College of Physicians & Surgeons of Alberta

ADVICE TO THE PROFESSION

Boundary Violations: Sexual

Related Standards of Practice: *Boundary Violations: Sexual*

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the *CPSA Standards of Practice*. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

PLEASE NOTE: Complaints received by the College on or after April 1, 2019 will be adjudicated based on the sanctions of the *Health Professions Act* regardless of when the alleged incident occurred.

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Introduction

The medical profession has long acknowledged that the dynamics involved in the physician-patient relationship, including power, authority, control and trust, absolutely must preclude sexual involvement with a patient if the patient is to receive optimal care.

In fall 2018, the government of Alberta introduced new legislation, *An Act to Protect Patients*, to protect patients from sexual abuse and misconduct by healthcare providers. Given this, it is critical physicians understand how a patient is defined under this legislation; the *Boundary Violations: Sexual* standard of practice was passed by Council outlining the definition of "patient."

How long is a person considered a patient under sexual abuse and sexual misconduct legislation?

An individual is considered a "patient" for a minimum period of one year after the individual ceases to be the physician's patient.

For example, the one-year period may start on the date of the patient's last visit if there is no further medical interaction, the date any prescribed medications are completed or the date the physician-patient relationship is explicitly terminated. If a physician has any doubt, they should refrain from sexual conduct with their former patient.

There are many instances in which patients do not see their physician every year, but this does not mean the physician-patient relationship has ended.

Are there exceptions to the one year rule?

There are two broad exceptions to the one-year rule, for the purpose of sexual abuse and sexual misconduct legislation. They are as follows:

Psychotherapy

If a physician has **ever** provided a patient with psychotherapeutic treatment, a sexual relationship can **never** occur. Any time a patient is counselled regarding personal problems, it could be considered psychotherapy: doing so is considered sexual abuse under the *HPA* and will result in mandatory permanent revocation of the regulated member's practice permit.

As *supportive* counseling and psychotherapy is a component of family medicine, and it is likely a family physician's former patients have received some form of this care, a family physician should refrain from sexual conduct with a former patient.

Episodic Care

The College considers episodic care to be a single encounter with a patient, focused on a presenting concern, identified medical condition, or referred consultation with or without direct patient interaction (e.g., radiology consult), where neither the physician nor the patient have the expectation of ongoing care. In this event, the physician-patient relationship ends with the conclusion of the episodic care encounter, and it is clear from the medical record that any follow up (if required) will be with the patient's primary care physician or another healthcare provider.

What about conduct that falls outside of sexual abuse/sexual misconduct legislation?

Consensual sexual relationships with individuals who no longer meet the definition of a patient will not result in a finding of sexual abuse; however, physicians can still be found guilty of **unprofessional conduct** and may face serious penalties, up to and including license revocation. In these scenarios, a hearing tribunal will look carefully at the circumstances, including any power imbalance or if the physician used information they had to pursue a relationship with the individual.

CPSA advises physicians to avoid sexual relationships with **all** previous patients.

CPSA advises physicians to avoid sexual relationships with all previous patients. If, despite this advice, a physician chooses to enter into a sexual relationship with a previous patient, it is strongly recommended that physicians seek advice from CPSA or the Canadian Medical Protective Association prior to entering into a relationship with a former patient.

How does CPSA view medical treatment of spouses, partners and others in a pre-existing sexual relationships?

Under the *Code of Ethics*, a physician must limit treatment of family members to minor or emergency services and only when another physician is not immediately available. This principle applies to the physician's spouse, interdependent adult partner or other person with whom there is an ongoing, pre-existing sexual relationship. To clarify:

- a minor condition means a non-urgent, non-serious condition that requires only short-term, routine care and is not likely to be an indication of, or lead to, a more serious condition requiring medical expertise;
- an emergency means an individual is experiencing severe suffering or is at risk of sustaining serious bodily harm if medical intervention is not promptly provided; and
- another physician is not readily available, which means the individual could suffer harm from a delay in obtaining the services of another physician.

Providing treatment outside these parameters could result in a finding of unprofessional conduct. As such, physicians are advised to take great care in providing treatment only within the defined allowances.

How can physicians protect themselves against allegations of sexual abuse or sexual misconduct?

1. **Don't ever engage in sexual relations with or sexual touching of a patient.**
   All types of sexual conduct with patients are prohibited: even when a physician believes a patient has consented to sexual interaction, the *HPA* does not recognize such alleged "consent" as a valid defence. The physician's actions will be viewed as coercive, given the inherent power imbalance of the physician-patient relationship; therefore, the regulated member must maintain appropriate professional boundaries.

2. **Avoid risky behaviours**, such as undue physician touching, comments of a sexual nature, taking one's importance to the patient too seriously, undue self-disclosure with the patient or unusual office practice. Be aware of these behaviours, remove yourself from providing care and obtain help (e.g., AMA's Physician and Family Support Program) to avoid similar behaviour in the future.

3. **Always take steps to avoid misinterpretation of legitimate medical examinations.**
   Sometimes, a physician does not intend his or her actions to be sexual in nature, but a patient perceives them as such. This risk is reduced by explaining the nature and scope of any exam or procedure in advance: using appropriate examination techniques when touching sensitive or intimate areas of the body, offering a running commentary of the exam and explaining why certain questions are relevant and necessary, like those about a patient's sexual history, or obtaining personal information.

   While the patient's consent may be implied, explicit consent is necessary when the assessment involves an intimate exam (i.e., an examination including the breasts, rectum or genitalia). It is good best practice for a physician to document explicit consent in the patient record when provided by the patient. In situations where the examination or procedure may affect the patient's level of consciousness or carries significant risk to the patient, written consent is recommended to ensure the patient fully understands and agrees to the exam. Physicians should be familiar with and follow the College's expectations for obtaining informed consent.

4. **Use a chaperone.**
   The presence of a medical chaperone as an independent third person during clinical interactions can be helpful and provide a degree of reassurance, to both the physician and the patient. A chaperone may provide considerable reassurance to a patient and should be offered during exams considered personal, intimate or requiring significant removal of clothing. Consequently, the College strongly recommends the use of a chaperone if requested by a patient.

Specific training is available to chaperones who work in physician offices to provide an understanding of medical procedures and knowledge of positioning in the exam room during certain examinations.

Do physicians have a duty to report sexual abuse or sexual misconduct?

If in the course of acting in a professional capacity the physician believes, on reasonable grounds, that a physician is engaged in inappropriate sexual abuse of or sexual misconduct with a patient (or former patient), he or she **must** report this to the College. A similar duty exists with respect to other regulated health professionals under the *HPA* (section 127.2(1)); in those circumstances, the physician must report the matter to healthcare professional's regulatory college.

There is an exception to the reporting expectation in that reporting is not required if information regarding sexual abuse or sexual misconduct of a patient (or former patients) if the information is received in the course of providing professional services to the other regulated health professional (section 127.2(2) of the *HPA*).

Under Bill 21, the *HPA* (section 127.1) now requires regulated health professionals to report decisions of unprofessional conduct (in any jurisdiction), negligence and charges/ convictions under the *Criminal Code* to all regulatory colleges of which they are a member.

Appendix A

This table summarizes the prohibitions, the classification of a violation of those prohibitions (sexual abuse, sexual misconduct, or unprofessional conduct) and the consequences.

Type of Conduct	Classification	Consequences
Type of conduct described in the definition of sexual abuse with a patient.	Sexual abuse	Revocation with no possibility of reinstatement.
Type of conduct described in the definition of sexual misconduct with a patient.	Sexual misconduct	Hearing Tribunal must impose, at a minimum, a suspension and can impose more severe sanctions. If cancelled because of sexual misconduct cannot apply for reinstatement for five years.
Sexual conduct with a former patient within one year of the end of the physician-patient relationship (note special rules on episodic care).	Sexual abuse	Revocation with no possibility of reinstatement.
Sexual conduct with a former patient beyond the one year period and a consideration of the factors leads to the conclusion that this was inappropriate.	Unprofessional conduct	Hearing Tribunal has discretion to impose range of sanctions it considers appropriate, given all the circumstances.
Engages in type of conduct described in the definition of Sexual Abuse at any time, after providing psychotherapeutic care.	Sexual abuse—can never engage in sexual conduct with former patient, regardless of how much time has passed since the end of the physician-patient relationship.	Revocation with no possibility of reinstatement.
Episodic care: Type of conduct described in the definition of sexual abuse or sexual misconduct with a patient, while physician is providing episodic care.	Sexual abuse or sexual misconduct, as case may be.	Revocation with no possibility of reinstatement.
Episodic care: Sexual conduct any time after conclusion of episodic care and a consideration of the factors leads to the conclusion that this was inappropriate.	Unprofessional conduct	Hearing Tribunal has discretion to impose range of sanctions it considers appropriate, given all the circumstances.
Providing health service to spouse, partner or person with whom physician has a pre-existing sexual relationship. Medical care is considered inappropriate unless prescribed conditions are met.	Unprofessional conduct	Hearing Tribunal has discretion to impose range of sanctions it considers appropriate, given all the circumstances.