Ontario Medical Association

Submission to the College of Physicians and Surgeons of Ontario's Pre-Consultation on Maintaining Appropriate Boundaries and Preventing Sexual Abuse

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The OMA appreciates the opportunity to comment on the CPSO's pre-consultation on "Maintaining Appropriate Boundaries and Preventing Sexual Abuse". Please see our comments below. Any further comments will be provided during the CPSO's second round of consultation on this policy.

1. Separate and distinguish the sections on sexual abuse and other ethical sexual boundary issues

Given the fact that the *Regulated Health Professions Act* (RHPA) lays out very explicit and harsh penalties for "sexual abuse", it is important to clearly distinguish the rules and penalties relating to sexual abuse from other ethical sexual boundary issues.

The OMA recommends that the current policy be re-structured so as to make the distinction between circumstances of sexual abuse and other ethical sexual issues much more clear.

While Parts A, B and E of the current policy address "sexual abuse", Parts C and D do not. A sexual relationship between a physician and an individual who is no longer a "patient" (i.e. Part C) or an individual who is closely associated to a patient (i.e. Part D), does not constitute "sexual abuse" as defined in the RHPA. Rather, these sexual boundary issues raise ethical concerns regarding breach of trust and a physician's objectivity to act in the patient's best interests, as well as the potential for professional misconduct claims.

As such, a clear distinction must be made in the policy between the three sections which address sexual abuse and the two that do not. Conflating the two examples of ethical boundary issues within the sexual abuse sections can lead to confusion and misinterpretation that such situations constitute "sexual abuse". In addition to re-structuring within the policy, explicit language should be included in the substance of Parts C and D which states that these situations do not constitute "sexual abuse" as defined in the RHPA. The 'purpose' section should be further revised to include wording that reflects the fact that the policy does not only "help physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991* (RHPA) regarding sexual abuse", but also addresses other ethical boundary issues and professional misconduct that may arise in sexual relationships involving a physician.

2. Non-sexual boundary issues should not be covered in this policy

If the CPSO proceeds with setting out expectations for physicians on non-sexual boundary issues (e.g. physicians receiving gifts from patients, physicians employing patients, etc.), the OMA strongly recommends that such non-sexual boundary issues be covered in a separate policy and not be addressed in the current policy. As aforementioned, given the seriousness of sexual abuse claims and the unique nature of other ethical sexual boundary issues, it is important that the current policy remain focused and limited to addressing sexual boundary issues. Physicians should be able to consult one policy document to be informed of sexual boundary issues and the sexual abuse

legislation. The current policy should not become unnecessarily lengthy and complicated with the potentially vast range of non-sexual boundary issues that could be addressed.

3. Part B should be switched in order with Part A

Part B "Determining Whether a Physician-Patient Relationship Exists" describes whether a physician-patient relationship exists, whereas Part A "Sexual Relationships Prohibited During the Physician-Patient Relationship" states that sexual relationships are prohibited during such a relationship. As such, logically, it makes sense to first address whether a physician-patient relationship exists and then state the fact that sexual relationships are prohibited in such a relationship.

4. A footnote reference to the Bill 87 amendments to the HPPC should be added at the end of the sentence "within a short time following the end of the physician-patient relationship" in Part C

A footnote reference to the Bill 87 amendments to the *Health Professions Procedural Code* (HPPC) where an individual is defined as a "patient" for at least one year after the physician-patient relationship is terminated, should be added at the end of the sentence "within a short time following the end of the physician-patient relationship" in Part C. This is to provide clarity that after the Bill 87 amendments are proclaimed, entering into a "sexual relationship with the former patient within a short time following the end of the relationship" [emphasis added] will no longer be legal. Under the new law, a physician would have to wait at least one year after the physician-patient relationship has ended, and not just "a short time". Otherwise, the physician would be found to have engaged in sexual abuse. Alternatively, the line "within a short time following the end of the physician-patient relationship" can be deleted from this sentence, and the footnote reference added after the words "former patient" in that sentence.

5. Clarity and consistency on who a "former patient" is

Currently, the term "former patient" refers to an individual after he/she ceases to be a patient, which is immediately after the physician-patient relationship has ended (i.e. from the date of termination onwards). However, when the amendments to the HPPC as a result of Bill 87 come into force, an individual will still be defined as a "patient" under the HPPC for at least one year following termination of the physician-patient relationship. As such, a new meaning of "former patient" may emerge to refer to an individual who has ceased to be a "patient" as defined in the HPPC (i.e. after at least one year from the date of termination).

Given this new interpretation that may arise after the HPPC amendments come into force, as a general recommendation, it is important to provide clarity and be consistent in the use of the term "former patient". The CPSO will have to clearly delineate between the two interpretations of "former patient", perhaps by establishing two separate titles and definitions to represent: 1) former patients immediately after termination; and 2) former patients one year after termination. One suggestion for consideration would be terms such as "immediate former patients" and "prior patients".

After the HPPC amendments come into force, a physician entering into a sexual relationship with a former patient immediately after termination would be found to have engaged in sexual abuse; however, a physician entering into a sexual relationship with a former patient one year after termination would not be considered to have engaged in sexual abuse. As such, given the harsh penalties of sexual abuse, clarity and consistency will be critical.

6. Third party chaperones should not be a mandatory requirement for intimate examinations

The OMA continues to advocate that while the choice of physicians and patients to have a third party chaperone present during intimate examinations is important, the use of third party chaperones should not be made a mandatory requirement. A mandatory requirement for use of third parties during intimate examinations not only introduces significant additional costs to physicians who must pay the individual for his/her time, it also has the potential to compromise a patient's privacy. It is unacceptable to establish a system framework that creates discomfort for many patients, as well as expenses for all providers.

Further, while the policy explicitly states that "patients should be given the option of having a third party present", it does not explicitly state that physicians also have this option. The presence of a third party during an intimate examination can contribute to the physician's comfort. As such, the policy should be revised to explicitly state that physicians have the option of having a third party present during intimate examinations, and that physicians can refuse to perform an intimate examination if a third party is not available or the patient refuses to have a third party present.

Once again, the OMA appreciates the opportunity to participate in this consultation and welcomes the opportunity to discuss any of the aforementioned issues in greater detail. The OMA understands that the CPSO will release this policy for a second round of consultation in the near future, and as such, any further comments and recommendations regarding this policy will be provided by the OMA during that consultation.