

Mandatory Revocations Provisions and Treatment of Spouses by Regulated Health Professionals: A Jurisdictional Review

Health Professions Regulatory Advisory
Council (HPRAC)



Ontario

Health Professions Regulatory
Advisory Council

Conseil consultatif de
réglementation des professions
de la santé

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Objective:

The objective of this jurisdictional review is to provide evidence-informed observations on the treatment of spouses¹ by regulated health professionals in Canadian provinces, selected U.S. states, Australia, the U.K., South Africa and New Zealand. In order to adequately reach the information sought, a two-level research process was necessary. This approach was taken because the way a health professions regulator addresses the issue of spousal treatment is dependant upon how they address sexual misconduct between a practitioner and patient. In other words, in order to determine if a spousal exemption exists we must first identify the sexual misconduct provisions. Information on the following topics was gathered:

Level 1: How the legislation addresses sexual misconduct in general.

1. Does the legislation (i.e. acts, statutes), regulations (or rules), codes (i.e. code of ethics, code of conduct) or standards (i.e. standards of practice, practice guidelines) address sexual misconduct?
2. Is there a penalty specific to the act of sexual misconduct² in the legislation, regulations, codes or standards?
3. How does the legislation, regulations, codes or standards define sexual misconduct? What acts are included under sexual misconduct?

Level 2: How the legislation addresses the treatment of spouses by regulated health professionals.

1. Is the issue of treating a spouse addressed in the legislation, regulations, codes or standards? If so, can a health practitioner treat their spouse?
2. Is there a penalty under the legislation, regulations, codes or standards, for a practitioner who treats their spouse?
3. How does the legislation, regulations, codes or standards define the term "spouse"?

Context:

According to the *Regulated Health Professions Act, 1991, (RHPA)* health care professionals are prohibited from engaging in a sexual relationship with a patient. If they do, that is considered as professional misconduct, defined as sexual abuse. The Health Professions Procedural Code, Schedule 2, 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,*
- (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.*

¹ Based on the Minister's referral letter to HPRAC, the term spouse will include "common-law" partners.

² As will be discussed later on, the term "sexual misconduct" was chosen to encompass all the variations found in each jurisdiction, including "sexual abuse", "sexual impropriety" etc...

The Health Professions Procedural Code, Schedule 2, states further that certain acts of sexual abuse committed by a regulated health professional are grounds for *mandatory revocation* of registration 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.*

The zero-tolerance position set out in the RHPA regarding sexual abuse of patients by health professionals was further clarified by a recent Appeals Court decision³ which included health professionals' co-habiting partners and spouses. Further decisions have upheld this position, stating that regardless of the type of relationship between a treating health professional and the patient/client, where sexual intercourse and a professional relationship co-exist, the mandatory revocation penalty applies.

In April, 2011, the Minister of Health and Long-Term Care informed the Health Professions Regulatory Advisory Council (HPRAC) that she intends to seek advice from HPRAC on possible alternatives to the mandatory revocation provisions relating to sexual abuse where the patient is a spouse.

On June 24, 2011, the Minister of Health and Long-Term Care sent a letter of referral to HPRAC, formally requesting advice whether or not alternatives to the mandatory revocation provisions should exist in the Act respecting the treatment of a spouse by a regulated health professional. The Minister also requested that the HPRAC analysis include an evaluation of the 'risk of harm' that alternatives, if any, may pose, and whether such alternatives, if any, best serve the public interest. The letter defines spouse as a person with whom the regulated health professional is married or with whom the regulated health professional lives in a conjugal relationship with outside of marriage. Advice is requested by June 1, 2012.⁴

Search Methodology:

HPRAC reviewed the legislation, regulations, codes and standards relating to 7 professions across 20 jurisdictions, including 10 Canadian provinces, 6 selected jurisdictions in the U.S., as well as the U.K., Australia, South Africa and New Zealand. HPRAC chose to review the following American states: California, Florida, Minnesota, New York, Texas and Virginia. These states were chosen based on geographical characteristics, maturity of the regulatory regime and demographic characteristics.

It was necessary to select only certain health professions for the jurisdictional review in order to efficiently manage the wide range of information available on the topic. The following 7 professions were chosen:

1. Physician
2. Chiropractor
3. Dentist

³ *Leering v. the College of Chiropractors*, [2010] O.J. No. 406, 2010 ONCA 87

⁴ The Minister's June 24th, 2011 referral letter to HPRAC can be found at <http://www.hprac.org/en/index.asp> under "HPRAC updates".

4. Dental Hygienist
5. Massage Therapist
6. Nurse
7. Psychologist

These professions were chosen based on a combination of the number of sexual misconduct complaints their colleges receive annually (taken from the annual reports) in Ontario and the profession's exposure to the patient. It must be noted that in some of the jurisdictions selected, one of the reviewed professions, massage therapists, was not regulated. Therefore, in such cases, information was not gathered relating to this profession.

The websites for each jurisdiction's regulatory body and professional association were also examined for supporting documentation. Where adequate information was not available online, key informant interviews were held by telephone with representatives of regulatory bodies and government. Email correspondence served to gather further documentation.

Limitations:

Although this jurisdictional review undertook extensive background research in order to draw its conclusions, limitations still may exist. In some jurisdictions where spousal treatment is not explicitly addressed in the available legislation, regulations, codes or standards reviewed, a jurisdictional policy in this regard may still exist although not available for circulation. In some of these cases, a phone or email communication occurred and information was gathered. However, considering the extremely wide span of this jurisdictional review in conjunction with the resources available to HPRAC and time restrictions, it was deemed not efficient for HPRAC to contact each jurisdiction where a gap of information existed.

Organization of the paper:

- Summary of Key Findings: Review of the key findings related to each of the topic questions.
- Description of Findings:
 - Spousal Treatment: Synthesis of how each profession reviewed addresses the issue of spousal treatment. Table 1 accompanies the findings.
 - Power Imbalance: Discussing the concept of "power imbalance" and its role in the practitioner-patient relationship.
 - Trust: Discussing the concept of "trust" and its role in the practitioner-patient relationship.
 - Consent: Discussing the concept of "consent" and its role in the practitioner-patient relationship.
- Case Studies: A review of four jurisdictions, with similar health professions regulatory schemes to that of Ontario, to outline different models for dealing with spousal treatment by regulated health professionals.
 - British Columbia

- Quebec
- California
- New Zealand
- Lessons from the case studies

Summary of Key Findings:

Level 1: The following is a summary of the key findings related to how the legislation addresses sexual misconduct on a general level.

1. Does the legislation, regulations, codes or standards explicitly address sexual misconduct?

- Among the Canadian provinces with omnibus⁵ legislation governing health professions (Alberta, British Columbia (B.C.), Manitoba, Quebec and Ontario), only three provinces, B.C., Quebec and Ontario address sexual misconduct explicitly in their omnibus legislation governing health professions.
- Among the provinces without omnibus legislation governing health professions, and those with omnibus legislation but not addressing sexual misconduct, the topic of sexual misconduct can be found to be addressed through different mechanisms depending on the profession and province. For example, in Saskatchewan sexual misconduct is addressed in profession-specific regulatory bylaws governing physicians, chiropractors, dentists and psychologists to a varying degree. Whereas in Manitoba, sexual misconduct is addressed through practice guidelines for physicians, code of ethics and regulations for chiropractors etc.
- Where sexual misconduct is not addressed directly in legislation, (i.e. omnibus legislation or health profession-specific Acts or regulations) but rather in ethical codes or standards, sexual misconduct may fall under the concepts of “unprofessional conduct,” “professional conduct,” “dishonourable conduct” and the like, which can be found explicitly in the legislation. For example, in Manitoba, according to the *Regulated Health Professions Act, 2009*, a practitioner may be found guilty of professional misconduct, which when allowed to be defined by the regulations governing chiropractors includes; sexual impropriety with a patient and failure to observe the code of ethics, which contains in it, codes referring to sexual conduct between a chiropractor and patient.
- In the American jurisdictions reviewed, of the five states with omnibus legislation governing health professions, four (California, Florida, New York and Virginia) address sexual misconduct in their omnibus legislation. However, New York only addresses it in regards to psychologists⁶ (personal

⁵ The term “omnibus legislation” is used in this report to refer to umbrella legislation that governs all regulated health professions in a jurisdiction and provides general provisions that apply to everyone, such as Ontario’s RHPA, 1991. In the Canadian provinces and international jurisdictions reviewed this definition of “omnibus legislation” is appropriate. However, this term, may be more difficult to apply to the American jurisdictions, which instead of Acts employ Codes, such as the *Business and Professions Code* of California. Although, in order to be consistent throughout, the term “omnibus legislation” was used to refer to American codes or statues that had general provisions which govern all the health professions under the subject code or bill similar to Ontario’s RHPA. Where such governing general provisions did not apply, the term “omnibus legislation” was not used.

⁶ The Rules of the Board of Regents, only makes reference to sexual misconduct for psychologists. Regarding the other regulated health professions, acts of sexual misconduct will be charged under other unprofessional conduct provisions, such as,

communication, July 6, 2011). For the reviewed state (Texas) with omnibus legislation but not addressing sexual misconduct and the reviewed state (Minnesota) without omnibus legislation, the topic of sexual misconduct can be found to be addressed through different mechanisms depending on the profession. For example, Minnesota addresses sexual misconduct through health profession-specific Acts for all the relevant health professions and in the case of some professions (chiropractors, psychologists and dentists), through administrative rules as well. Whereas in Texas, sexual misconduct is addressed through profession-specific Administrative Rules.

- Australia, South Africa and New Zealand all have omnibus legislation governing health professions similar to that of Ontario. However, only Australia explicitly addresses sexual misconduct through the *Health Practitioner Regulation National Law Act, 2009*. South Africa is unique in that, an omnibus code of ethics applies to all regulated health professions; however, it only addresses sexual misconduct in the context of psychologists.

2. How does the legislation, regulations, codes or standards define sexual misconduct? What acts are included under sexual misconduct?

- “Sexual misconduct” is referred to by the reviewed jurisdictions in many different ways. The concepts of sexual “misconduct”, “abuse”, “impropriety”, “contact”, “relations” and more, are used more or less interchangeably in each jurisdiction. Sexual misconduct is the most common, and therefore was chosen to be the consistent concept for this analysis.
- Among the Canadian provinces there is a consensus among just three provinces; B.C., New Brunswick and Ontario, on a definition of sexual misconduct. Their consensus definition includes the following three acts:
 - sexual intercourse or other forms of physical sexual relations between the member and the patient,
 - touching, of a sexual nature, of the patient by the member, or
 - behaviour or remarks of a sexual nature by the member towards the patient.
- These three acts appear to encompass all other acts of sexual misconduct referred to in other jurisdictions. For example, “kissing of a sexual nature” (Saskatchewan chiropractor regulatory bylaws), “inappropriate body contact, including hugging of a sexual nature”, “voyeurism as may be expressed by inappropriate disrobing or draping practices that reflect a lack of respect for the patient’s privacy (Nova Scotia physician standards of practice)”, “making a request to date” (Texas Administrative Code, Board of Chiropractic Examiners) and many more.

3. Is there a penalty specific to the act of sexual misconduct in the legislation, regulations, codes or standards?

- Of the 10 Canadian provinces reviewed only three provinces, Ontario, Quebec and Prince Edward Island (PEI) have explicit references to penalties for sexual misconduct in their legislation governing health professionals. Ontario, as discussed above, has a five year mandatory revocation period for “sexual abuse” (RHPA, 1991), while Quebec also enforces a minimum provisional

“moral unfitness” or “undue influence on the patient or client”. (Rules of the Board of Regents, Part 29, Unprofessional Conduct, S. 29.1, can be found at <http://www.op.nysed.gov/title8/part29.htm>)

“striking off the roll” sanction, but does not state a minimum time of re-application for re-instatement (Professional Code). PEI gives a specific penalty for a physician who engages in sexual misconduct, of revocation for a minimum 5 years (Medical Act, 1998).

- Chiropractors in Alberta and New Brunswick have also adopted standards of practice proposing certain penalties (on a proportional scale) for certain acts of sexual misconduct.
- Of the six American states reviewed, three have specific penalties for sexual misconduct (Florida California and Texas). Florida’s omnibus statute regulating health professions requires each health profession’s regulatory board or department (if there is no board) to have disciplinary guidelines “applicable to each ground for disciplinary action which may be imposed by the board. The disciplinary guidelines shall specify a meaningful range of designated penalties based upon the severity and repetition of specific offences.” In the case of sexual misconduct, the sanctions range anywhere from probation with conditions to permanent revocation depending on each profession’s guidelines. California has a similar form of disciplinary guidelines to Florida. For example, in the disciplinary guidelines governing psychologists the minimum penalty for any act of sexual abuse or sexual relations with a patient or former patient within two years following termination of therapy is revocation or surrender of license/registration (California Board of Psychology, 2007(amended)). Texas also has similar guidelines. For example, the professions of dentistry, dental hygiene and nursing all have a “disciplinary matrix”. As well, the section of the Administrative Code governing psychologists in Texas lists certain sexual misconduct offences that are subject to automatic revocation (Texas Administrative Code).
- None of the international jurisdictions reviewed have specific legislated penalties for sexual misconduct.
- Throughout all the jurisdictions there is a consistent range of penalties when it comes to professional misconduct (which may be interpreted to include sexual misconduct, explained above) on a general level. These penalties include; reprimand or imposition of conditions or limitations of license to practice, suspension or revocation. Monetary fines are included as well, but were not seen as relevant to this review.

Level 2: The following is a summary of the key findings related to how the legislation addresses the treatment of a spouse by regulated health professionals.

1. Is the issue of treating a spouse addressed in the legislation, regulations, codes or standards? If so, can a health practitioner treat their spouse?

- Among the Canadian provinces with omnibus legislation governing the regulation of health professions, none “explicitly” address the issue of spousal treatment in their omnibus legislation. However, by way of interpretation, B.C., Ontario and Quebec all address it through their legislation. Ontario, as explained previously, has interpreted sexual abuse of a patient, through court decisions, to include a spouse. As well, the Ministry of Health Services of B.C. has stated there will be no spousal exemptions to the sexual misconduct provisions of the *Health Professions Act, 1996*

(HPA) (D.K. Beckett, personal communication, Feb.11, 2011⁷). The other Canadian provinces with omnibus legislation, address the issue of spousal treatment through other mechanisms. For example, Alberta by way of “standards of practice,” permits chiropractors to treat their spouse, but prohibits psychologists from doing the same.

- Among the American states reviewed, California addresses spousal treatment through omnibus legislation. By way of the *Business and Professions Code*, California exempts a regulated health professional from being charged with sexual misconduct if found to be treating his/her spouse or persons in an equivalent domestic relationship (other than psychotherapeutic treatment). New York, although not found in the legislation, regulations etc. permits spousal treatment (personal communication, July 6, 2011). The other American jurisdictions that address spousal treatment do so through different mechanisms for each profession. For example, Minnesota, by virtue of the Minnesota Board of Chiropractic Examiners Administrative Rules, permits chiropractors to treat a spouse or anyone with whom a sexual relationship pre-dates the patient-doctor relationship but prohibits psychologists from treating a spouse or clients with whom the psychologist is cohabiting by virtue of the Administrative Rules governing the Minnesota Board of Psychology.
- The international countries reviewed with omnibus legislation governing health professions make no reference to spousal treatment in their omnibus legislation, but rather through other mechanism depending on the profession. For example, New Zealand by way of standards, informs physicians to avoid treating family members unless unavoidable (Medical Council of New Zealand, 2008) but permits chiropractors to treat their spouse by way of a code of ethics (New Zealand Chiropractic Board, 2004).

2. Is there a penalty under the legislation, regulations, codes or standards, for a practitioner who treats their spouse?

- Of the 20 jurisdictions reviewed, only Ontario and Quebec, although not explicit, have a legislated penalty for the treatment of a spouse. This comes by way of interpretation as explained above. Ontario includes spouses and co-habiting partners under their “mandatory revocation provisions” for sexual abuse and therefore would apply the sexual abuse penalties to any regulated health professional that is treating their spouse or co-habiting partner. Quebec does as the same, but instead of enforcing a mandatory revocation provision, requires a minimum provisional striking off the roll.
- B.C. does not have specific penalties for sexual misconduct explicitly in their omnibus legislation, which allows a disciplinary committee to use discretion in cases involving a health professional treating their spouse. They may choose to employ a less serious penalty in such cases, considering factors such as a spouse’s consent or a practitioner’s lack of knowledge etc (H. Mackay, personal communication, June 28, 2011).

3. How does the legislation, regulations, codes or standards define the term “spouse”?

⁷ Letter from the Director of Professional Regulation, Daryl K. Beckett, at the B.C. Ministry of Health Services to Heather Mackay, Registrar of the College of Dental Surgeons of B.C. dated Feb. 11, 2011. The letter was obtained through email communication with Heather Mackay.

- There were only a few definitions of the term “spouse” found in this review.
- Alberta, in the standards of practice applicable to chiropractors refers to “spouse” as interpreted to include a common-law spouse as defined by the *Adult Interdependence Partnership Agreement, 2002*.
- California does not define the term “spouse”, but the legislation includes a “person in an equivalent domestic relationship” as permissible for a health professional to treat.
- Minnesota, in the Administrative Rules governing chiropractors does not define spouse, but does include any person with whom the sexual relationship pre-dates the professional-patient relationship. As well, regarding psychologists, Minnesota not only prohibits treating a spouse but also a client with whom the psychologist is co-habiting with.
- In the Code of Ethics governing chiropractors in New Zealand, a chiropractor is not guilty of sexual misconduct for treating their spouse (New Zealand Chiropractic Board, 2004). The code refers to spouse as “one who is engaged in a lawful relationship” which is defined in the code to mean “marriage” or a “de-facto relationship” (ibid).

Description of Findings:

Spousal Treatment:

The review analyzed how 7 different professions across the jurisdictions reviewed addressed the issue of spousal treatment. These professions were chosen based on a combination of the number of sexual misconduct complaints their colleges receive annually (taken from the annual reports) in Ontario and the profession’s exposure to the patient. The following is a summary per each profession. Table 1 accompanies the findings.

Physician:

Of the twenty jurisdictions reviewed, a majority of 13⁸ jurisdictions agreed that physicians should limit treatment of their family members (including spouse) or themselves unless it is for emergency or minor services and no other physician is readily available.⁹ Each of the 10 Canadian jurisdictions adopted, and in some cases adapted, the Canadian Medical Association (CMA) Code which contains this principal regarding treatment of one’s family and self. In addition, Ontario, B.C. and Quebec would include the treatment of a spouse (aside from emergency or minor services as the CMA code of ethics states) in their

⁸ The issue was not addressed in South Africa legislation, regulation, codes or standards. Attempts at personal communication were not answered.

⁹ According to the CPSO guideline “*Treating self and family members*”, episodic treatment of family members for minor conditions is acceptable because such care is unlikely to result in the commencement of physician-patient relationship. As well, emergency care of family members where no else is available is acceptable because the benefits outweigh the “challenges posed by the personal relationship”. Guideline may be found at http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/treating_self.pdf

sexual misconduct provisions. PEI is unique among Canadian jurisdictions in that they advise physicians against treating their spouse (personal communication, July 18, 2011). However, they explicitly exempt spousal treatment from the sexual abuse provisions of the legislation (Medical Act, 1988). As well, the UK, Australia and New Zealand subscribe to similar codes with the same limiting principles for treating one's family. Among the American jurisdictions, the principles found in the CMA codes of ethics are less adopted.¹⁰ Texas, California, Florida, Minnesota, New York and Virginia all permit physicians to treat their spouse. Although, Virginia regulations require that if a physician (or chiropractor) is treating/prescribing for their spouse or family member it must be based on a "bona-fide practitioner-physician relationship and must only be certain controlled substances"¹¹ (Virginia Board of Medicine, 2010)."

Chiropractor:

Among the jurisdictions reviewed, when it comes to a chiropractor treating one's spouse, many jurisdictions are more permissive. For example, although Alberta, Manitoba, New Brunswick, Nova Scotia and Saskatchewan, all adopt the CMA code of ethics to prevent physicians from treating their family members, all of these provinces permit a chiropractor to treat their spouse through various codes and standards. In particular, Nova Scotia permits the treatment of family members for the following reason, "due to the limited number of chiropractors, there are several regions of the province where access to other chiropractors would involve significant hardship in terms of travel (Nova Scotia College of Chiropractors, 2001).¹²" Internationally, New Zealand allows this exemption as well. All of the American states that permit a physician to treat their spouse also permit a chiropractor. Minnesota (Administrative Rules S. 2500.6050) and Virginia (Virginia Code § 54.1-2915) also permit chiropractors to treat any person with whom a sexual relationship pre-dates the patient relationship.

Psychologist:

An overwhelming majority (18) of the jurisdictions reviewed inform psychologists to refrain from treating a spouse or family member. The common concept that is stated regarding the treatment of family members by a psychologist is "dual relationship". According to the Code of Conduct governing psychologists in B.C., the prohibition of a dual relationship entails that, "a registrant must not undertake or continue a professional relationship with a client when the objectivity or competency of the registrant could reasonably be expected to be impaired because of the registrant's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship." This concept has slight definitional variations across the jurisdictions that utilize it, but its connotation remains constant throughout. The only jurisdiction

¹⁰ The American Medical Association (AMA) has also published a Code of Ethics advising physicians not to treat their immediate families unless "in emergency settings or isolated settings where there is no other qualified physician available...until another physician becomes available". Short-term treatment for minor care is also acceptable. This document may be found at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion819.page?>

¹¹ The Virginia Code § 54.1-3303 defines a "bona-fide practitioner-patient relationship" as, " a bona fide practitioner-patient relationship means that the practitioner shall (i) ensure that a medical or drug history is obtained; (ii) provide information to the patient about the benefits and risks of the drug being prescribed; (iii) perform or have performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically (see full section)"

¹² The Board of the Nova Scotia College of Chiropractors also states the following reason why it does not prohibit its members from treating their spouses or family members:

b.) The Board regulations, Chiropractic Act, and Code of Ethics are clear that any form of "fraudulent" behavior with regard to insurance billing is subject to disciplinary consequences.

to explicitly permit a psychologist to treat their spouse would be California, based on their omnibus legislation governing all regulated health professionals, which permits spousal treatment.

Nurses

Other than in jurisdictions with omnibus legislation (governing all regulated health professionals) addressing spousal treatment, this issue is rarely addressed in relation to nurses. Australia in the practice guidelines for nurses, advises nurses to avoid dual relationships unless it is an emergency case, in which case nurses must then take all steps to minimize the risks (Australian Midwifery and Nursing Council, 2010). As well, New Brunswick takes a similar position in a practice standard of the Nursing Association of New Brunswick.

Dentist, Dental Hygienist and Massage Therapists

Where regulated, these professions would be included under the omnibus legislation governing regulated health professions. However, in jurisdictions where this legislation does not exist, the issue of spousal treatment in relation to these three professions was not addressed. Massage therapists were not regulated in 7 of the 20 jurisdictions reviewed.

Table 1 below outlines whether a health professional is permitted to treat a spouse according to each of the professions reviewed per each jurisdiction. Numbers in Table 1 refer to notes on page 14 following the chart.

Table 1: Can a practitioner treat their spouse?

	Does Jurisdiction have Omnibus legislation?	Physician (enabling mechanism)	Chiropractor (enabling mechanism)	Dentist (enabling mechanism)	Nurse (enabling mechanism)	Psychologist (enabling mechanism)	Massage Therapist (enabling mechanism)	Dental Hygienist (enabling mechanism)
Alberta	Yes	Only in emergency/minor services when no other physician is around (CMA code of ethics)	Yes (Standards of Practice)	n/a	n/a (1)	No (Standards of Practice)	Not Regulated	n/a
British Columbia	Yes	No (HPA) Only in emergency/minor services when no other physician is around (CMA code of ethics)	No (HPA)	No (HPA)	No (HPA)	No (HPA) No (Code of Conduct)	No (HPA)	No (HPA)
Manitoba	Yes	Only in emergency/minor services when no other physician is around (Code of Conduct)	Yes (Code of Ethics)	n/a	n/a	No (Practice Guidelines)	Not Regulated	n/a
New Brunswick	No	Only in emergency/minor services when no other physician is around (CMA Code of ethics)	Yes (Standards of Practice)	n/a	Only until alternative care is available (Practice Standard)	No (Code of Ethics)	Not Regulated	n/a
Newfoundland and Labrador	No	Only in emergency/minor services when no other physician is around (CMA code of ethics)	Case by case basis	n/a	n/a	No (Practice Guideline)	n/a	n/a
Nova Scotia	No	Only in emergency/minor	Yes (Practice Guidelines)	n/a	n/a	No (Code of Ethics)	Not Regulated	n/a

	Does Jurisdiction have Omnibus legislation?	Physician (enabling mechanism)	Chiropractor (enabling mechanism)	Dentist (enabling mechanism)	Nurse (enabling mechanism)	Psychologist (enabling mechanism)	Massage Therapist (enabling mechanism)	Dental Hygienist (enabling mechanism)
		services when no other physician is around (CMA code of ethics)						
Ontario	Yes	Only in emergency/minor services when no other physician is around (Policy), No (RHPA) (2)	No (RHPA)	No (RHPA)	No (RHPA)	No (RHPA)	No (RHPA)	No (RHPA)
PEI	No	Only in emergency/minor services when no other physician is around (CMA code of ethics)(3)	n/a	n/a	n/a	No (Rules of Conduct)	Not Regulated	n/a
Quebec	Yes	No (Professional Code)(4) Only in emergency/minor services when no other physician is around- (Code of ethics)	No (Professional Code)	No (Professional Code)	No (Professional Code)	No (Professional Code) Only in emergency situations (Code of Ethics)	Not Regulated	No (Professional Code)
Saskatchewan	No	Only in emergency/minor services when no other physician is around (Regulatory Bylaws)	Yes (Regulatory Bylaws)	n/a	n/a	No (only in emergency situations - Code of Ethics)	Not Regulated	n/a
New York	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Texas	Yes	Yes (personal communication)(5)	Yes	n/a	n/a	No (Rules)(6)	n/a	n/a
California	Yes	Yes (Business and Professions)	Yes (Business and	Yes (Business	Yes (Business	Yes (Business and	Not Regulated	Yes (Business

	Does Jurisdiction have Omnibus legislation?	Physician (enabling mechanism)	Chiropractor (enabling mechanism)	Dentist (enabling mechanism)	Nurse (enabling mechanism)	Psychologist (enabling mechanism)	Massage Therapist (enabling mechanism)	Dental Hygienist (enabling mechanism)
		Code)(7)	Professions Code)	and Professions Code)	and Professions Code)	Professions Code)		and Professions Code)
Florida	Yes	Yes (personal communication)	Yes	n/a	n/a	No (Administrative Rules)	n/a	n/a
Minnesota	No	Yes (personal communication)(8)	Yes (Rules)	n/a	n/a	No (Administrative Rules)	n/a	n/a
Virginia	Yes	Yes (Regulation)	Yes (Regulation)	n/a	n/a	No (Regulation)	n/a	n/a
United Kingdom	No	Avoid (Guideline)	n/a	n/a	n/a	No	Not Regulated	n/a
South Africa	Yes	n/a	n/a	n/a	n/a	No (Ethical Rules)	n/a	n/a
Australia	Yes	No- unless unavoidable (Code of Conduct)	n/a	n/a	No (Practice Guidelines)	No (Code of Ethics)	Not Regulated	n/a
New Zealand	Yes	No- avoid wherever possible (Guideline)	Yes (Code of Ethics)	n/a	n/a	No (Code of Ethics)	Not Regulated	n/a

Notes:

- (1) "n/a" signifies that no information was available in the legislation, regulations, codes or standards reviewed relating to spousal treatment by a regulated health professional.
- (2) A regulated health professional under the RHPA who is found to be treating a spouse will be subject to the sexual abuse and mandatory revocation provisions of the RHPA.
- (3) According to the College of Physicians and Surgeons of PEI, a physician is not supposed to treat their family. However, the Medical Act, 1988, governing physicians in PEI, exempts spouses from the sexual abuse provisions. In other words, a physician who is found to be treating their spouse, although advised against, will not be charged with sexual abuse (personal communication, July 18, 2011).
- (4) A regulated health professional under the *Professional Code* who is found to be treating their spouse will be subject to the derogatory act provisions (defined to include sexual relations with a patient) and the minimum provisional sanction.
- (5) According to the Texas Medical Board, there is no statute of the Texas Occupations Code or regulation of the Texas Medical Board Rules which specifically prohibits or forbids a physician from treating their spouse or family member, as long as a proper professional relationship is maintained and there is medical record proof to support this. However, with regards to controlled substances, in addition to maintaining and documenting patient records, the controlled substance prescription for a spouse should, in the absence of immediate need, only be for a 72-hour period (personal communication July 21, 2011).
- (6) Treatment of a spouse is not permitted, although, if a psychiatrist is found to be treating a spouse, they would most likely not be charged with sexual misconduct, but rather disciplined on another basis (personal communication, July 20, 2011)
- (7) A regulated health professional under the *Business and Professions Code* will not be subject to sexual misconduct provisions for treating their spouse unless the treatment is of the psychotherapeutic nature.
- (8) Historically, the Minnesota Board of Medical Practice has generally discouraged treatment of family members, even though it is not illegal. These matters are always considered on a case-by-case basis.

Power Imbalance:

In prohibiting a sexual relationship between a health professional and a patient, the concept of “power imbalance” is often cited as the consistent rationale. As the College of Physicians and Surgeons on Ontario (CPSO) explains in their policy on *Maintaining Appropriate Boundaries and Preventing Sexual Abuse*, a patient allows a physician to conduct intimate physical examinations and relies on the physician to provide care based upon the physician’s training and knowledge (CPSO, 2008). A patient also provides sensitive information about themselves or family members (ibid). These activities are all one-sided from the patient to the physician, giving the physician an imbalance of power over the patient (CPSO, 2008). Further, a patient most often comes to see a physician when they are unwell, in pain, etc. which puts the patient in even more of a vulnerable position (College of Physicians and Surgeons of Manitoba).

When it comes to creating an exception for a sexual relationship between a patient and professional to occur, this concept cannot be ignored. Therefore, for an exception to occur, it only follows that this concept must not be applicable. This is indeed the case with chiropractors in Minnesota, who are exempted from sexual misconduct provisions if they are found to be treating their spouse. The Minnesota Board of Chiropractic Examiners explains that a “power imbalance” is absent when a chiropractor treats a spouse or even someone with whom a sexual relationship has begun prior to the patient-chiropractor relationship (personal communication, June 22, 2011). In other words, a power imbalance arises from a patient-professional relationship, but since a spousal relationship existed prior to that, a power imbalance would no longer be a factor in the patient-professional relationship (ibid). To take action in this case, against a chiropractor treating their spouse or co-habiting partner from prior to the patient relationship, defies the intent of the rule, which is to prohibit the chiropractor from exploiting the power differential which was created as a result of the establishment of the doctor-patient relationship (ibid).

In stark contrast to this application by the Minnesota Board of Chiropractic Examiners, the B.C. Ministry of Health Services does not grant an exemption from sexual misconduct provisions to any health professional regulated under the omnibus HPA, who is found to be treating their spouse. Some spousal relationships may indeed be abusive (personal communication, June 28, 2011). Therefore, just because there is a spousal relationship does not automatically interpret that a power imbalance no longer exists (ibid). As explained above, many jurisdictions (Manitoba, Alberta, New Zealand etc.) are more lenient when it comes to allowing chiropractor’s to treat their spouse as a patient but it is not known whether they base their leniencies on the same reasoning of the Minnesota Board of Chiropractic Examiners. For example, Nova Scotia bases their leniency on the limited access to chiropractors in their jurisdiction (Nova Scotia College of Chiropractors, 2001).

In many cases, the issue of “power imbalance” does not cease to be applicable with the ending of the patient-professional relationship. In the case of physicians, according to the CPSO policy, *Maintaining Appropriate Boundaries and Preventing Sexual Abuse*, “a factual inquiry must be made in each case to determine whether a physician-patient relationship exists, and when it ends (CPSO, 2008, p.4).” In some cases, the courts have found that despite the ending of a formal relationship, a physician-patient relationship may still be standing due to that continuing trust, knowledge, or influence derived from the previous professional relationship (CPSO, 2008). For example, according to the practice guidelines governing physicians in New Brunswick, “the relationship will be considered to remain extant so long as the patient remains vulnerable for a period of time afterward. This period will depend on the potential for the

physician to use or exploit the trust, knowledge, emotions or influence derived from the previous relationship (College of Physicians and Surgeons of New Brunswick).” This concept also applies to the other health professions reviewed, and is especially prevalent regarding the psychologist-patient relationship. As the Florida Board of Psychology explains, “the Board finds that the effects of the psychologist-client relationship are powerful and subtle and that clients are influenced consciously and subconsciously by the unequal distribution of power inherent in such relationships (Florida Administrative Code).” The majority of jurisdictions reviewed, including Alberta, Virginia, Australia and more do not permit a psychologist to engage in a sexual relationship with a former patient until at least two years after cessation or termination of professional services. Many of the jurisdictions reviewed have adopted the same or similar timelines as well. There may also be times that despite the ending of any practitioner-patient relationship, a sexual relationship will never be permitted such as, when a physician provided psychotherapy or psychoanalysis (College of Physicians and Surgeons of Alberta, 2010). An example of this concept relating to another reviewed health profession is the prohibition in B.C. for a massage therapist to engage in sexual intimacies with a former patient within a year of termination of service (College of Massage Therapists of B.C., 2001).

Trust

“Trust is the cornerstone of the physician-patient relationship (CPSO, 2008, p.3).” The College of Physicians and Surgeons of Manitoba explains that the physician/patient relationship is a “fiduciary” relationship (College of Physicians and Surgeons of Manitoba). In other words, the patient considers the physician to be a trustee, and the physician has the duty to act primarily for the benefit of the patient (ibid). The physician assumes this responsibility because he/she holds the more powerful position in the relationship, as explained above (ibid).¹³ Therefore, this relationship can not be used to further the physician’s own interests, but only for the therapeutic interests of the patient (ibid). Engaging in sexual conduct would be a “clear breach of trust” (CPSO, 2008).

Consent

In prohibiting a sexual relationship between a health professional and a patient, the concept of “consent” also plays a major role. As an effect of the “power imbalance” referenced above, consent between a health professional and patient may be compromised and hence cannot be used as an excuse to engage in a sexual relationship with a patient. As stated in the practice guidelines governing physicians in Manitoba, “Physician/patient sexual contact is abusive regardless of whether the physician believes that the patient consents. Patient consent is never an acceptable rationalization (CPSM, p. 1-G45).” This is seen throughout the jurisdictions reviewed. In Australia, the practice guidelines guiding nurses state, “even if the person (or their legal representative) consents, or the person initiates the sexual conduct it is still the nurse’s responsibility to maintain the professional boundary in the relationship (Australian Nursing and Midwife Council, 2010 p. 5).” Lastly, in Florida, the statutes regulating physicians state, “a patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician (Florida Administrative Code).” Although a patient may be deemed capable (except in cases of

¹³ The Medical Council of New Zealand outlines principles in the *Good Medical Practice: A Guide for Doctors* in order for a doctor to justify their patient’s trust in them. See *References (p.20)* for the retrieval of this document.

incapacity) to give informed consent to therapies and treatments, when it comes to sexual misconduct, the power imbalance clearly acts as a major barrier.

Case Studies:

Ontario regulates health professions through the omnibus RHPA, governing 23 health professions (soon to be 28 upon final proclamation of Bill 171, Health Systems Improvements Act, 2007). As explained earlier, the mandatory revocation sanctions for sexual abuse and in-turn treating your spouse, apply to all health professionals regulated under the RHPA. In order to properly analyze and compare Ontario's approach to sexual abuse and spousal treatment to other jurisdictions, it is imperative to identify the jurisdiction(s) which most closely mirror the RHPA of Ontario and, if possible, its sexual abuse provisions. California, B.C., Quebec and New Zealand are four jurisdictions that best meet the criteria for comparison.

Quebec:

Quebec governs its regulated health professionals through an omnibus legislation referred to as the *Professional Code*. For the purposes of this review, except for massage therapists, each of the professions reviewed are regulated under the *Professional Code*. The *Professional Code* addresses sexual conduct in section 59.1, titled "Derogatory Act", as follows:

59.1. The fact of a professional taking advantage of his professional relationship with a person to whom he is providing services, during that relationship, to have sexual relations with that person or to make improper gestures or remarks of a sexual nature, constitutes an act derogatory to the dignity of his profession.

As mentioned above, Quebec is one of just three provinces that have a legislated penalty for sexual misconduct; the *Professional Code* also lays out a specific penalty for sexual misconduct as follows:

The disciplinary council shall impose at least provisional striking off the roll and a fine in accordance with subparagraphs b and c of the first paragraph on a professional found guilty of having engaged in a derogatory act referred to in section 59.1.

Section 59.1 above uses the term "person to whom he is providing services" in reference to sexual misconduct. A lawyer on council at the Quebec Interprofessional Council explained that this broad terminology does not provide any exceptions and seemingly includes any patient with whom a health professional is engaging in a sexual relationship ("*derogatory act*") with, including a spouse (personal communication, July 2011). It was also mentioned that each case is dealt with on a "case-by-case" basis at the discretion of the discipline committee (*ibid*). However, the *Professional Code* above also provides a minimum penalty for sexual misconduct as per section 59.1, and therefore a regulated health professional who is brought to the disciplinary committee for treating their spouse would seemingly receive at least the minimum punishment. Quebec is unique from Ontario, in that they do not employ a mandatory revocation provision for sexual abuse; therefore it affords the disciplinary committees some leeway (aside from the minimum penalty) on a case by case basis to deal with a health professional that is treating their spouse.

British Columbia:

B.C. governs regulated health professions and addresses sexual misconduct and spousal treatment in a very similar manner to that of Quebec. The HPA governs all regulated health professionals in B.C., which includes all of the professions considered in this review. The HPA addresses sexual misconduct in section 26 by defining “professional misconduct” as follows:

26 In this Part: “professional misconduct” includes sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession;

The HPA in Section 16(2f) also mandates each College to establish a patient relations program concentrated on seeking to prevent “*professional misconduct of a sexual nature*”.

The definition of “*professional misconduct of a sexual nature*” can be found in each profession’s by-laws, and has been synchronized across the physician, dentist, chiropractor, nurse and other professions (not related to this referral) to include the following:¹⁴

- (a) sexual intercourse or other forms of physical sexual relations between a registrant and a patient,*
- (b) touching, of a sexual nature, of a patient by a registrant,*
- (c) behaviour or remarks of a sexual nature by a registrant towards a patient but does not include touching, behaviour and remarks by a registrant to a patient that are of a clinical nature appropriate to the service being provided.*

This definition of sexual misconduct is identical to that of Ontario in the RHPA. The bylaws quoted above use the broad term of “patient” in their definition and according to the B.C. Ministry of Health, this term does not leave any room for any exceptions, i.e. spouse (D.K. Beckett, personal communication, Feb.11, 2011) . Therefore, a health professional can be disciplined on the basis of professional misconduct, upon a finding that he/she is treating their spouse with whom they are having a sexual relationship. However, similar to Quebec and unlike Ontario, B.C. does not have a “mandatory revocation” provision for sexual misconduct. This affords the disciplinary committees some leeway on a case by case basis to deal with a health professional that is treating their spouse (personal communication, June 28, 2011). They may choose to employ a less serious penalty in such cases, considering factors such as a spouse’s consent or a practitioner’s lack of knowledge etc. (ibid). Nonetheless, the HPA does outline penalties that may be imposed by the discipline committee upon a finding of professional misconduct (defined above) that range from a simple reprimand to a cancellation of the member’s registration.

¹⁴ At the moment, not all of the professions regulated under the HPA have updated their bylaws to synchronize the definition of “professional misconduct of a sexual nature”. At the moment only the priority groups have, including physicians, dentists etc, however the Ministry is working on and hopes to complete in the near future, all the profession’s bylaws that are regulated under the HPA (personal communication Aug. 2, 2011).

California:

California has an omnibus piece of legislation, the *Business and Professions Code*, which governs all regulated health professionals. For the purposes of this review all the subject professions, except massage therapists¹⁵, are regulated under the *Business and Professions Code*. In section 726, of the *Business and Professions Code*, the issue of sexual misconduct between a patient and health care professional is addressed as follows:

"726. the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3."

This section continues on and presents an exception to the rule above:

This section shall not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.

The *Code* uses the terms "physician" or "surgeon", however this section is part of the general provisions of the *Code* and applies to all regulated health professionals. It is clear from the *Code* that a health care professional may treat their spouse or any person with whom there is an equivalent domestic relationship (other than psychotherapeutic treatment), without being charged with sexual misconduct.

In addition to the disciplinary sanctions set out in the Business and Professions Code and profession specific regulations for actions of professional misconduct including sexual misconduct and others, each profession's board has adopted recommended guidelines for disciplinary orders and conditions of probation for violations of relevant acts and/or regulations¹⁶. However, the guidelines are merely guidelines and the board may determine that certain *mitigating factors* in a particular case require deviation from the guidelines (California Board of Chiropractic Examiners, 1999). For example, according to the California Board of Chiropractic Examiners' *Disciplinary Guidelines and Model Disciplinary Orders, 1999* (last revised October 21, 2002) the mitigating factors include:

1. Actual or potential harm to the public.
2. Actual or potential harm to any consumer.
3. Prior disciplinary record, including level of compliance with disciplinary orders.
4. Prior warnings of record.
5. Number and/or variety of current violations.
6. Nature and severity of the act(s), offence(s) or crime(s) under consideration.

¹⁵ This profession is not formally regulated in California. A voluntary certification process is offered by the California Massage Therapy Council (<https://www.camtc.org/GovernmentAgencies.aspx>)

¹⁶ According to the California Business and Professions Code, Article 10.5, Section 729, certain acts of sexual abuse (as defined above) between a health professional and patient are criminalized.

7. Mitigating evidence.
8. Rehabilitation evidence.
9. Compliance with terms of any criminal sentence.
10. Overall criminal record.
11. Time passed since the act(s) or offence(s).
12. Whether the conduct was intentional or negligent, demonstrated incompetence, or, if respondent is being held to account for conduct committed by another, the respondent had knowledge of or knowingly participated in such conduct.
13. The financial benefit to the respondent from the misconduct.

Not one of the above factors is required to justify the minimum and maximum penalty as opposed to an intermediate one.

As well, in their disciplinary guidelines, the California Board of Chiropractic Examiners sets out categories of violations and recommended penalties based on the offences specified for which the Board may take disciplinary action against. Sexual relations with a patient fall into either a category 3 or category 4 violation. The penalty for category 3 is a minimum of revocation stayed (revocation does not go into effect, but you are placed on probation instead) with a minimum of 30 days suspension and 5 years probation (probation terms are set out in the guidelines as standard or optional, depending on the nature of the case) while the maximum penalty is revocation. The penalty for category 4 is revocation without a minimum or maximum. Sexual relations with a patient may fall into both categories, but in order to determine which category it falls into, the egregiousness of the sexual conduct is taken into consideration. In less egregious cases the penalties under category 3 would apply, but in more egregious cases the penalties under category 4 would apply.

New Zealand¹⁷

New Zealand has an omnibus piece of legislation, the *Health Practitioners Competence Assurance Act, 2003, (HPCAA)*, which governs all regulated health professionals. For the purposes of this review all the subject professions, except massage therapists, are regulated under the HPCAA. The HPCAA does not address the issue of sexual misconduct, but rather addresses the broader issue of professional misconduct as follows in section 100:

- (1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—*
- (b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred;*

¹⁷ Many of the jurisdictions reviewed present a similar case to that of New Zealand; however New Zealand was chosen to give an international perspective. New Zealand is also similar to Ontario in that an omnibus legislation governs all regulated health professionals.

Instead, sexual misconduct is addressed through other profession specific mechanisms such as standards and codes. The power for each Board to establish such standards and codes is mandated in section 118 of the HPCAA as follows:

*The functions of each authority appointed in respect of a health profession are as follows:
(i) to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession:*

As a result of each profession having the authority to set their own codes or standards, and within them address the issue of sexual misconduct, certain professions have come to include spousal exemptions, while others have not. For example, the Code of Ethics governing chiropractors provides a spousal exemption, permitting a chiropractor to treat their spouse (New Zealand Chiropractic Board, 2004). Section 3.2 relating to sexual misconduct reads as follows:

*Acceptable Relationships: Only a Chiropractor who is engaged in a lawful relationship may have both a doctor/patient and a sexual relationship. A lawful relationship is defined as:
a. Marriage (as defined by section 2 of the Property (Relationships) Act 1976).
b. De Facto Relationship (as defined by section 2 of the Property (Relationships) Act 1976).¹⁸*

However, the physician and psychologist regulatory bodies address the issue of spousal treatment differently. In the standards of practice of the Medical Council of New Zealand, doctors are told to “wherever possible, avoid providing medical care to anyone with whom you have a close personal relationship (p.7),” due to the lack of objectivity and possible discontinuity of care (Medical Council of New Zealand, 2008). As well, the New Zealand Psychologists Board, by way of a code of ethics, informs psychologists to avoid “dual relationships” that may present a conflict of interest (New Zealand Psychologist Board, 2002). Treating family members (i.e. a spouse) would be included in this “off-limits” category for psychologists, although the Psychologists’ Board does not have a specified or recommended penalty if one were found to be treating their spouse (personal communication, July 7, 2011). In regards to the other professions reviewed for this report, the issue of spousal treatment was not addressed in the profession-specific codes or standards, but based on the above trend; it appears that spousal treatment will differ from one profession to another in New Zealand.

In terms of the orders taken against a practitioner found guilty of professional misconduct, the HPCAA lays out a range of penalties from censuring the health practitioner to cancellation of registration. There are no specified penalties for sexual misconduct in either the HPCAA or the profession-specific codes or standards.

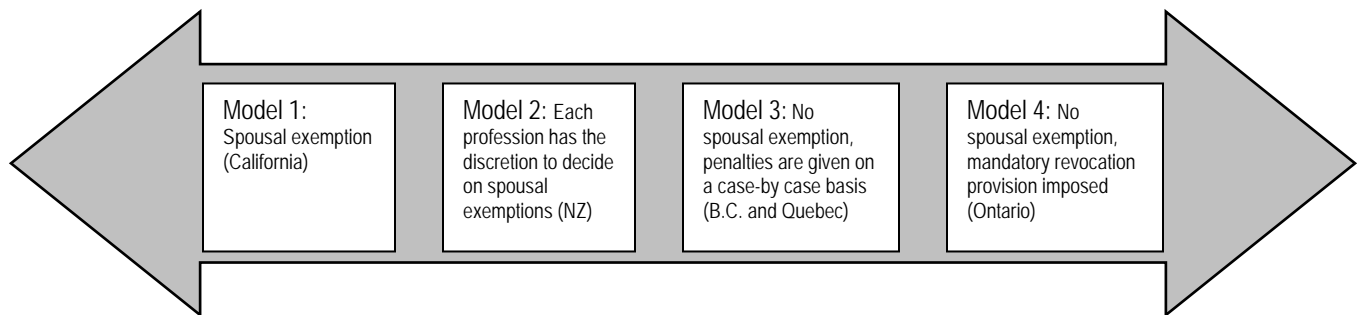
¹⁸ According to the *Property (Relations) Act, 1976, S.2D* a “de-facto” relationship is defined as “a relationship between 2 persons (whether a man and a woman, or a man and a man, or a woman and a woman)—
(a) who are both aged 18 years or older; and (b) who live together as a couple; and (c) who are not married to, or in a civil union with, one another.” In order to determine (b) the Act a number of circumstances of the relationship are taken into account see Section 2 D(2).

Lessons from case studies:

Based on the case studies above, and taking into account Ontario's current model, we are presented with four distinct models for dealing with spousal treatment by a regulated health professional.

- Model 1: To exempt a regulated health professional from sexual misconduct sanctions for treating their spouse or equivalent domestic relationship partner, except in the case of psychotherapeutic treatment (based on the California model).
- Model 2: To allow each profession in a jurisdiction the discretion to decide, through different mechanisms (i.e. regulations, codes or standards) whether to allow a practitioner to treat their spouse.
- Model 3: Not to exempt a regulated health professional from sexual misconduct for the treatment of a spouse, but to deal with the discipline on a case-by-case basis to allow the discipline committee leeway in laying out a sanction (based on the B.C. model). Or, setting a "provisional" minimum penalty that must be given for sexual abuse (including a case of spousal treatment), which still allows for leeway on a case-by-case basis (based on the Quebec model).
- Model 4: Not to exempt a regulated health professional from sexual misconduct for the treatment of a spouse and impose the "mandatory revocation provision" for sexual abuse in any case (based on Ontario model)

Figure 1: Treatment of a spouse by a regulated health professional:



All four models (figure 1) present their own arguments for the minimization of "risk of harm" and for best serving the public interest. The four models can be further broken down into two categories: permissive and non-permissive.

The difference between the two categories does not need any clarification. The first category allows for spousal exemptions, whereas the models in the second category do not. However, the difference in the

second category between models 3 and model 4 requires further clarification. The key difference between the two latter models is the presence of a “mandatory revocation provision” for a health professional who engages in a sexual relationship with a patient. A “mandatory revocation provision,” does not leave room for any exceptions whatsoever in a case where sexual misconduct occurred. Ontario (Model 4) has established a “mandatory revocation provision” for sexual abuse, in the RHPA, for a minimum of 5 years. This means that even in a case where a health professional was found to be treating their spouse, he/she will have their license revoked for a minimum of 5 years. This provision does not leave any room for leeway for less severe punishments in sexual misconduct decisions of the College discipline committees. Model 3, present in both Quebec and B.C., does not have a “mandatory revocation provision” installed and therefore, allows the discipline committees to judge certain cases of sexual misconduct (i.e. spousal treatment) on a case-by-case basis. Quebec differs from B.C. in that the *Professions Code* mandates a minimum punishment for sexual misconduct, of provisional striking off the roll, but still affords leeway in discipline decisions by not installing a “mandatory revocation provision”.

Model 2, although depicted in the case study section as New Zealand, was the most commonly found model in this review. It is present in both; jurisdictions with omnibus legislation governing health professions and those without. In the case of New Zealand’s model, each professional Board is granted the autonomy to create standards and codes under the HPCAA (section 118 above) and include a spousal exemption under sexual misconduct provisions. Such a model is made possible because the jurisdiction’s omnibus legislation does not address sexual misconduct and thereby eliminate any room for exceptions, as is the case in models 3 and 4. Alberta and Manitoba also adopt model 2 as well, by only addressing professional misconduct in their omnibus legislation and allowing the Colleges to define and interpret sexual misconduct through other mechanisms, paving the way for the Colleges to introduce spousal exemptions.

The California model is straight-forward regarding the treatment of a spouse by a regulated health profession; however a lot can be noted from the disciplinary scheme that California has in place. California as depicted above, requires that each Board create disciplinary guidelines for disciplinary orders for registrants who violate relevant acts, regulations, etc. The example of the disciplinary guidelines surrounding chiropractors (above) displays the flexibility in judgement that disciplinary committees are afforded when it comes to sexual relations between a health professional and patient. The recommended penalties should by no means be seen as lenient, but they give each regulatory Board enough room to consider mitigating factors (above) in determining the appropriate penalty instead of installing a mandatory revocation penalty as we see in Ontario. Instead, the guidelines suggest a minimum and maximum penalty and it is up to the Board to review the case, consider mitigating factors and pass judgement.

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