or to the harmful effects caused by such conduct to the victims. In this respect I adopt the following passage summarizing the pertinent authorities, taken from para. 71 of the respondent College’s factum:

The test is aimed at “punishments that are more than merely excessive.”¹⁶ As the Supreme Court stated in *Smith*, “we should be careful not to stigmatize every disproportionate or excessive sentence as being a constitutional violation.”¹⁷ Penalties need not be “perfectly suited to accommodate the moral nuances of every crime and every offender.”¹⁸ Finding a sentence to be demonstrably unfit for a particular offender does not amount to gross disproportionality. When Canadians would find a penalty “abhorrent or intolerable,”¹⁹ a sentence will be grossly disproportionate. Accordingly, it will “only be on rare and unique occasions that a court will find a sentence so grossly disproportionate” as to violate s. 12.²⁰

[98] The “gross disproportionality” analysis is a two-stage process as well. First, the court must consider whether the particular facts of the case warrant a finding of gross disproportionality. If that is not the case, then the court must still consider whether the impugned sanction is invalid “on grounds of gross disproportionality as evidenced in reasonable hypothetical circumstances, as opposed to far-fetched or marginally imaginable cases”: *R. v. Goltz*, *supra*, at 505-506 and 515-516.

[99] Here, there is ample evidence in the record to support the view that in the circumstances of this case the penalty of revocation is not grossly disproportionate. Indeed, it is appropriate. I note, for example, that:

- a) Dr. Mussani and A.K. met very frequently during the period leading up to, and during the affair, on what were billed as medical or psychotherapy sessions. During those sessions, where Dr. Mussani was exercising his role as her doctor, A.K. revealed her unhappiness in her marriage and her difficulties in dealing with her marital dysfunction;
- b) A.K. was therefore emotionally vulnerable;
- c) Dr. Mussani did not refer A.K. for marital counselling, even though he noted that she needed it and requested it. Instead, he placed himself in that role;
- d) During the affair, A.K. became pregnant, but did not know whether her husband or Dr. Mussani was the father. Without

¹⁶ *R. v. Smith*, *supra*, at 1072.

¹⁷ *Ibid.*

¹⁸ *R. v. Lyons*, [1987] 2 S.C.R. 309 at 345.

¹⁹ *R. v. Morrissey*, *supra*, at para. 26.

²⁰ *R. v. McDonald* (1998), 40 O.R. (3d) 641 (C.A.) at 665.

referring her to counselling about the pregnancy, Dr. Mussani referred her to an obstetrician, who performed the abortion;

e) Dr. Mussani made no attempt to terminate either the doctor-patient relationship or the affair;

f) While the affair was going on, Dr. Mussani engaged in unwanted touching with another female patient; and, finally,

g) All of this took place in a professional environment where there was heightened public awareness of a significant problem of sexual abuse by doctors of patients and where the recommendations of the Task Force and the new amendments to the Code calling for mandatory revocation were well known.²¹

[100] With respect to the appellant's arguments regarding "reasonable hypotheticals" – dealt with earlier under the subject of "overbreadth", as well – I would dismiss them for the reasons set out in paras. 75-82 above, and for the reasons of *Then J.* at paragraphs 152-163 of the judgment below. I would simply add the following.

[101] While the spousal hypotheticals appear troubling at first blush, I agree with the conclusion of *Then J.*: "It is far fetched to characterize the intimate relationship between spouses as 'sexual abuse' merely because a physician may have treated his or her spouse." (Reasons below, para. 153). The fact that during the course of a marriage a physician may provide incidental medical care to his or her spouse is unlikely, in my view, to establish a physician/patient relationship which would attract the discipline procedures of the Code.

[102] The consequences of mandatory revocation are severe. Nonetheless, a disciplined health professional is entitled to apply for reinstatement after five years. The fact the College has a Policy on Physician-Patient Dating that prohibits sexual relations with a patient after termination of the doctor-patient relationship, when that relationship has involved psychoanalysis or psychotherapy, does not affect the constitutional validity of the Mandatory Revocation Provisions. Moreover, it does not follow from the mere existence of that policy that a doctor who breaches the policy will necessarily be refused re-admission to the profession after the five-year revocation.

[103] I therefore reject the appellant's arguments based upon s. 12 of the Charter.

²¹ See the respondent College's factum, at para. 78.

Section 2(d) of the Charter

[104] The final Charter argument is advanced by the OMA. It is based on s. 2(d), which guarantees freedom of association. Section 2(d) of the Charter states:

2. Everyone has the following fundamental freedoms:
 - (d) freedom of association.

[105] In my view, the argument is without merit.

[106] The OMA submits that the protection afforded by s. 2(d) is not confined only to “social” as opposed to “sexual” intercourse. It argues that freedom of association “protects the fundamental right of the individual to join, interact with, support and be supported by his or her fellow human beings, consistent with the profoundly social nature of human endeavours, including ‘inherently associational activities’”.²²

[107] Section 2(d) is designed to promote social interaction and collective action of a mostly public nature, however. It has not been applied to protect intimate personal relationships. See, for example, *Catholic Children’s Aid Society of Metropolitan Toronto v. S(T.)* (1989), 69 O.R. (2d) 189 at 203-204 (C.A.) (access to child by birth parents after adoption); *R. v. S.(M.)* (1996), 111 C.C.C. (3d) 467 at 474 (B.C.C.A.) (sexual relations between parent and child); *R. v. Skinner*, [1990] 1 S.C.R. 1235 (soliciting prostitution); *Re Horbas et al and Minister of Employment and Immigration et al.* (1985), 22 D.L.R. (4th) 600 (F.C.T.D.) (the right of spouses to cohabit); *Gray v. Canada (Minister of Manpower and Immigration)*, [1985] F.C.J. No. 407 (T.D.) (the right to marry). In my view, s. 2(d) does not protect the right of a health professional to have sexual intercourse with a patient.

[108] In *Harper v. Canada (Attorney General)*, [2004] 1 S.C.R. 827, Bastarache J. emphasized the associational and collective nature of the s. 2(d) protection. At para. 125 he said:

Section 2(d) will be infringed where the State precludes activity because of its associational nature, thereby discouraging the collective pursuit of common goals; see *Dunmore v. Ontario (Attorney General)*, [2001] 3 S.C.R. 1016, 2001 SCC 94, at para. 16. It is only the associational aspect of the activity, not the activity itself, which is protected; see *Canadian Egg Marketing Agency v. Richardson*, [1998] 3 S.C.R. 157, at para. 104. [underlining in original]

²² OMA factum, at paras. 70 and 71.

[109] Here, the Mandatory Revocation Provisions do not prohibit health professionals from associating with their patients but merely from sexually abusing them. There is no breach of s. 2(d) of the Charter.

Section 1 of the Charter

[110] Since I have concluded that the Mandatory Revocation Provisions do not violate any of ss. 7, 12 or 2(d), there is no need to conduct an analysis under s. 1. If there were, however, I would hold that the Mandatory Revocation Provisions are justified and that they meet the pressing and substantial objective test and the rational connection, minimal impairment, and proportionality criteria set out by the Supreme Court of Canada in *R. v. Oakes*, [1986] 1 S.C.R. 103.

Remedy

[111] The appellant submits that the Mandatory Revocation Provisions should be struck down and that a reprimand should be imposed in lieu of the revocation of his certificate of registration, as the appropriate sanction. I do not accept this argument.

[112] The Discipline Committee found that even if the Mandatory Revocation Provisions had no application, it would have revoked Dr. Mussani's certificate of registration in the circumstances, in any event. The Divisional Court accepted this finding, and so do I.

[113] It is well settled that the disposition of a professional disciplinary committee respecting the appropriate sanction to be imposed in a particular case is entitled to great deference from the courts: *Re College of Physicians & Surgeons of Ontario and K* (1987), 59 O.R. (2d) 1 at 20 (C.A.); *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 S.C.R. 869 at 890; *Dr. Q v. College of Physicians and Surgeons of British Columbia*, [2003] 1 S.C.R. 226; *Law Society of New Brunswick v. Ryan*, [2003] 1 S.C.R. 247. I see no error in principle on the part of the Discipline Committee in concluding that revocation is the appropriate sanction on the record in this case, absent application of the Mandatory Revocation Provisions. Indeed, there are many aggravating factors, which render such a disposition entirely appropriate. I refer, for example, to the factors outlined in paras. 8-18, 21 and 71 above.

DISPOSITION

[114] I would therefore dismiss the appeal and uphold the constitutionality of the Mandatory Revocation Provisions of the Code. As indicated, I would also uphold the sanction of revocation in the circumstances of this case, even if I had concluded that the Mandatory Revocation Provisions were of no force and effect.

[115] For all of the foregoing reasons, therefore, the appeal is dismissed. Counsel advise that the appellant and the respondent have agreed to bear their own costs. The intervenors are not entitled to costs in accordance with the terms of the Orders granting them intervenor status.

[116] In closing, I would like to thank all counsel for their extremely able and helpful submissions.

“R.A. Blair J.A.”

“I agree R.P. Armstrong J.A.”

“I agree R.G. Juriansz J.A.”

RELEASED: December 29, 2004