



Maintaining Appropriate Boundaries and Preventing Sexual Abuse

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COLLEGE CONTACT:	Physician Advisory Service

Maintaining Appropriate Boundaries and Preventing Sexual Abuse

PURPOSE

This policy has been developed to provide guidance to physicians and to help physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991 (RHPA)* regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.

BACKGROUND

Sexual relations between physicians and patients have long been considered to be unethical. The Hippocratic Oath states that physicians:

"...will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons be they free or slaves."

Sexual abuse of patients by physicians was identified as a significant problem in 1991, when the College of Physicians and Surgeons of Ontario released several reports from its Task Force on patient sexual abuse. These reports provided the impetus for changes to the *RHPA*, and a number of provisions that deal with sexual abuse were specifically added to the *RHPA* to address this issue. In doing so, the notions of Hippocrates have been brought into the modern regulation of the profession of medicine.

Under the *RHPA*, any form of sexual relations between physicians and patients is considered to be sexual abuse. Consent by the patient is no defence to sexual abuse.

Under the *Health Professions Procedural Code*¹ (the "Code") it is an act of professional misconduct for a physician to sexually abuse a patient.

The *RHPA* defines "sexual abuse" as follows:

"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.

Note: Touching, behaviour or remarks of a clinical nature appropriate to the service provided do not constitute sexual abuse.²

¹ Clause (b.1), subsection 51(1) *Health Professions Procedural Code (HPPC)*.

² Subsections 1 (3) and (4) *HPPC*.



The *Code* provides for mandatory revocation of a physician's certificate of registration for certain acts of sexual abuse.³ For sexual abuse that does not involve these acts, the penalty is at the discretion of the Discipline Committee. If a physician's certificate of registration is revoked for sexual abuse, he or she cannot reapply until five years after the revocation.⁴

While it is not considered 'sexual abuse' under the legislation, if sexual contact takes place after the physician-patient relationship has been ended, the physician may still be found to have committed professional misconduct.⁵

FOUNDATION OF A PHYSICIAN-PATIENT RELATIONSHIP

Trust

Trust is the cornerstone of the physician-patient relationship. When a patient seeks care from a physician, the patient trusts that the physician is a professional and as such will treat them in a professional manner. To maintain trust, a physician must avoid making or responding to sexual advances. Sexualizing the relationship is a clear breach of trust.

Power

The physician-patient relationship is characterized by a power imbalance in favour of the physician.

- A patient depends upon the physician's knowledge and training to provide care.
- To receive care, patients provide information of a sensitive nature about themselves or family members.
- Patients also allow the physician to conduct intimate physical examinations.
- The transfer of information and the physical examination is one-sided, from patient to physician.
- Patients may feel particularly vulnerable if they:
 - are feeling unwell, experiencing pain, and/or are worried or afraid;

- do not speak the same language as the physician;
- are undressed or exposed.

PRINCIPLES

1. A physician, being in a position of trust and power, has a duty to act in the patient's best interest.
2. Physicians must establish and maintain appropriate professional boundaries with patients.
3. Sexual activity and 'romantic interactions' interfere with the goals of the physician-patient relationship and may obscure the physician's objective judgment concerning the patient's health care.
4. Physician sexual misconduct is detrimental to the physician-patient relationship, harms individual patients and erodes the public's trust in the medical profession.
5. Patients must be protected from sexual abuse by physicians.

COLLEGE POLICY

The policy has several sections which are as follows:

Part A: **Sexual Relationships Prohibited during the Physician-Patient Relationship** specifically addresses sexual abuse as defined in the *RHPA*.

Part B: **Determining Whether a Physician-Patient Relationship Exists.**

Part C: **Sexual Relationships after Termination of the Physician-Patient Relationship** does not address sexual abuse, but focuses on professional misconduct as a result of inappropriate behaviour.

Part D: **Relationships between Physicians and Persons Closely Associated with Patients.** Similar to Part C, this section does not address sexual abuse, but focuses on professional misconduct as a result of inappropriate behaviour.

Part E: **Reference to the CPSO's Mandatory Reporting policy.**

³ Sexual intercourse; genital to genital, genital to anal, oral to genital, or oral to anal contact; masturbation of the member by, or in the presence of, the patient; masturbation of the patient by the member; encouragement of the patient by the member to masturbate in the presence of the member. (Subsection 51 (5) *HPPC*).

⁴ Subsection 72 (3) *HPPC*.

⁵ Allegations of professional misconduct that could be made under the following grounds: act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and/or conduct unbecoming a physician. (O. Regulation 865/93 under the *Medicine Act, 1991*, Subsection 1(1), paragraph 33 and 34).

Maintaining Appropriate Boundaries and Preventing Sexual Abuse

A. Sexual Relationships Prohibited during the Physician-Patient Relationship

A physician must not become sexually involved with his or her patient. Sexual involvement with a patient is sexual abuse under the *RHPA* regardless of whether the physician believes there is ‘consent’ from the patient.

It is always the physician’s responsibility to ensure that appropriate boundaries are maintained, regardless of the patient’s behaviour.

Physicians should follow the guidelines below when treating a patient in order to maintain proper boundaries within the physician-patient relationship:

1. A physician must not make sexual advances towards a patient nor respond sexually to any form of sexual advance made by a patient.
2. Physicians should explain the scope of an examination and reasons for examinations/procedures to patients.
3. Although third parties are not mandatory, the presence of a third party during an intimate examination may contribute to both patient and physician comfort. Patients should be given the option of having a third party present. In cases where a physician is unable to provide such a person, he/she should inform the patient that they may bring in a person of their choosing with them.
4. While physicians may intend non-sexual and non-clinical touching of patients to be therapeutic or comforting, supportive words or discussion may be preferable to avoid misinterpretation.

Appendix “A” lists additional guidelines for ensuring proper boundaries within the physician-patient relationship. The Boundaries Self-Assessment Tool is also a good resource to help physicians understand boundary issues. It can be accessed on the CPSO website at www.cpso.on.ca.

B. Determining Whether a Physician-Patient Relationship Exists

Because the *RHPA* prohibits sexual relationships between a physician and a patient, it is important to determine whether a physician-patient relationship exists.

The existence of a physician-patient relationship will be established having regard to the nature and frequency of the treatment provided, whether there is an ongoing treatment relationship (which may be evident by the presence of a medical record), whether the physician bills for services provided and any other relevant factors. The longer the physician-patient relationship and the more dependency involved, the longer the relationship will endure. A factual inquiry must be made in each case to determine whether a physician-patient relationship exists, and when it ends.⁶ Where a physician is in doubt as to whether the physician-patient relationship has terminated, they should refrain from any relationship with the patient until they seek advice.⁷

⁶ The Courts have found that certain physician-patient relationships may endure subsequent to the end of the formal relationship, for example, in the case of a long-standing psychotherapeutic relationship.

⁷ Physicians are advised to contact the CMPA.



C. Sexual Relationships after Termination of the Physician-Patient Relationship

Ending the physician-patient relationship does not eliminate the possibility that sexual contact between a physician and a former patient may be considered to be professional misconduct⁸ even though it is not sexual abuse as defined in the *RHPA*. This is because there may be continuing trust, knowledge, or influence derived from the previous professional relationship.

A physician must end the physician-patient relationship before starting a sexual relationship with a former patient. When doing so, physicians must comply with the College's policy on *Ending the Physician-Patient Relationship*. Specifically, it is the physician's responsibility to ensure that termination of the physician-patient relationship is communicated to the patient and documented in the patient's record. Physicians should also ensure that alternative services are arranged or the patient is given a reasonable opportunity to arrange alternative services.⁹

In determining the propriety of a sexual relationship between a physician and a former patient, a number of factors will be considered, including:

- the length and intensity of the former professional relationship;
- the nature of the patient's clinical problem;
- the type of clinical care provided by the physician;
- the extent to which the patient has confided personal or private information to the physician; and
- the vulnerability the patient has in the physician-patient relationship.

For example, when the physician-patient relationship involves a significant component of psychoanalysis or

psychotherapy, sexual involvement with the patient is likely inappropriate at any time after termination. However, if a physician saw a patient on one or two occasions to provide routine clinical care, it may not be inappropriate to have a sexual relationship with the former patient within a short time following the end of the physician-patient relationship.

At all times, a physician has an ethical obligation not to exploit the trust, knowledge and dependence that develops during the physician-patient relationship for the physician's personal advantage. A physician who is considering an intimate or sexual relationship with a former patient should act cautiously, making sure to consider the potentially complex issues. As well, a physician should ensure that the former patient has a good understanding of the dynamics of the physician-patient relationship and the boundaries applicable to that relationship.

8 Allegations of professional misconduct that could be made under the following grounds: act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and/or conduct unbecoming a physician. (O. Regulation 865/93 under the *Medicine Act, 1991*, Subsection 1(1), paragraph 33 and 34).

9 O.Reg. 856/93 under the *Medicine Act, 1991*, paragraph 7, S. 1 (1).

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D. Relationships between Physicians and Persons Closely Associated with Patients¹⁰

Sexual relationships between physicians and individuals who are closely associated with a physician's patients may also raise concerns about breach of trust and power imbalance.

In addition to the risk of exploitation, a sexual relationship between a physician and a person closely associated with a patient can detract from the goal of furthering the patient's best interests. It has the potential of affecting the objectivity of the physician's and the closely associated person's decisions.

The decisions of persons closely associated with a patient impact on the health care provided to the patient. As such, these individuals play an important role in the fiduciary relationship between a physician and his/her patient and therefore the physician should maintain the same professional boundaries as he or she would with a patient.

Therefore, it is advisable that physicians refrain from intimate or sexual relationships with these individuals. If a physician engages in these types of intimate or sexual relationships he or she may be found to have committed professional misconduct.¹¹

A physician should weigh the following factors when considering entering into a sexual relationship with a person closely associated with a patient:

- the nature of the patient's clinical problem;
- the type of clinical care provided by the physician;
- the length and intensity of the professional relationship;
- the degree of emotional dependence the individual associated with the patient has on the physician; and
- the degree to which the patient is reliant on the person closely associated with them.

E. Mandatory Duty to Report

A physician must comply with the reporting requirements of the *Code*.¹²

Briefly, a physician must report if he or she has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different college has sexually abused a patient. For a full description of this reporting requirement, a physician should consult the College's Mandatory Reporting policy.

¹⁰ Examples of these individuals include but are not limited to: patients' spouses or partners, parents, guardians, substitute decision-makers and persons who hold powers of attorney for personal care. Such individuals possess one or more of the following features:

- They are responsible for the patient's welfare and hold decision-making power on behalf of the patient.
- They are emotionally close to the patient. Their participation in the clinical encounter, more often than not, matters a great deal to the patient.
- The physician interacts and communicates with them about the patient's condition on a regular basis, and is in a position to offer information, advice, and emotional support.

¹¹ Allegations of professional misconduct that could be made under the following grounds: act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and/or conduct unbecoming a physician. (O. Regulation 865/93 under the *Medicine Act, 1991*, Subsection 1(1), paragraph 33 and 34).

¹² Sections 85.1 to 85.6 of the *HPPC*.



APPENDIX A

Guidelines for Maintaining Professional Boundaries

1. Avoid physical contact with a patient (except what is required to perform medically necessary examinations).
2. Use gloves when examining genitals.
3. Show sensitivity and respect for the patient's privacy and comfort at all times:
 - avoid watching a patient dress or undress,
 - provide privacy and appropriate covers and gowns.
4. Avoid any behaviour or remarks that may be interpreted as sexual by a patient.
5. Endeavour to be aware and mindful of the patient's particular cultural or religious background.
6. Do not make sexualized comments about a patient's body or clothing.
7. Do not criticize or comment unnecessarily on a patient's sexual preference.
8. Do not ask or make comments about sexual performance except where the examination or consultation is pertinent to the issue of sexual function or dysfunction.
9. Do not ask details of sexual history or sexual behaviour unless related to the purpose of the consultation or examination.
10. Be cognizant of social interactions with patients that may lead to romantic involvement.
11. Do not talk with your patients about your own sexual preferences, fantasies, problems, activities or performance.
12. Learn to control the therapeutic setting and to detect possible erosions in boundaries.

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