

Boundaries between Health Care Providers and Patients

A Consultation Guide to the Ministerial Referral on Mandatory Revocation Provisions and Treatment of Spouses by Regulated Health Professionals

Health Professions Regulatory Advisory
Council (HPRAC)



Ontario

Health Professions Regulatory
Advisory Council

Conseil consultatif de
réglementation des professions
de la santé

The Minister's Referral to the Health Professions Regulatory Advisory Council (HPRAC)

On June 24th, 2011, the Minister of Health and Long-Term Care, Hon. Deb. Matthews has asked HPRAC to advise on the issue of mandatory revocation provisions and treatment of spouses by health care professionals under the *Regulated Health Professions Act, 1991* (RHPA).¹ The Minister has stated that the government's position on zero tolerance for sexual abuse has not changed, and that the Minister is not requesting advice related to these provisions generally. In her referral to HPRAC, the Minister stated that her request relating to the sexual abuse provisions focuses solely on one issue.² The issue is whether or not alternatives to the mandatory revocation provisions should exist in the RHPA with respect to the treatment of a spouse by a regulated health professional. Consequently, the Minister's referral to HPRAC focuses on two (2) key issues:

- Issue 1: an evaluation of the risk of harm that alternatives, if any, may pose; and,
- Issue 2: whether such alternatives, if any, best serve the public interest.

A spouse, within the context of this referral, is defined as a person with whom the regulated health professional is married, or with whom the regulated health professional is living in a conjugal relationship outside marriage.

The Purpose of the Backgrounder

The purpose of this background paper is to act as a brief synthesis of the context and issues surrounding the Minister's referral on the topic of mandatory revocation provision and treatment of spouses by regulated health professionals. This paper presents key concepts and principles highlighted in medical and ethical literature to examine the issue of sexual relationships between health professional and their patients. The rationale for presenting these principles and concepts is that they are relevant and foundational to addressing the issue of mandatory revocation provisions and treatment of spouses by health care professionals. Please note that this background paper does not provide a comprehensive overview of all principles and concepts related to sexual relations between health care professionals and patients, nor it provides a critical evaluation/analysis of those principles and concepts.³

Context

The RHPA outlines the provisions related to the sexual abuse of patients by regulated health care professionals. The impetus for including the sexual abuse provisions to the RHPA came from the task force commissioned by the College of Physicians and Surgeons of Ontario (CPSO) to report on the sexual abuse of patients by health care professionals. The Task Force on Sexual Abuse of Patients developed several reports, including 34 recommendations, which led to the *Regulated Health Professions Amendment Act, 1992*. This Act amended the RHPA by adding requirements to encourage the reporting of sexual abuse and ultimately, to eradicate the sexual abuse of patients by members of regulated health professions. The amendments defined the sexual abuse of patients for the first time and established new procedures and standards.⁴ The Health Professions Procedural Code of the RHPA defines "sexual abuse" of a patient by a member as:

- (a) sexual intercourse or other forms of physical sexual relations between the member and the patient,

¹ The RHPA is an umbrella legislation governing 23 (soon to be 28 upon proclamations) regulated health professions in Ontario to carry out self-regulatory functions and separate health professions acts. Can be found at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

² The referral letter can be found at http://www.hprac.org/en/resourcesGeneral/MinisterLetter_June242011.pdf

³ HPRAC has conducted three other research reviews (literature, jurisdictional and jurisprudence). Please refer to these reviews for further details on the topic. These reviews can be found at <http://www.hprac.org/en/projects/spousaltreatment.asp>

⁴ Ontario Women's Justice Network (2008). *Doctor-Patient Sexual Assault and Abuse*. Retrieved May 10, 2011, from http://www.owjn.org/owjn_2009/index.php?option=com_content&view=article&id=99&Itemid=107

- (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.

The Health Professions Procedural Code states further that certain acts of sexual abuse committed by a regulated health professional are grounds for *mandatory revocation* for a minimum of 5 years. These acts include:

- i. sexual intercourse,
- ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
- iii. masturbation of the member by, or in the presence of, the patient,
- iv. masturbation of the patient by the member,
- v. encouragement of the patient by the member to masturbate in the presence of the member.

In the RHPA, sexual abuse is defined by an action, not by the intent. In addition, under the RHPA's definition of sexual abuse, only a patient can be sexually abused. As such, regulated health professionals who provide treatment to spouses to make them their patients fall within this definition. Since the introduction of the sexual abuse provisions above, college disciplinary panels have ruled against health professionals who sexually abuse their clients, and applied sanctions that have included a five-year revocation of their name from the official register.

A recent appellant court decision (*Leering v. College of Chiropractors*⁵) upheld a disciplinary panel decision, ruling that, where a health professional/client relationship has been established and sexual intercourse has occurred, sexual abuse will be the resulting finding regardless of the nature of the relationship, including a pre-existing spousal or conjugal relationship between the health professional and patient. In other words, if a health professional is found to be treating their spouse (with whom they have an established sexual relationship) they too would be subject to the mandatory revocation provision of the RHPA. In addition, previous appellant court decisions (see *Mussani*⁶, and *Rosenberg*⁷) found no constitutional right to practise a profession unfettered by the applicable rules and standards. The courts further found that the requirement to choose between terminating a professional relationship with a patient or entering into what can be a consensual, non-exploitive sexual relationship with that patient entails no loss of life, liberty or security under the Charter, thus upholding the sexual abuse provisions of the RHPA.

Concepts and Principles Related to Health Professional-Patient Sexual Relationships

The deleterious effects of health professional-patient sexual relationships on patients have become increasingly recognized and documented in the literature.⁸ Boundaries are enforced to prevent harm from befalling patients. In medical ethics, for instance, non-maleficence and beneficence are recognized as important principles. Health care providers are expected to refrain from causing harm to their patients, but they also have an obligation to help their patients. Health care providers should not provide ineffective treatments to patients as these offer risk with no possibility of benefit and thus have a chance of harming patients. In addition, health care providers must not do anything that would purposely harm patients without the action being balanced by proportional benefit. As such, the obligation is placed on the health care provider to work within defined legal and ethical boundaries and ensure that the encounter is therapeutic, despite the seeming intimacy of the situation.

Consequently, violations of sexual boundaries are viewed from a number of ethical principles. Some analysts have listed the relevant underlying ethical principles and examined whether sexual relations between health professionals

⁵ *Leering v. the College of Chiropractors*, [2010] O.J. No. 406, 2010 ONCA 87

⁶ *Mussani v. College of Physicians and Surgeons of Ontario* (2004), 74 O.R. (3d) 1

⁷ *Rosenberg v. College of Physicians and Surgeons of Ontario* (2006), 275 D.L.R. (4th) 275

⁸ See, for example, Zelas, K. (1997). Sex and doctor-patient relationship, *New Zealand Medical Journal*, 110: 60-62; Hall, K. H. (2001).

Sexualization of the doctor-patient relationship: is it ever ethically permissible? *Family Practice*, 18,(5): 511-515; Subotsky, F., Bewley, S., and Crowe, M. (eds.). (2010). *Abuse of the Doctor-Patient Relationship*. London: The Royal College of Psychiatrists.

and patients are consistent with each of them. The widely acknowledged principles are *trust*, *power imbalance*, and *consent*.⁹ The reason is that there are concerns present in a health professional-patient relationship which preclude a sexual relationship between a health professional and patient from occurring. The first concern needed to be addressed is the *power* imbalance between a health professional and patient. A patient allows a health professional to conduct intimate physical examinations, relies on the professional to provide care based upon their training and knowledge and provides sensitive information about themselves or family members. These activities are all one-sided from the patient to the physician. Further, a patient most often comes to see a physician when they are unwell or in pain, or in some cases do not speak the language of the health professional, which puts the patient in even very vulnerable position. All of these factors add up to the imbalance of power which the health professional has over the patient. It is argued that unequal relationships have the potential for sexual abuse and abuse of power built into it. As a result of this power imbalance, a professional has the ability to manipulate the patient by putting their interests, such as sexual desire, ahead of the patient's best-interest.¹⁰

The inequality of the professional-patient relationship caused by the imbalance of power may foster what is known as transference. Transference occurs when a patient develops feelings, originally associated with "other figures" toward a health professional unrelated to the professional care provided. When this happens, patients often idealize the health professional and can experience the feeling of "falling in love" with them. This idealization places the patient in a vulnerable and dependant position that may be exploited by the health professional. As a result, it is the professional's responsibility to identify and maintain the boundaries of the therapeutic relationship.¹¹

The relationship of *trust* is another crucial aspect of a health professional-patient relationship. It has been described as "... [the] special confidence reposed in one who in equity and good conscience is bound to act in good faith and with due regard to the interests of one reposing the confidence."¹² Trust is required for patients to divulge intimate details, to take potentially harmful medications, and to undergo procedures when unconscious. Three key features describe the circumstances in which this type of relationship occurs: there is an expectation of trustworthiness, a power differential exists, and the interaction occurs under conditions of privacy.¹³ It is an underlying principle of the concept of boundaries and it has been argued that it is a health professional's breach of trust, not patient's consent, which is the crucial issue regarding sexual impropriety.¹⁴

The concepts of power imbalance, and trust have serious ethical implications on another crucial concept in the health professional-patient relationship: *consent*. As a result of the power imbalance and idealization present in the professional-patient relationship, a patient is no longer considered capable to consent to a sexual relationship with a health professional: "even if consent can be given, exploitation can be nevertheless be argued if the fiduciary has acquired information about the client's vulnerabilities that otherwise would remain concealed."¹⁵ Thus, patient consent is never considered an acceptable rationalization for a health professional to engage in sexual relations with a patient.¹⁶

⁹ See, for example, Zelas, K. (1997). Sex and doctor-patient relationship, *New Zealand Medical Journal*, 110: 60-62; Gillon R. (1985). *Philosophical medical ethics*. Chichester: John Wiley and Sons.

¹⁰ Task Force on Sexual Abuse (Commissioned by the College of Physicians and Surgeons of Ontario), (1991). *The final report of the task force on sexual abuse of patients*. Toronto: Author; Brody, H. (1992). *The healer's power*. New Heaven: Yale University Press.

¹¹ College of Physicians and Surgeons of Nova Scotia (2000) *Sexual misconduct in the physician-patient relationship*. Retrieved from <http://www.cpsns.ns.ca/LinkClick.aspx?fileticket=PYFECzS40GY=&tabid=92&mid=628>; Hall, K. H. (2001). Sexualization of the doctor-patient relationship: is it ever ethically permissible? *Family Practice*, 18(5): 511-515; Simon, R.I.(1994). Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1; *Psychiatric Annals*, (24): 509-515

¹² Feldman-Summers, S. (1989). Sexual contact in fiduciary relationships. In Gabbard, G. O. (ed.), *Sexual exploitation in professional relationships*, pp. 193-209, Washington D.C.: American Psychiatric Press.

¹³ Ibid.

¹⁴ Simon R. I. (1999). Therapist-patient sex. From boundary violations to sexual misconduct, *Psychiatry Clinics of North America*, 22(1): 31-47; Simon, R.I.(1994). Transference in therapist-patient sex: the illusion of patient improvement and consent, part 1; *Psychiatric Annals*, (24): 509-515; Friedman, J. and Boumil, M. M. (1995). *Betrayal of trust: sex and power in professional relationships*. Westport, CT: Praeger Publishers.

¹⁵ Supra, see note 12.

¹⁶ Supra. see note 10.

To illustrate the impact of these concepts even further, one judge outlined the dynamics of sexual abuse by health professions in a 1998 decision that was quoted in "What about Accountability to the Patient?" which was the final report of the Task Force on Sexual Abuse of Patients issued in 2000:

She went to him for help at a time when she was particularly vulnerable and insecure. He had the professional knowledge to help her, but instead used that knowledge to manipulate the situation to his own advantage, playing on [her] lack of confidence, her search for a positive father-figure and her sexual inhibitions. In these circumstances, as has been attested by Dr. Jackson and Dr. Freebury, [the patient] could not exercise free will. Her participation in sexual activities with Dr. B. [a psychologist] was not based on any understanding on her part as to what was really happening. He kept her in a constant state of confusion as to whether his advances were part of her treatment, evidence of his love for her, or something else. This was coupled with her overwhelming dependency on him, which he let develop unchecked, so that she was rendered incapable of coming to her own assessments or conclusions. There could be no genuine consent in these circumstances. Therefore everything from the initial touching to the hugging, kissing, fondling, masturbating and finally intercourse were all forms of battery.¹⁷

As evidenced in the case above, the psychologist wrongly used his position of power and idealization over the patient, created by the vulnerability, lack of confidence and the patient's complete dependency and trust to engage in a sexual relationship with the patient. All these factors made it impossible for the patient to rightfully give consent to the sexual relationship.

However, opinions on sexual relations between health care providers and their patients vary. Some analysts have argued, the crossing of sexual boundaries "per se does not necessarily mean that an unethical act occurred: after all, the crossing or erosion of boundaries is a normal part of evolution of intimate relationships between human beings. Nor all boundary transgressions between doctor and patient ultimately lead to sexual misconduct."¹⁸ Others have noted that "even if one accepts trust, power balance, and consent as necessary conditions they do not lead to a zero tolerance position as it is possible to imagine sets of circumstances where all three are complied with. Moreover, it seems as if the list of principles could be continued indefinitely and there would still be circumstances where all were complied with. One cannot leap from a realisation that in some circumstances telling the truth (or sexual contact) can be "ill advised" and "hazardous" ... to a conclusion that it is always, or even generally, wrong to tell the truth."¹⁹ Many analysts, however, accord with the premise that sexual contact between a health care provider and a patient is harmful to the patient.

In summary, health care providers occupy a privileged space in their patient's lives and have a relationship that falls between the public and private domain in a challenging way. Literature suggests that the relationship between a health professional and a patient is characterised by unequal power, and as a consequence has the potential for abuse. This is for the very good reason that the less powerful member of the relationship is at a disadvantage, and therefore not able to give free, informed and voluntary consent to what is happening. The enforcement of boundaries within unequal relationships is based on a number of ethical principles. Health care providers are constrained by legal and ethical duties of confidentiality, consent and competence in ways in which are not necessary for patients. According to many analysts, the maintenance of professional boundaries is a one-sided responsibility. As such, at the outset, it is important to define the boundaries within which any relationship must be conducted.

¹⁷ Supra, see note 4.

¹⁸ Hall, K. H. (2001). Sexualization of the doctor-patient relationship: is it ever ethically permissible? *Family Practice*, 18(5): 511-515.

¹⁹ Cullen, R. M (1999). Arguments for zero tolerance of sexual contact between doctors and patients, *Journal of Medical Ethics*, 25: 483-486.

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