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Is Alberta Doing Enough to Protect Patients from Abuse by Health Professionals?

By: Lorian Hardcastle

Headlines such as "Grande Prairie doctor suspended, charged over inappropriate examinations", "Disgraced Calgary psychiatrist Aubrey Levin facing new abuse allegations" and "Southern Alberta doctor accused of sex assault on disabled patient" are not isolated incidents. Despite limited data, one news report found that at least 250 Canadian doctors were disciplined by self-regulatory bodies for boundary offences between 2001 and 2016. The term "boundary offences" encompasses a wide range of conduct including sexual comments, inappropriate touching (often under the guise of a physical exam), taking photographs or videos without a patient's knowledge, or sexual intercourse with a patient (without or with consent—if a patient can truly provide valid consent in this context). Although evidence on the prevalence of sexual misconduct by health professionals is limited, in a study of 10,000 US doctors, 9% reported sexual contact with patients. Ten of the 21 disciplinary decisions currently listed on the website of the Alberta College of Physicians and Surgeons relate to boundary offences. The harm resulting from sexual abuse by health professionals is substantial. Patients are often in a vulnerable position and, when a health professional exploits his or her position of trust and power, victims report feeling shame, confusion, anxiety, and depression. These cases not only damage the relationship between the victim and the perpetrator, but harm public trust in health professionals and self-regulation. In what follows, I recommend several reforms to better protect patients from abuse.

1. Enhanced Reporting Requirements

Colleges (the entities to which governments have delegated authority to self-regulate) rely on complaints from patients as the primary means of detecting concerns with the conduct of health professionals. There are several reasons why reliance on patient complaints is problematic. Patients may underreport abuse due to a sense of shame or confusion. A patient may not be aware that he or she was abused, either because the patient was under sedation or was unsure whether a physical exam was clinically appropriate. A patient may be reluctant to report abuse against a health professional with whom he or she has a longstanding clinical relationship, particularly in a community with a shortage of health professionals. One study estimated that fewer than ten percent of victims report abuse by physicians.

In recognition of the inadequacy of relying on patient complaints, governments mandate reporting of abuse by third parties. In Ontario, which has broad mandatory reporting laws, one third of sexual abuse complaints resulted from mandatory reporting or through College investigations. Under s 57(1) of Alberta's *Health Professions Act*, RSA 2000, c H-7 (*HPA*), if, "because of conduct that in the opinion of the employer is unprofessional conduct, the employment of a regulated member is terminated or suspended or the regulated member resigns,

the employer must give notice of that conduct to the complaints director" of the relevant College. Given that most doctors are independent contractors, employment is helpfully defined broadly to include "contractor" (thereby creating an obligation to report when a physician loses his or her hospital privileges). However, some other provinces have broader reporting requirements. For example, Ontario also requires reporting by a person "who dissolves a partnership, a health profession corporation or association with a member" (*Regulated Health Professions Act, 1991*, SO 1991, c 18, s 85.5(1) (*RHPA*)).

The Standards of Practice of the College of Physicians and Surgeons of Alberta require a physician to report when he or she has reasonable grounds to believe that another physician has committed unprofessional conduct, including sexual conduct with a patient. This obligation should be enshrined in the *HPA* in order to cover all regulated health professions and it should specify that individuals not only have an obligation to report members of their own profession, but members of any heath profession covered by the legislation. This would have the effect, for example, of requiring that nurses report suspected abuse by doctors they work with (and vice versa). For example, British Columbia's *Health Professions Act*, RSBC 1996, c 183, s 32.4(1), states that "[i]f a registrant has reasonable and probable grounds to believe that another registrant has engaged in sexual misconduct, the registrant must report the circumstances in writing to the registrar of the other registrant's college."

2. Interim Sanctions

Between the time that a complaint is filed and the penalty order, a College may "impose conditions on an investigated person's practice permit" (*HPA*, s 65(1)). Common interim sanctions for allegations of sexual abuse include a condition that a health professional only treat patients of a particular gender with a chaperone present (i.e. can only treat male patients if the complainant is a woman), or the health professional may be banned from treating patients of a particular gender altogether. It is also common for Colleges to require that health professionals post notices specifying these interim conditions in their offices.

At first blush, these interim sanctions may seem to strike an appropriate means of balancing the protection of patients with the concern of unduly punishing a health professional against whom allegations have not yet been proven. However, as I discuss below, there are many instances of non-compliance with conditions, in which case patients were not adequately protected. If Colleges are to properly fulfill their mandate of protecting the public, then they must do more to monitor compliance with these interim conditions.

3. Adequacy of Disciplinary Sanctions

Following the completion of a disciplinary hearing, a health professional may be subject to an array of sanctions, ranging from less severe penalties like a reprimand, to more serious sanctions such as temporary suspension from practice or loss of license (*HPA*, s 82(1)). Colleges are often criticized for their lax approach to discipline. For example, an Alberta doctor was suspended from practice for 6 months after inappropriately examining two patients, which included unnecessarily examining the labia of a 16 year old patient without gloves. In another case, a doctor developed a personal relationship with a patient who was emotionally vulnerable and for

whom he was prescribing narcotics, which progressed to a sexual relationship shortly after the termination of the clinical relationship. The doctor received a 6 month suspension, with 3 of those months to be held in abeyance pending the satisfaction of conditions. An Alberta nurse was suspended for 6 months for developing an intimate relationship with a patient, shortly after that patient was discharged from a mental health inpatient unit. When the penalty does not seem to correspond with the egregiousness of the conduct, it not only puts patients at risk, but erodes public trust in health professionals and the efficacy of self-regulation. An Ontario report on sexual abuse of patients found a "[l]ack of faith in the College's ability to self-regulate effectively" and that the public, particularly those who approached the College for help, "perceived it as a self-serving organization which protects the doctors". Unlike most provinces, whose Colleges have broad discretion to penalize misconduct, Ontario employs a "zero tolerance" approach to abuse. Under this approach, the most egregious types of abuse result in mandatory loss of license with no discretion given to the College to impose a lesser penalty (*RHPA*, s 51(5)).

The penalty most commonly imposed by the College of Physicians and Surgeons of Alberta in cases of sexual abuses is a temporary suspension from practice, an assessment (which could result, for example, in treatment), training in boundary issues and, after the suspension is complete, conditions on seeing patients (i.e. a requirement that visits with patients of a particular gender are overseen by a chaperone). There are concerns with the compliance with such conditions. A CBC reporter visited the office of an Ontario doctor who had allegedly licked the breast of a patient. This doctor did not have the required "prominently displayed" sign indicating that he must have a chaperone present when treating female patients. In another case, the reporter found the requisite notice had been posted on a bulletin board cluttered with other papers. In that case, the doctor was accused of making inappropriate comments and pushing his pelvis against a patient's arm during a breast exam. In an Alberta case, a doctor had failed to have a chaperone present in the examination room during his attendance with female patients, contrary to an undertaking he entered into with the College following a complaint.

If Colleges are to retain their discretion over disciplinary sanctions and continue to sanction members with temporary suspensions and conditions, then compliance must be adequately monitored by College staff. Given that most cases of abuse by physicians occur in non-academic settings and those in which doctors examine patients alone (such as an independent general practitioner), it is especially important that College staff conduct inspections, because protections such as mandatory reporting by other doctors will not sufficiently protect patients.

4. Transparency

When professions are given the power to self-regulate, it is essential that they are transparent in order to maintain public trust in the efficacy of their regulatory processes and the adequacy of their sanctions. While some provinces report interim sanctions, and others report allegations prior to a disciplinary hearing, Alberta does not report either. Given that there are numerous cases of non-compliance with interim sanctions and given the long period of time between a complaint and a penalty order, patients should be able to access comprehensive disciplinary information. While Alberta only maintains disciplinary records online for 5 years, other provinces go back much further. This is concerning given high rates of recidivism and under-

reporting and it is unclear how removing this information furthers the goal of protecting the public.

Information about physician discipline in Alberta is accessible either through a list of disciplinary decisions (dating back 5 years) or by searching an individual physician by name. Many other Colleges are much less transparent. For example, the College and Association of Registered Nurses of Alberta only prints the names of disciplined nurses whose "behaviour is very serious" or "highly unethical". Evidently, a case in which a nurse pursued a romantic relationship "[a]lmost immediately after the patient was transferred from the mental health facility where the member had participated in the patient's mental health assessment" did not meet this standard. In addition, disciplinary decisions are not published in a place that is easily accessible to the public, but rather brief summaries are buried within a monthly magazine that is intended for nurses.

Alberta should amend its *HPA* to improve transparency in the disciplinary process. For example, Ontario requires that Colleges report a broad array of information about each member "on the College's website" (*RHPA*, s 23). This includes conditions on a certificate of registration, cautions received, matters referred to the discipline committee and the allegations made against the member, results of disciplinary proceedings, acknowledgements or undertakings relating to allegations of misconduct, findings of negligence, revocations or suspensions of a certificate of registration, and various other pieces of information.

5. Victim Participation

Victims of sexual abuse by physicians often report feeling re-victimized during the disciplinary process. While the College and doctors are represented at a disciplinary hearing by lawyers, the victim has no such party status, despite the fact that allegations may be made about the victim's conduct. The legislation gives the power to a health professional under investigation (*HPA*, s 73) or the College (*HPA*, s 74) to call witnesses, and the complainant has no such right. Similarly, if a hearing is held in private, the investigated person and his or her counsel and the College's counsel may attend. However, the complainant's counsel (if any) has no right to attend and even the complainant may be excluded by the hearing tribunal (*HPA*, s 78(3)).

Another potential reform to enhance the role of the victim is to adopt an Ontario law, which requires that a disciplinary panel "consider any written statement that has been filed, and oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient" (*RHPA*, s 51(6)). Regulators may also assist victims by providing funding for counselling. For example, an Ontario disciplinary disposition for sexual abuse can include an order that the doctor "reimburse the College for funding provided for that patient" (*RHPA*, s 51(2)). Colleges are required to "provide funding for therapy and counselling for persons who, while patients, were sexually abused by members" (*RHPA*, 85.7(1)).

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