Maintaining Appropriate Boundaries and Preventing Sexual Abuse: Online Survey Report

From the Preliminary Consultation on the Current Policy
September-December, 2017
Introduction

The College’s current *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy was released for external consultation between September-December, 2017. The purpose of this consultation was to obtain stakeholders’ feedback to help ensure that the policy reflects current practice issues, embodies the values and duties of medical professionalism, and is consistent with the College’s mandate to protect the public.

Invitations to participate in the consultation were sent to a broad range of stakeholders, including the entire CPSO membership, and a notice was posted on the CPSO website and social media platforms.

Feedback was collected via regular mail, email, an online discussion forum, and an online survey. In accordance with the College’s posting guidelines, all feedback received through the consultation is posted online.

This report summarizes only the stakeholder feedback that was received through the online survey.
Caveats

34 respondents initiated the survey, however, 11 failed to provide responses to any substantive questions (see Table 1). For the purposes of this report, these 11 surveys are considered incomplete, and have not been included.

Note: Participation in this survey was voluntary, and one of a few ways in which feedback could be provided. As such, no attempt has been made to ensure that the sample of participants is “representative” of any sub-population.

- The **quantitative** data captured in this report are complete, and the number of respondents who answered each question is provided.
- The **qualitative** data captured in this report are a summary of the general themes or ideas conveyed through the open-ended feedback. Where reported, stakeholder feedback to open-ended questions has been paraphrased.

<table>
<thead>
<tr>
<th>Summary of surveys received</th>
<th>n = 34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete or partially complete</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>68%</td>
</tr>
<tr>
<td>Incomplete</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>32%</td>
</tr>
</tbody>
</table>
Profile of Respondents

Nearly 9 out of 10 survey respondents were physicians (*Table 2)*.

### Table 2: Respondent demographics

<table>
<thead>
<tr>
<th>Are you a...?</th>
<th>n = 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician (incl. retired)</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Medical Students</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Member of the Public</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Other health care professional (incl. retired)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Organization</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4%</td>
</tr>
</tbody>
</table>

And the majority of survey respondents (92%) were residents of Ontario (*Table 3*).

### Table 3: Respondent location

<table>
<thead>
<tr>
<th>Do you live in...?</th>
<th>n = 23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>92%</td>
</tr>
<tr>
<td>Rest of Canada</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Outside Canada</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4%</td>
</tr>
</tbody>
</table>
Part 1: General Questions

The following questions assess respondents’ opinions of the current policy.

As they did not require respondents to have read the current policy, the questions in this section were posed to all respondents.

Note: In some cases, in order to provide respondents with relevant context, additional detail was provided in the survey. For the sake of brevity, this additional contextual detail is not always reproduced in this report.
Q4. “In your view, is there content we should consider including in the next iteration of the policy specifically for patients?”

Almost half of respondents (48%) didn’t know if there is patient-specific content that should be included in the next iteration of the policy.

**Figure 1: Patient-specific content**

<table>
<thead>
<tr>
<th>Is there content we should consider including specifically for patients?</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30%</td>
<td>22%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Base: n = 23
Open-ended feedback regarding the patient-specific content was received from 7 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- The policy should explain why physicians cannot accept coffee meetings, or become your friend, etc. Not a mean physician, but one who follows the rules.
- Define “sexual abuse” and “boundaries”.
- Physicians feel vulnerable too when they see patients who make them uncomfortable.
- The policy is overly focused on “sexualization” of the physician-patient relationship and needs to address “crossing boundaries of intimacy” including emotional, physical and social parameters that reflect a power imbalance.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q6. “In your view, would it be helpful to develop separate document(s) regarding boundaries and sexual abuse that are patient-focused?”

Almost half of respondents (44%) thought it would be helpful to develop separate document(s) regarding boundaries and sexual abuse that are patient-focused.

![Figure 2: Patient-specific document(s)](image-url)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>44%</td>
<td>30%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Base: n = 23
Suggestions on the type of information we should address or the type of documents we should develop were received from 10 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Definitions for “boundaries” and “sexual abuse”.
- Two separate documents: one for boundaries and one for sexual abuse.
- Discussion of the range of boundary issues that can arise and how to recognize them.
- A list of patient responsibilities.
- A fact sheet.
- Posters that state patients can bring a third party (chaperone) to each visit or ask for one.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q8. “Please indicate the extent to which you agree or disagree with each of the following statements regarding the foundational aspects of a physician-patient relationship.”

Overall, respondents agreed with the statements regarding the foundational aspects of a physician-patient relationship.
Q8. “Please indicate the extent to which you agree or disagree with each of the following statements regarding the foundational aspects of a physician-patient relationship.” (Continued)

Overall, respondents agreed with the statements regarding the foundational aspects of a physician-patient relationship.

Figure 3: Foundational Aspects

Physicians are in a position of power because the transfer of information and the physical exam is one-sided, from the patient to the physician.

- Strongly agree: 25%
- Somewhat agree: 33%
- Neither agree nor disagree: 14%
- Somewhat disagree: 14%
- Strongly disagree: 14%

Physicians are in a position of power because patients provide information of a sensitive nature about themselves or family members.

- Strongly agree: 38%
- Somewhat agree: 38%
- Neither agree nor disagree: 10%
- Somewhat disagree: 14%

Physicians are in a position of power because patients allow the physician to conduct intimate physical examinations.

- Strongly agree: 38%
- Somewhat agree: 43%
- Neither agree nor disagree: 5%
- Somewhat disagree: 14%

Patients may feel particularly vulnerable if they are feeling unwell.

- Strongly agree: 44%
- Somewhat agree: 38%
- Neither agree nor disagree: 4%
- Somewhat disagree: 14%

Base: n = 21
Q8. “Please indicate the extent to which you agree or disagree with each of the following statements regarding the foundational aspects of a physician-patient relationship.” (Continued)

Overall, respondents agreed with the statements regarding the foundational aspects of a physician-patient relationship.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients may feel particularly vulnerable if they are experiencing pain.</td>
<td>29%</td>
<td>48%</td>
<td>18%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Patients may feel particularly vulnerable if they are worried or afraid.</td>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Patients may feel particularly vulnerable if they do not speak the same language as the physician.</td>
<td>48%</td>
<td>37%</td>
<td>10%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Patients may feel particularly vulnerable if they are undressed or exposed.</td>
<td>48%</td>
<td>37%</td>
<td>10%</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

Base: n = 21

Figure 3: Foundational Aspects
Q9. “The statements above reflect the foundational aspects of a physician-patient relationship that are included in the current policy. In your view, are there any revisions that should be made to these statements?”

Respondents were divided as to whether revisions should be made to these statements.

Figure 4: Revisions to foundational aspects

Are there any revisions that should be made to these statements?  

- Yes: 48%
- No: 43%
- Don't know: 9%

Base: n = 24
Open-ended feedback regarding revisions to the foundational aspects of a physician-patient relationship was received from 11 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Concepts of trust and power need to be described from both the patient’s and physician’s perspective.
- Trust should be used instead of power.
- It should be acknowledged that patients have power in the physician-patient relationship.
- Patients are no longer totally dependent upon physicians to provide information and care; they should be encouraged to research and take charge of their health.
- Patients who are in pain, ill or share more information are vulnerable.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q11. “In your view, are there any foundational aspects regarding the physician-patient relationship that are missing from the current policy and should be included in the next iteration?”

The majority of respondents (61%) didn’t think there were any foundational aspects missing from the current policy.

Figure 5: Foundational aspects missing

<table>
<thead>
<tr>
<th>Are there any foundational aspects that are missing?</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>61%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Base: n = 21
Open-ended feedback regarding the foundational aspects of a physician-patient relationship that are missing was received from 6 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Patients should play an active role and take steps to limit a physician’s opportunity to sexually abuse them.
- Patients may be the ones who initiate sexual relations with the physician and this shouldn’t be considered sexual abuse.
- Add good communication, shared values (e.g. honesty, truthfulness) and mutual respect.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q13. “Please indicate the extent to which you agree or disagree with each of the following statements regarding the use of third parties (i.e. chaperones).”

Overall, respondents agreed with the statements regarding the use of third parties (i.e. chaperones).

Figure 6: Third parties (i.e. chaperones)

- The presence of a third party during an intimate examination contributes to the patient’s comfort.
  - 25% Strongly agree
  - 35% Somewhat agree
  - 25% Neither agree nor disagree
  - 10% Somewhat disagree
  - 5% Strongly disagree

- The presence of a third party during an intimate examination contributes to the physician’s comfort.
  - 35% Strongly agree
  - 45% Somewhat agree
  - 5% Neither agree nor disagree
  - 5% Somewhat disagree
  - 10% Strongly disagree

- Physicians must give patients the option of having a third party present during an intimate examination.
  - 50% Strongly agree
  - 20% Somewhat agree
  - 5% Neither agree nor disagree
  - 10% Somewhat disagree
  - 15% Strongly disagree

- If a physician is unable to provide a third party, he/she must inform the patient that they may bring a person of their choosing with them.
  - 25% Strongly agree
  - 35% Somewhat agree
  - 15% Neither agree nor disagree
  - 15% Somewhat disagree
  - 10% Strongly disagree

- Third parties can only be used if both the patient and physician agree on one.
  - 15% Strongly agree
  - 25% Somewhat agree
  - 15% Neither agree nor disagree
  - 15% Somewhat disagree
  - 30% Strongly disagree

Base: n = 20
Q13. “Please indicate the extent to which you agree or disagree with each of the following statements regarding the use of third parties (i.e. chaperones).”

(Continued)

Overall, respondents agreed with the statements regarding the use of third parties (i.e. chaperones).

Patients can refuse an intimate examination if they are not comfortable with the third party that would be present. 

Physicians can refuse to do an intimate examination if the patient refuses to have a third party present.

The policy should require the use of third parties for intimate examinations.

The policy should set out criteria for who can be a third party.

Base: n = 20
Open-ended feedback regarding the use of third parties (i.e. chaperones) was received from 9 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Some physicians don’t want to do intimate examinations without a chaperone because of fear of legal repercussions.
- The use of electronic/video chaperones should be used to protect physicians and patients.
- Having third parties present suggest that physicians can’t be trusted.
- It shouldn’t be mandatory for a third party to be present.
- The third party should not be a friend of family member of the patient or employed by the physician. It should be a neutral third party (e.g. someone from the College).

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q15. “In your view, are there any circumstances in which it would ever be appropriate for a physician to be sexually involved with a patient after termination when the physician-patient relationship involved a significant component of psychoanalysis?”

Respondents were divided with respect to whether it would ever be appropriate for a physician to be sexually involved with a patient after termination when the physician-patient relationship involved a significant component of psychoanalysis.

Figure 7: Sexual involvement after termination

<table>
<thead>
<tr>
<th>Are there any circumstances in which it would ever be appropriate?</th>
<th>30%</th>
<th>35%</th>
<th>35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base: n = 17</td>
<td>Yes</td>
<td>No</td>
<td>Don't know</td>
</tr>
</tbody>
</table>
Open-ended feedback regarding whether it would ever be appropriate for a physician to be sexually involved with a patient after termination when the physician-patient relationship involved a significant component of psychoanalysis was received from 13 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

• There may be some circumstances where a sexual relationship may be appropriate (e.g. consenting adults and an appropriate amount of time has passed).
• The transference relationship that is an integral part of every psychoanalysis does not end with termination of treatment.
• It is always inappropriate to be involved with a current or previous patient.
• Shouldn’t be limited to psychotherapy; all physician-patient relationships involve some element of “psychological interaction”.
• There are lots of kinds of psychotherapy (e.g. CBT) which were designed to take the intimacy out of psychoanalysis.
• “Significant component“ of psychoanalysis should be defined.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q17. “In your view, are there other circumstances (outside of a relationship involving psychotherapy) in which sexual involvement would be inappropriate at any time after termination?”

Respondents were divided with respect to whether there are other circumstances in which sexual involvement would be inappropriate at any time after termination. 41% of respondents thought there were no other circumstances.

![Figure 8: Other circumstances in which sexual involvement would be inappropriate after termination](image)

<table>
<thead>
<tr>
<th>Are there other circumstances in which sexual involvement would be inappropriate?</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35%</td>
<td>41%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Base: n = 17
Q18. “If yes, please describe the circumstances in which sexual involvement would be inappropriate and explain why.”

Open-ended feedback regarding the circumstances in which sexual involvement would be inappropriate was received from 8 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- When the relationship has a power imbalance or the patient is dependent on the physician.
- Even a long-standing clinical relationship may make it inappropriate.
- When physicians or patients are in crisis, they are vulnerable even if a year has passed.
- All forms of treatment, regardless of the time that has passed.
- Impossible to list all the possibilities; must be evaluated on a case-by-case basis.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q19. “Please indicate the extent to which you agree or disagree with each statement regarding relationships between physicians and persons closely associated with patients.”

Overall, respondents agreed with the statements regarding the relationships between physicians and persons closely associated with patients.

**Figure 9: Statements re: persons closely associated with patients**

- Physicians must maintain the same professional boundaries with persons closely associated with patients as he or she would with a patient. 38% Strongly agree, 25% Somewhat agree, 12% Neither agree nor disagree, 6% Somewhat disagree, 19% Strongly disagree

- It is reasonable to require that physicians refrain from intimate or sexual relationships with persons closely associated with patients. 38% Strongly agree, 31% Somewhat agree, 6% Neither agree nor disagree, 6% Somewhat disagree, 19% Strongly disagree

- Sexual relationships between physicians and persons closely associated with patients can raise concerns about breach of trust and power imbalance. 38% Strongly agree, 31% Somewhat agree, 12% Neither agree nor disagree, 6% Somewhat disagree, 13% Strongly disagree

- Sexual relationships between physicians and persons closely associated with patients can result in the risk of exploitation of the patient. 38% Strongly agree, 25% Somewhat agree, 6% Neither agree nor disagree, 12% Somewhat disagree, 19% Strongly disagree

Base: n = 16

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
Q19. “Please indicate the extent to which you agree or disagree with each statement regarding relationships between physicians and persons closely associated with patients.” (Continued)

Overall, respondents agreed with the statements regarding the relationships between physicians and persons closely associated with patients.

Figure 9: Statements re: persons closely associated with patients

Sexual relationships between physicians and persons closely associated with patients can detract from the goal of furthering the patient’s best interests.

- Strongly agree: 38%
- Somewhat agree: 19%
- Neither agree nor disagree: 25%
- Somewhat disagree: 6%
- Strongly disagree: 12%

Sexual relationships between physicians and persons closely associated with patients can affect the objectivity of the physician’s decisions.

- Strongly agree: 38%
- Somewhat agree: 31%
- Neither agree nor disagree: 13%
- Somewhat disagree: 6%
- Strongly disagree: 12%

Sexual relationships between physicians and persons closely associated with patients can affect the objectivity of the patient’s decisions.

- Strongly agree: 38%
- Somewhat agree: 25%
- Neither agree nor disagree: 25%
- Somewhat disagree: 12%

Sexual relationships between physicians and persons closely associated with patients can impact the health care provided to the patient.

- Strongly agree: 38%
- Somewhat agree: 31%
- Neither agree nor disagree: 13%
- Somewhat disagree: 6%
- Strongly disagree: 12%

Base: n = 16
Open-ended feedback regarding the statements about the relationships between physicians and persons closely associated with patients was received from 5 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Bad physicians may do all of these things without any of it being sexual.
- Potential conflict between social and professional obligations could interfere with both the physician’s and patient’s objectivity. It may be especially difficult for physicians in small communities to keep their social and professional lives separate.
- Working with the elderly can be intense because you are overvalued. It is never in the patient’s best interest to act on these transferences.
- An intimate relationship that has the elements of unbalance between a physician and ANY other person has the potential for harm.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q21. “In your view, does the current policy accurately describe the factors that physicians should consider?”

The majority of respondents (67%) thought the current policy accurately described the factors that physicians should consider when entering into a sexual relationship with a person closely associated with a patient.

Figure 10: Factors physicians should consider

<table>
<thead>
<tr>
<th>Does the current policy accurately describe the factors that physicians should consider?</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67%</td>
<td>26%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Base: n = 15
Open-ended feedback regarding the factors physicians should consider when entering into a sexual relationship with a person closely associated with a patient was received from 5 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Some might be hard to quantify (e.g. emotional dependence). The person closely associated with the patient may feel emotionally dependent on the physician, but the physician may not think they are.
- The impact the relationship will have on the physician’s judgement should be considered on a case-by-case basis.
- It is the nature of the relationship (e.g. when one party has the power to exploit the other), not the nature of the clinical relationship that should guide whether it would be a boundary violation to have a relationship with persons closely associated with patients.
- Physicians should never have a sexual relationship with patients.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q23. “In your view, are there any factors missing from the current policy and should be included in the next iteration?”

The majority of respondents (53%) thought there weren’t any factors missing from the current policy.

**Figure 11: Factors missing**

Are there any factors missing from the current policy?

- Yes: 33%
- No: 53%
- Don’t know: 14%

Base: n = 15
Q24. “If yes, please describe the features that should be added and explain why.”

Open-ended feedback regarding whether there are any factors missing from the current policy was received from 5 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

• The patient’s clinical situation, history and the vulnerability of the physician.
• Communication, shared values and mutual respect.
• Alternative care options available in each case. The physician may be the only one available to provide that care and the person closely associated with the patient shouldn’t be penalized for that.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q25. “Please indicate the extent to which you agree or disagree with each statement contained in the Guidelines.”

Overall, respondents agreed with the statements contained in the Guidelines (Appendix A).

**Avoid physical contact with a patient (except what is required to perform medically necessary examinations).**
- Strongly agree: 60%
- Somewhat agree: 20%
- Neither agree nor disagree: 20%

**Use gloves when examining genitals.**
- Strongly agree: 80%
- Somewhat agree: 13%
- Neither agree nor disagree: 7%

**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.**
- Strongly agree: 86%
- Somewhat agree: 7%
- Neither agree nor disagree: 7%

**Avoid any behaviour or remarks that may be interpreted as sexual by a patient.**
- Strongly agree: 66%
- Somewhat agree: 20%
- Neither agree nor disagree: 7%
- Somewhat disagree: 7%
- Strongly disagree: 7%
Q25. “Please indicate the extent to which you agree or disagree with each statement contained in the Guidelines.” (Continued)

Overall, respondents agreed with the statements contained in the Guidelines (Appendix A).

Figure 12: Statements re: Guidelines

- Endeavour to be aware and mindful of the patient’s particular cultural or religious background. 73% strongly agree, 20% somewhat agree, 7% neither agree nor disagree.
- Do not make sexualized comments about a patient's body or clothing. 86% strongly agree, 7% somewhat agree, 7% neither agree nor disagree.
- Do not criticize or comment unnecessarily on a patient's sexual preference. 86% strongly agree, 7% somewhat agree, 7% neither agree nor disagree.
- 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. 66% strongly agree, 7% somewhat agree, 7% neither agree nor disagree, 20% strongly disagree.

Base: n = 15

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
Q25. “Please indicate the extent to which you agree or disagree with each statement contained in the Guidelines.” (Continued)

Overall, respondents agreed with the statements contained in the Guidelines (Appendix A).

Figure 12: Statements re: Guidelines

- Do not ask details of sexual history or sexual behaviour unless related to the purpose of the consultation or examination.
  - Strongly agree: 66%
  - Somewhat agree: 20%
  - Neither agree nor disagree: 7%
  - Somewhat disagree: 7%
  - Strongly disagree: 7%

- Be cognizant of social interactions with patients that may lead to romantic involvement.
  - Strongly agree: 60%
  - Somewhat agree: 27%
  - Neither agree nor disagree: 13%

- Do not talk with your patients about your own sexual preferences, fantasies, problems, activities or performance.
  - Strongly agree: 93%
  - Somewhat agree: 7%

- Learn to control the therapeutic setting and to detect possible erosions in boundaries.
  - Strongly agree: 73%
  - Somewhat agree: 20%
  - Neither agree nor disagree: 7%
Open-ended feedback regarding the statements in the Guidelines (Appendix A) was received from 4 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

• “May be interpreted” is quite vague as sometimes people have unexpected interpretations and therefore instructing to avoid any such behaviours or remarks could be restrictive to the point of impracticality if taken as an inflexible rule.
• It is appropriate to identify sexual orientation when taking a history because there are sometimes differences in risk generated by different sexual preferences.
• Sexual history is appropriate in the context of a clinical interaction; it is part of good history taking.
• There is nothing wrong with letting a grateful patient give you a hug as long as it’s not of a sexual nature or context.
• What is said vs. what is perceived is often different so there should be a trained chaperone or video monitoring to ensure nothing is taken out of context.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q27. “Do you refer to the Guidelines?”

The majority of respondents (67%) said they refer to the Guidelines (Appendix A).

Figure 13: Refer to Guidelines

- **Do you refer to the Guidelines?**
  - Yes: 67%
  - No: 33%

Base: n = 15

- Yes
- No
Q28. “In your view, are the Guidelines helpful?”

Almost half of respondents (47%) said they think the Guidelines (Appendix A) are helpful.

Figure 14: Helpfulness of Guidelines

Do you refer to the Guidelines?

47% 13% 7% 33%

Base: n = 15

Yes No Don't know Please explain
Open-ended feedback regarding whether the Guidelines (Appendix A) are helpful was received from 5 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- If you are reading the Guidelines you are probably already in trouble.
- Acknowledging that context and patient’s past behaviour/personality is important.
- Guidelines can’t cover all situation, but they do address the more difficult situations.
- Guidelines do not apply to patients and should set out the rights and responsibilities of both patients and physicians in a more understandable way.
- College should be more balanced and acknowledge that patients can be abusive, manipulative and ill-intended. Physicians need to be protected.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q29. “In your view is there anything missing from the Guidelines that should be included in the next iteration?”

Respondents were divided about whether there was anything missing from the Guidelines (Appendix A).

Figure 15: Anything missing from Guidelines

<table>
<thead>
<tr>
<th>Is there anything missing from the Guidelines?</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>42%</td>
<td>42%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Base: n = 12
Open-ended feedback regarding the content that should be included in the Guidelines (Appendix A) was received from 6 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- College cannot assume guilt because someone complains; need a fair process for physicians.
- Missing is the need to discuss patient’s preferences when making decisions.
- Missing context/patient’s past behavior.
- Sometimes common sense dictates flexibility and touch is not always negative.
- Foundationally trust and power are underpinned by communication, shared values and mutual respect.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q31. “Do you use the Boundaries Self-Assessment Tool?”

The majority of respondents (79%) said they don’t use the Boundaries Self-Assessment Tool.

Figure 16: Use Boundaries Self-Assessment Tool

<table>
<thead>
<tr>
<th>Do you use the Boundaries Self-Assessment Tool?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Base: n = 14
Q32. “In your view, is the Boundaries Self-Assessment Tool helpful?”

The majority of respondents (57%) said they don’t know if the Boundaries Self-Assessment Tool is helpful.

Figure 17: Helpfulness of Boundaries Self-Assessment Tool

<table>
<thead>
<tr>
<th>Is the Boundaries Self-Assessment Tool helpful?</th>
<th>14%</th>
<th>29%</th>
<th>57%</th>
</tr>
</thead>
</table>

Base: n = 14

Yes  No  Don’t know
Open-ended feedback regarding whether the Boundaries Self-Assessment Tool is helpful was received from 3 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- Never heard of it, but will try it.
- It doesn’t help identify at which threshold one’s behaviour would be concerning, and what to do if one had issues with boundaries (e.g. preventative tactics, resources, training to help address and prevent boundary violations).

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q33. “In your view is there anything missing from the Boundaries Self-Assessment Tool that the College should address?”

Respondents were divided as to whether there is anything missing from the Boundaries Self-Assessment Tool.

Figure 18: Helpfulness of Boundaries Self-Assessment Tool

Is there anything missing from the Boundaries Self-Assessment Tool?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>50%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>50%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Base: n = 2
Open-ended feedback regarding the content that should be included in the Boundaries Self-Assessment Tool was received from 1 respondent.

- It doesn’t help identify at which threshold one’s behaviour would be concerning, and what to do if one had issues with boundaries (e.g. preventative tactics, resources, training to help address and prevent boundary violations).

The comment has not been reproduced verbatim.
Q35. “In your view, do you think the College should set out expectations for physicians on non-sexual boundary issues?

The majority of respondents (64%) said they don’t think the College should set out expectations for physicians on non-sexual boundary issues.

Figure 19: Non-sexual boundary issues

<table>
<thead>
<tr>
<th>Should the College set out expectations for physicians on non-sexual boundary issues?</th>
<th>29%</th>
<th>64%</th>
<th>7%</th>
</tr>
</thead>
</table>

Base: n = 14
Q36. “Please elaborate.”

Open-ended feedback regarding whether the College should set out expectations for physicians on non-sexual boundary issues was received from 10 respondents. Of those respondents who provided open-ended feedback, the following statements are representative:

- The College is disadvantaging physicians and patients by sexualizing boundary challenges.
- If the College addresses physician-patient relationships that are non-therapeutic, be mindful of differences between urban and rural environments.
- The College should address gifts.
- If non-sexual boundary issues are not causing major problems, don’t address them.
- The College should not micromanage physicians; physicians and patients are capable of making their own decisions.
- The College has no business in a physician’s bedroom.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Familiarity with the Current Policy

The majority of respondents (79%) indicated that they had read the current policy.

Respondents who indicated that they had not read the current policy were given the opportunity to do so before proceeding, or skip to the questions at the end of the survey (regarding consultation experience).

Table 4: Read policy

<table>
<thead>
<tr>
<th>Have you read the <em>Maintaining Appropriate Boundaries and Preventing Sexual Abuse</em> policy?</th>
<th>n = 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11</td>
</tr>
<tr>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>
Part 2: Clarity and Comprehensiveness

The following questions assess respondents’ general opinions of the clarity and comprehensiveness of the current policy.

As such, the questions in this section were only posed to those respondents who indicated that they had read the current policy.
Overall, the majority of respondents agreed (either *strongly* or *somewhat*) that the draft policy clearly articulated physicians’ professional obligations (73%), was easy to understand (55%), clearly written (64%), and well organized (64%).

**Figure 20: Clarity**

- **The policy clearly sets out physicians’ professional obligations**: 55% strongly agree, 18% somewhat agree, 18% neither agree nor disagree, 9% somewhat disagree, 9% strongly disagree.
- **The policy is easy to understand**: 55% strongly agree, 36% somewhat agree, 9% neither agree nor disagree, 9% somewhat disagree, 9% strongly disagree.
- **The policy is clearly written**: 64% strongly agree, 27% somewhat agree, 9% neither agree nor disagree, 9% somewhat disagree, 9% strongly disagree.
- **The policy is well organized**: 55% strongly agree, 9% somewhat agree, 27% neither agree nor disagree, 9% somewhat disagree, 9% strongly disagree.

*Base: n = 11*
5 respondents provided feedback with respect to how the clarity of the policy could be improved:

- The design, language and goal of the policy is for the College to “get” the physician and not to protect the public as a whole.
- The policy attempts to be educational and judicial simultaneously which it cannot be.
- The policy is too limited in scope and should expand on the roles and responsibilities of both patients and physicians.
- Section 3 (Part C: Sexual Relationships after Termination of the Physician-Patient Relationship) is too vague.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.
Q40. “We’d like to understand whether the draft policy is comprehensive. That is, it addresses all of the relevant or important issues related to boundaries and sexual abuse. Please indicate whether you agree or disagree that the policy is comprehensive.”

While most respondents agreed that the draft policy was comprehensive (64%), some felt that it had failed to address at least one relevant or important issue (36%).

Figure 21: Comprehensiveness

<table>
<thead>
<tr>
<th>The policy is comprehensive.</th>
<th>55%</th>
<th>9%</th>
<th>18%</th>
<th>18%</th>
</tr>
</thead>
</table>

Base: n = 11
- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree
Q41. “Are any specific issues regarding boundaries and sexual abuse that we don’t cover in the current policy, but should in next iteration of the policy?”

6 respondents provided suggestions for additional items that could be included in the next iteration of the policy:

- The policy should include examples.
- The policy should include clear and comprehensive definitions (e.g. “sexual” and “abuse”).
- The policy should address non-sexual boundary issues.
- The policy should require that patients report sexual abuse allegations to the College and police in a timely fashion.
- Those who struggle with boundaries think the previous version of the policy was clearer. The current policy isn’t as black and white as it allows for some discretion.

This is a representative sample of the key feedback received. Comments have not been reproduced verbatim.