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Professional Standards and Guidelines Regarding Sexual Misconduct by Physicians

This document sets out both **standards** and **guidelines** approved by the Council of the College of Physicians and Surgeons of Nova Scotia.

A standard reflects the minimum professional and ethical behaviour, conduct or practice expected by the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are required to be familiar with and comply with the College **standards**.

Guidelines contain recommendations endorsed by the College of Physicians and Surgeons of Nova Scotia. The College encourages its members to be familiar with and to follow its **guidelines**.

1. Preamble

Physicians are trusted by the individuals and communities they serve. Sexual misconduct undermines the trust that is essential to all relationships involving physicians, including the physician-patient relationship, and undermines the confidence of the public in the medical profession.

This document:

- establishes the College's Standards regarding sexual misconduct;
- defines the type of conduct that constitutes sexual misconduct;
- outlines the approach to be taken by the College when addressing allegations of sexual misconduct and other relevant conduct;
- provides guidance to physicians to assist them to comply with the Standards.

2. Explanation of terms

2.1 Several terms used in this Standards document require elaboration in order to ensure clarity. When addressing the matter of sexual misconduct, that term itself, along with others such "sexualized conduct" and "sexual abuse", require definition. Other terms such as "current patient", "former patient" and "vulnerable former patient" also require definition. Each of these terms when used in this Standards document will be interpreted as set out below.

2.2 What is meant by "*sexualized conduct*", "*sexual misconduct*" and "*sexual abuse*"?

2.2.1 "Sexualized conduct" refers to conduct including threatened, attempted or actual conduct, behaviour or words of a physician, with a sexual connotation, character or quality.

2.2.2 The term "sexualized conduct" does not include clinically indicated or medically relevant questions, discussions, examinations or procedures.

2.2.3 "Sexual misconduct" includes:

2.2.3.1 any sexualized conduct engaged in by a physician with a *current patient*, including but not limited to:

(a) sexualized comments or questions by a physician to a current patient that lack medical relevance, including comments or questions about a patient's body, clothing or sexual history;

(b) threatened or attempted sexual contact by a physician to a current patient;

(c) sexual touching of any kind between a physician and a current patient;

(d) intimate examinations or procedures[1] involving a current patient that are not clinically indicated or are performed in a sexualized manner;

(e) a physician encouraging a current patient to engage in sexualized behaviour (including masturbation) within the physician-patient relationship;

(f) sexual abuse;

2.2.3.2 Subject to Article 2.2.4, any sexualized conduct by a physician *toward any person*, including a current patient, a former patient,

[1] An "intimate examination or procedure" is an examination or procedure involving the breasts, genitals, or anus of a patient.

family members or support persons of patients or former patients, other health professionals, employees, learners, or others, which the physician knows or ought reasonably to know would be objectionable, unwelcome, cause offence or humiliation to the person, or adversely affect the person's health and well-being. This includes but is not limited to:

(a) sexual abuse;

(b) discriminatory comments on the basis of sex and gender, including about a person's appearance, manner of dress, gender identity, sexual orientation or sexual preferences.

2.2.4 For further clarity, "sexual misconduct" does not include conduct, behaviour or discussions of a sexual or intimate nature which are clinically indicated or medically relevant. Such conduct may include circumstances, for example, where the presenting clinical issue requires inquiries into the sexual history of the patient, or the conduct of a clinically appropriate intimate examination or procedure.

2.2.5 "Sexual abuse" is a form of sexual misconduct, and includes the following acts between a physician and a current patient or vulnerable former patient of that physician:

2.2.5.1 sexual intercourse, including: genital to genital, genital to anal, oral to genital, or oral to anal contact;

2.2.5.2 masturbation of the patient by the physician; or

2.2.5.3 a physician encouraging a patient to masturbate in the presence or for the benefit of that physician.

2.3 Who is a "*current patient*"?

2.3.1 A person becomes a current patient when a physician-patient relationship is formed. When determining whether a physician-patient relationship exists, consideration should be given to one or more of the following factors:

2.3.1.1 the physician has charged or received payment from the individual (or a third party on behalf of the individual) for a health care service provided by the physician;

2.3.1.2 the physician has contributed to a health record or file for the individual;

2.3.1.3 the individual has consented to the health service provided by the physician;

2.3.1.4 the physician has prescribed the individual a drug for which a prescription is needed; and/or

2.3.1.5 other factors relevant to the circumstances of the individual and the physician.

2.3.2 When a physician-patient relationship is established in an episodic care setting[2], a person continues to be a current patient only where a reasonable person would expect care to continue beyond the last episode.

2.3.3 If the current patient is a partner or spouse of the physician, or someone with whom the physician had an existing sexual relationship prior to becoming a current patient, that person is not considered a current patient for purposes of these Standards. However, physicians must refrain from providing any medical services to such persons unless exceptional circumstances exist. In this regard, physicians must abide by the College's *Professional Standards and Guidelines Regarding Treating Self and Family Members*.[3]

2.4 Who is a "*former patient*"?

2.4.1 A person ceases to be a current patient and becomes a former patient when

2.4.1.1 in an ongoing physician-patient relationship, the physician actively terminates the relationship in accordance with the College's *Professional Standards and Guidelines for Ending the Physician-Patient Relationship*[4];

2.4.1.2 in an episodic care relationship, a reasonable person would not expect that care would extend beyond the last episode[5].

[2] An "episodic care setting" includes those settings where physicians provide services to patients on an emergency or irregular basis, outside of an established and ongoing physician-patient relationship. It includes, eg, emergency rooms and walk-in clinics where care is provided intermittently.

[3] Professional Standards and Guidelines regarding Treating Self and Family Members

[4] It is the physician's responsibility to ensure the termination of the relationship is conducted and documented as set out in such Standard.

[5] For example, a patient who sees a physician once in a walk-in clinic or an emergency room with no plans to return, is not a current patient of the physician who provided medical services on that one occasion.

2.5 Who is considered a "*vulnerable former patient*"?

2.5.1 A “vulnerable former patient” is a patient who is no longer a current patient, but who requires particular protection from sexual misconduct for reasons of ongoing vulnerability. For some former patients, their degree of vulnerability is such they always will be considered vulnerable former patients. For other former patients, their degree of vulnerability will lessen with the passage of time from the termination of the physician-patient relationship.

2.5.2 When determining whether a former patient is a vulnerable former patient, consideration should be given to:

2.5.2.1 the length and intensity of the former professional relationship;

2.5.2.2 the nature of the former patient’s clinical problem;

2.5.2.3 the type of clinical care provided by the physician;

2.5.2.4 the extent to which the former patient has confided personal or private information to the physician;

2.5.2.5 the vulnerability the former patient had in the physician-patient relationship; and

2.5.2.6 such other factors relevant to the particular circumstances.

2.5.3 Generally, the lengthier the former physician-patient relationship and the greater the dependency, the more likely the person will be found to be a vulnerable former patient by those adjudicating an allegation of sexual misconduct.

2.5.4 The patient for whom psychotherapy services formed a substantial part of the physician-patient relationship will always be considered a vulnerable former patient who cannot consent to a sexual interaction with their former physician. Sexualized conduct with such a vulnerable former patient constitutes sexual misconduct regardless of the passage of **any** time period.

2.5.5 Where the application of the factors in Article 2.5.2 suggests a low degree of vulnerability of the former patient, the former patient will nonetheless be considered a vulnerable former patient for a period of time. The nature of the power imbalance between a physician and a patient creates a vulnerability for every patient, and some period of time must elapse prior to the commencement of any sexual interaction in order to reduce the presence of the vulnerability. The application of the factors in Article 2.5.2 will govern the determination of the appropriate period of time that must elapse prior to any conduct, behaviour or remarks of a sexual nature by a physician toward a former patient amounting to anything other than sexual misconduct.

2.5.6 In considering whether to engage in any conduct, behaviour or remarks of a sexual nature with a former patient, the physician must fully assess the vulnerability of the former patient.

2.5.7 Where a physician is in doubt as to the vulnerability of the former patient, or whether the physician-patient relationship has been properly terminated, they may wish to seek advice from the CMPA.

3. Professional Standards

3.1 A physician must not engage in sexual misconduct.

3.2 A physician must not engage in any conduct, behaviour or remarks of a sexual nature with a former patient, unless all of the following apply:

3.2.1 the physician-patient relationship has been terminated as set out in Article 2.4.1;

3.2.2 an appropriate time interval has elapsed since the termination of the physician-patient relationship[6];

3.2.3 the physician has made a full assessment of the vulnerability of the former patient; and

3.2.4 the former patient is not a vulnerable former patient[7].

3.3 A physician must always obtain informed consent prior to performing a clinically indicated intimate examination or procedure.

3.4 In keeping with the College's *Standards and Guidelines regarding Duty to Report Health Professionals*[8], a physician must immediately notify the College upon forming reasonable grounds to believe that another physician is committing or has committed sexual misconduct.

4. Consent

4.1 Consent is not a defence to an allegation of sexual misconduct involving a current patient or vulnerable former patient. A current patient or vulnerable former patient cannot consent to any sexual interaction with a physician.

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[6] See Article 2.5.5 for additional information

[7] A "vulnerable former patient" is described in Article 2.5

[8] *Standards and Guidelines regarding Duty to Report Health Professionals*

5. College's Approach to Complaints Alleging Sexualized Conduct

5.1 The College recognizes the authority of the Investigation Committee and the Hearing Committee under the *Medical Act* to make findings and to determine the disposition of matters brought before them. As a party in a proceeding under the *Medical Act,* the College will take the following positions:

5.1.1 Sexual misconduct involving a current patient or a vulnerable former patient constitutes professional misconduct[9] within the meaning of the *Medical Act;*

5.1.2 Sexualized conduct by a physician with a former patient that runs contrary to Article 3.2 also constitutes professional misconduct within the meaning of the *Medical Act;*

5.1.3 Sexualized conduct by a physician that is entirely unconnected to the physician's medical practice, his or her status as a physician, or the medical profession may constitute "conduct unbecoming"[10]as defined in the *Medical Act,* if the sexualized conduct tends to bring discredit upon the medical profession;

5.1.4 Where there is a finding of either professional misconduct or conduct unbecoming that constitutes sexual abuse, the College will seek the revocation of the physician's licence.

5.1.5 Where there is a finding of professional misconduct or conduct unbecoming arising from a finding of sexual misconduct that does not constitute sexual abuse, the College will seek a licensing sanction against the physician. The licensing sanction will be commensurate with the relevant circumstances. A licensing sanction creates a disciplinary record for the physician, and can include one or more of a reprimand, conditions or restrictions, periods of suspension from practice, or a revocation of the physician's licence.

5.1.6 Where an intimate medical examination or procedure is clinically indicated but is performed contrary to acceptable standards in a manner that does not constitute sexual misconduct, the College will consider whether to address the actions of the physician as "incompetence" as defined in the *Medical Act*,[11] or

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[9] S. 2(aj) "professional misconduct" includes such conduct or acts in the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional and that, without limiting the generality of the foregoing, may include breaches of

(i) the Code of Ethics approved by the Council
(ii)the accepted standards of the practice of medicine, and
(iii) this Act, the regulations and policies approved by the Council;

[10] S. 2(f): "conduct unbecoming" means conduct outside the practice of medicine that tends to bring discredit upon the medical profession.

[11] s. 2(r): "incompetence" means the lack of competence in the respondent's care of an individual or delivery of medical services that, having regard to all the circumstances, renered the respondent unsafe to practice

as a matter that should lead to a non-disciplinary outcome such as advice, remedial education or a caution.

5.1.7 Where there is any other finding of a breach of these Standards, the College will seek a disposition that is commensurate with the relevant circumstances.

6. Guidelines

6.1 To ensure compliance with the Standards set out above, physicians should have regard to the following Guidelines. A breach of a Guideline may constitute a breach of this Standard.

6.2 Physicians should:

(a) conduct themselves professionally at all times;

(b) explain the scope of an examination, the steps involved, and the reasons for examinations/procedures to patients, particularly where the examination involves the potential for touching the breasts, genitals or anus of a patient;

(c) with the patient's consent, consider having a third party ("chaperone") present for examinations of a sensitive nature such as pelvic or breast exams or in cases where this not possible, inform the patient that they may bring with them a person of their choosing;

(d) provide an adequate gown or drape and refrain from assisting with removing or replacing the patient's clothing, unless the patient is having difficulty and consents to such assistance;

(e) show sensitivity and respect for the patient's privacy and comfort at all times, including providing privacy to a patient when undressing and dressing;

(f) consider the patient's cultural or religious background and recognize that different cultural needs arise in a diverse patient population;

(g) not ask or make comments about sexual performance except where the examination or consultation is pertinent to the issue of sexual function or dysfunction;

(h) In situations where it is clinically appropriate to ask questions of a sexual nature, explain why the questions are being asked;

(i) encourage the patient to ask questions and to speak up immediately if they feel uncomfortable or are in distress;

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at the time of such care of the individual or delivery of medical services or that renders the respondent unsafe to continue in practice without remedial assistance.

(j) avoid lighthearted banter or use of humor during a sensitive examination;

(k) refrain from responding sexually or providing encouragement to any form of sexual advance made by a patient or a person close to them;

(l) respect the boundaries that separate the patient and physician relationship. For example, refrain from using the patient as a confidante or for personal support; and

(m) document any sexualized behaviour by the patient in the chart.

Resources

When a physician has any uncertainty about the application of these Standards or Guidelines, they should seek advice from the Canadian Medical Protection Association.

Acknowledgements

In the preparation of this document, the College acknowledges reliance on the College of Physicians and Surgeons of Ontario Policy Statement, *Maintaining Appropriate Boundaries and Preventing Sexual Abuse*, updated May 2018, and the College of Physicians and Surgeons of Alberta's Standard, *Boundary Violations: Sexual* issued on April 1, 2019.

Document History

Approved by the Council of the College of Physicians and Surgeons of Nova Scotia:

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