LEGAL BRIEF

Patient protection laws and the issue of consensual sexual relationships with physicians

Recently, the Ontario Superior Court of Justice heard an appeal of a decision of the Discipline Committee of the College of Physicians and Surgeons of Ontario.[1] The significance of this case is that it established a precedent by examining constitutional questions regarding legislation that has mandatory penalties for physicians who have consensual sexual relations with current patients.

The case concerned Dr. Anil Mussani, a primary care physician whose certificate had been revoked after he engaged in a consensual sexual relationship with a patient. Mussani had provided care to the patient on approximately 170 occasions (including several sessions involving marital counselling) over 10 years. On reviewing the evidence, the Committee concluded that a power imbalance existed between Mussani and his patient and that he had breached his fiduciary duty by entering into the sexual relationship. Mussani was convicted of professional misconduct on a finding of patient sexual abuse. His certificate to practise was revoked. A provincial Code,[2] based largely on recommendations from a Task Force on Sexual Abuse of Patients,[3] enforces "zero tolerance" with respect to patient sexual abuse. There is a mandatory minimum penalty of certificate revocation for no less than 5 years.

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The appeal concerned the mandatory revocation of Mussani's certificate to practise. The physician and the Ontario Medical Association argued that applying such a penalty in this case was a breach of the Charter of Rights and Freedoms[4] at sections 7 and 12. (Section 7 protects 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," while Section 12 protects the "right not to be subject to any cruel and unusual treatment or punishment.") The main question for the appeal court was whether the penalty imposed by provincial legislation was a violation of Mussani's Charter rights, given that the sexual relationship between himself and his patient was consensual.

The decisional reasoning was complex. In essence, the court was not persuaded by arguments that a certificate to practise medicine was a right (rather than a privilege), or that a sexual relationship with a current patient could truly be consensual. The court's detailed consideration of the latter issue cited a Supreme Court of Canada case[5] (among others), which convinced the court that a physician's position of trust, power and authority renders the patient's consent to a sexual relationship suspect. That Mussani had an intimate relationship with a *current* patient was crucial in the decision. The court said a physician must choose whether to pursue a physician–patient relationship or a sexual relationship, and cannot choose both. After having determined that the provincial legislation did not violate the Charter (and that it was also not a Charter violation to remove the discretion of the Discipline Committee), the court then said that the penalty administered in the Mussani case was also not a Charter breach.

Earlier, the Discipline Committee of the College of Physiotherapists of Ontario had decided that the same mandatory revocation provisions were constitutionally invalid for an "exceptional" case in which a finding of professional misconduct had been made. In this case the Committee had held that although the finding of misconduct was just, the mandatory revocation of the certificate to practise was not. The Committee said the personal relationship was less susceptible than a physician–patient relationship to power imbalance and that the positive victim impact statement needed to be considered. However, the constitutional issue was not argued on appeal,[6] and the judge in the Mussani case did not consider that Committee's ruling, as it was not a court decision.

A recent Charter challenge in Prince Edward Island also considered the matter of mandatory penalties for physicians who sexually abuse patients.[7] In this case, a psychiatrist and patient entered into a personal relationship 7 and a half years after the physician–patient relationship had ended. The court determined that the legislation was contrary to s. 7 of the Charter, as it was overly and unnecessarily broad in meeting its statutory objectives. Although the views of the court in that

case ought to be respected, said the judge in the Mussani case, they did not need to be followed because there were distinguishable differences between the 2 cases. Indeed, a key factor in the Mussani case was that the sexual relationship was with a current patient. The case in PEI involved, among other things, the blanket prohibition against psychiatrists having sexual relationships with former patients as well as the issue of the length of time since the professional relationship had ended.

The issue of time is an important one. Though determining whether a patient is "current" or "former" would appear to be straightforward, the amount of time that has elapsed from the end of a professional relationship and the nature of the care that was provided are most certainly other factors that must be taken into account. That is, the Mussani case should not suggest that physicians can simply terminate a longstanding professional relationship with a patient in order to engage in a personal one. It is very possible that the courts will be asked in the future to decide at what point (and under what circumstances), ex-patients are capable of providing consent to a private relationship with their former physicians.

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References

1. *Dr. Anil Mussani* v. *The College of Physicians and Surgeons of Ontario*. [2003] OJ No 1956; 2003 OnC LEXIS 739.
2. *RHPA/Code: Health Professions Procedural Code*, sched. 2 to the *Regulated Health Professions Act*, 1991, s4 SO 1991, c18.
3. College of Physicians and Surgeons of Ontario, Task Force on Sexual Abuse of Patients. *Final report: Task Force report on sexual abuse of patients*. Toronto: College of Physicians and Surgeons of Ontario; 1991.
4. *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c11 [Charter].
5. *Laura Norberg Appellant* v. *Morris Wynrib Respondent and Women's Legal Education and Action Fund Intervener* [1992] 2 SCR 226; 1992 SCR LEXIS 693.
6. *Melunsky* and the *College of Physiotherapists* [1999] ACWSJ LEXIS 44871.
7. *A.B.* v. *The College of Physicians and Surgeons of Prince Edward Island (PEI)* [2001] Nfld & PEIR LEXIS 323; 205 Nfld & PEIR, 131; 615 APR 131.

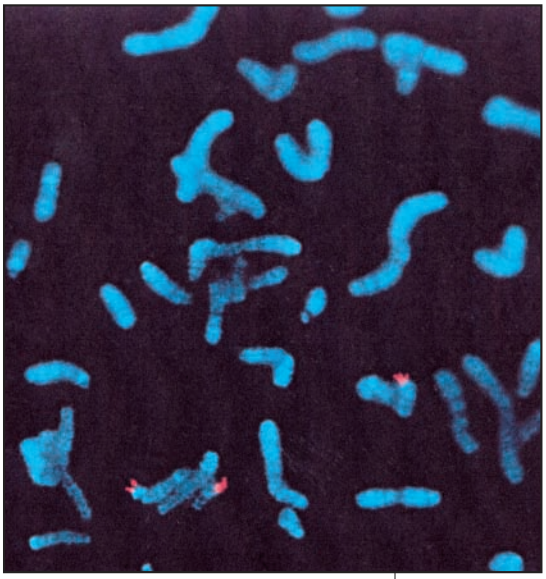
SCIENCE AND MEDICINE

Genetic profiling may offer insight into leprosy

Genetic profiling may help to define different clinical forms of leprosy. The severity of the disease depends partly on how an individual's immune system responds to the causative organism, *Mycobacterium leprae*. Tuberculoid leprosy is typically a self-limited disease with a low bacterial load. In contrast, patients who have lepromatous leprosy present with disseminated lesions and high bacterial loads, which reflects the suppression of cell-mediated immunity (see pages 55 and 71 in this issue).

To determine the reason for this difference in immune response, Bleharski and colleagues compared the patterns of expression of about 12 000 genes between patients with either form of leprosy. They demonstrated that there were clear differences in the expression of certain genes within the skin lesions between the tuberculoid and lepromatous groups. Specifically, they found an increase in the expression of type 2 cytokines in the lepromatous samples, which had been previously associated with immune suppression. However, they also discovered an increase in the expression of receptors in the leukocyte immunoglobulin-like receptor family. Hypothesizing that these receptors may also inhibit the immune response, they found that manipulating them with antibodies indeed resulted in an imbalance between the cytokines necessary for mounting an inflammatory response.

Within a larger context, the authors state that the importance of such findings indicates that genes involved in beneficial or maladaptive immune responses can be identified,



which may lead to a greater understanding of disease progression in general, and perhaps therapy. (Bleharski et al. *Science* 2003;301:1527)