Frequently-Asked Questions for Registered Massage Therapists
College of Massage Therapists of Ontario's (CMTO's) *Standards for Maintaining Professional Boundaries and Preventing Sexual Abuse (Standards)*

Why did CMTO establish the new *Standards*?

CMTO established the new *Standards* to improve client safety and CMTO's enforcement abilities, in response to the *Protecting Patients Act, 2017*, which amended the *Regulated Health Professions Act, 1991, (RHPA),* and aims to eradicate sexual abuse by health professionals.

In the new legislation, touching of a sexual nature of a client's breasts, anus, genitals or buttocks has been added to the list of acts for which a CMTO Disciplinary Panel must revoke a Registered Massage Therapist's ("RMT's" or "MT's") Certificate of Registration where the conduct has been found to have occurred.

As Massage Therapy can involve the appropriate touching of some of these parts of the body (e.g., the breasts or buttocks) in the course of therapeutic or clinical treatment, it was necessary for CMTO to ensure that RMTs were provided with professional *Standards* to help navigate the treatment of sensitive areas with their clients.

As part of CMTO's quality improvement and regulatory modernization initiatives, the new *Standards* were developed to provide information to the public and registrants regarding sexual abuse prevention and to strengthen CMTO's ability to hold RMTs accountable for conduct involving sexual abuse. The new *Standards* provide updated guidance on maintaining professional boundaries, post-termination relationships, treating friends and family and obtaining consent, and support CMTO's longstanding policy on zero tolerance for all forms of abuse, particularly sexual abuse.

Why do RMTs need written consent for sensitive areas, and why at each treatment?

The informed consent process is an important client right in Ontario, reinforcing the client's authority and control over what will happen to them. Informed consent promotes communication between the RMT and their client/substitute decision-maker (as appropriate). CMTO has long recognized, through the former *Position Statement on Treatment of Sensitive Areas, 2004,* that particularly in relation to specific areas of a client's body (the "sensitive areas"), the need to obtain specific consent before touching those areas is important to support and promote client safety, autonomy and authority.

We also know that what a client consents to can change from treatment to treatment and sometimes, especially for those clients with a history of sexual abuse, consent can even change from moment to moment within the same treatment.

CMTO's experience with the sexual abuse complaints received over the years highlights that in many instances of sexual abuse by RMTs, no consent of any type was obtained prior to treatment. It also shows that abuse doesn't always happen on the client's first visit. It is also CMTO's experience with sexual abuse matters that when verbal consent is being relied upon by the RMT, it gives the RMT an advantage over the client by virtue of being the maker of the health record. That is, where written consent is not required, a practitioner can chart that verbal consent was obtained, even when it was not. Finally, we know from data obtained through the CMTO Quality Assurance program that the informed consent process needs to be strengthened within the Massage Therapy profession. A consideration of all these factors has resulted in the current approach by CMTO to require a documented conversation between the RMT and their client about treating a sensitive area prior to every treatment. Having the client initial on the consent form that they have consented to have particular sensitive areas treated will also assist in enforcement proceedings should they become necessary.

CMTO has received a significant amount of feedback on our new *Standards* since we released them on September 21, 2017. Most of this feedback focused on the new written consent form. We appreciate the feedback we've received and thank all those who have written, emailed, and communicated with us. CMTO will continue to gather input from RMTs, clients and other stakeholders, and monitor the implementation of the new *Standards*. Over the coming months, the College also plans to provide more education resources and interpretive guidance to support RMTs as they implement these new *Standards* into everyday practice.

The sample written consent form is complicated for me and my clients. Can't it be simplified?

In light of the feedback received by CMTO since the release of the *Standards*, CMTO revised the consent form to simplify it and make it more user-friendly, to support the right of the public to ensure that informed consent is obtained, to improve safety, and enhance CMTO's ability to hold RMTs accountable.

Please find the revised sample form here.

Why were the *Standards* issued on September 21, 2017 and came into effect on September 11, 2017?

CMTO apologizes for any confusion caused by the release date for the *Standards for Maintaining Professional Boundaries and Preventing Sexual Abuse.* The Standards were approved in a public council meeting on September 11, 2017. In future, CMTO will provide a notice period for RMTs to implement any new Standard into their practice setting and will accompany the Standard with educational materials or interpretive guidance to assist with the transition.

Will the new written consent process make my clients uncomfortable and reluctant to receive Massage Therapy?

We recognize that these conversations can be challenging and so to support these conversations, CMTO has prepared information to help RMTs answer clients' questions about written consent for treating sensitive areas. Please find client-focused information here.

CMTO will continue to gather feedback from clients, RMTs and other stakeholders, and monitor the implementation of the new *Standards* to determine whether any adjustments will be needed.

Will the *Standard* requiring written consent protect the RMT by preventing the client from coming forward if they were touched inappropriately?

The purpose of requiring written consent is to provide the client with a clear opportunity to consent or not consent to having their sensitive areas treated, and for them to document that a conversation about consent took place.

The sample written consent form provides a reminder to clients that they can withdraw their consent at any time. Should a client consent to a treatment of a sensitive area and

subsequently believe they have been touched inappropriately, clients can contact CMTO to find out the steps to take to report this behavior. Information would be collected related to the complaint. The credibility of testimony in light of all of the circumstances – not whether the client had initially provided written consent – would be an important consideration by a Disciplinary Hearing Panel.

How will a written consent form protect against sexual abuse?

As a regulator, CMTO must take all reasonable steps to prevent sexual abuse. While CMTO recognizes that it is impossible to completely prevent sexual abuse from occurring, evidence (CMTO discipline cases and peer assessment data) shows that consent is not being adequately obtained by RMTs. As well, the fact that the RMT is the maker of the client chart means that entries can theoretically be made to support the RMT's version of events. The requirement for written consent may prevent some cases of abuse, and where it cannot prevent abuse, it will make it easier to prove that the sexual abuse occurred. CMTO believes that written consent will improve client safety as it can prevent sexual abuse and help hold any RMT who abuses a client accountable for their actions.

Why don't other professions need to obtain written consent for treating sensitive areas?

Each of Ontario's 26 health regulatory colleges will determine how it will ensure that its standards comply with the changes to the RHPA made by the *Protecting Patients Act, 2017*.

CMTO chose to include the requirement to obtain written consent for sensitive areas based on the type of sexual abuse complaints that it receives, the *Protecting Patients Act, 2017,* and data about the informed consent process in the Quality Assurance Program as well as its long-standing commitment to zero tolerance for sexual abuse.

Could the public give up their right to consent (wishing to forego their rights) due to time constraints?

Being given the opportunity to provide, or decline to provide, consent is an important right of clients in Ontario. It is therefore important that RMTs ensure that a discussion about informed consent occurs, and that the client has a written opportunity to consent, or decline consent to the treatment of sensitive areas. It is hoped that through the use of the simplified consent form, the informed consent process will not be very time-consuming.

Is written consent needed every time for the gluteal region?

If treatment of the gluteal muscles (buttocks) is clinically indicated and is included in a written treatment plan, then written consent is required for the treatment plan only (once). Verbal consent to treat the gluteal muscles must be provided for each of the following sessions within the same plan. Should there be changes to the treatment plan, a new written consent to treat the gluteal region (or any other sensitive areas) would be necessary.

Why did CMTO not provide anatomical definitions / diagrams of the sensitive areas?

The sensitive areas are defined as the upper-inner thigh, the breasts, the anterior chest wall and the gluteal muscles (buttocks).

Each client's body is structured differently, and clients have differing views on where their own sensitive areas begin and end. The RHPA also does not anatomically define these body parts and this is why CMTO chose not to provide anatomical definitions of the areas.

However, this list of body areas will be interpreted using common sense and should be interpreted more broadly rather than narrowly. Asking yourself what a reasonable person would view as the "buttocks" or "breasts" is likely to be more appropriate than applying a very narrow anatomical definition.

CMTO recommends that RMTs discuss the boundaries of the sensitive area to be treated as part of the informed consent discussion/process. For example, if treating the buttocks, an RMT can show the client by touching the RMT's own body where they intend to treat.

Isn't it redundant to collect written consent for each treatment of a man's pectorals or gluteal muscles (buttocks)?

CMTO developed the *Standard* to be gender-neutral, as sexual abuse can impact a person of any gender.

CMTO receives sexual abuse complaints from all genders. For males, ensuring the consent discussion takes place prior to the treatment of sensitive areas, specifically the buttocks and upper inner thigh, is still important due to the proximity of these areas to the genitals and anus (both of which can never be touched by an RMT) and given that sexual touching of the buttocks would warrant automatic revocation.

How can I obtain written consent if electronic charting is used?

There are some options for using electronic record keeping and obtaining written informed consent. It is important to recognize that the client is the only one able to give his / her signature. Some possible electronic charting options are:

- Use of paper consent forms to obtain the signature and then scan them into the electronic record (ensure secure disposal of the paper copy once entered electronically).
- Create a form within the electronic system which allows the client to sign (using a stylus or finger).
- Check with your system provider to explore the options available or that have been used by other providers/professions. Some RMT software systems have already incorporated these changes.

My client is unable to provide written consent, but provides consent through a substitute decision maker. What should I do?

The involvement of Substitute Decision Makers ("SDM") (including Powers of Attorney) does pose unique challenges to treatment.

The SDM needs full information about the treatment to be able to provide informed consent and needs to indicate, in writing, that they provide their consent. Should circumstances prevent written consent for each treatment, the SDM must be informed of the requirements of the *Standards* and the risks associated with not following the requirements.

Should the SDM determine that they wish to consent to ongoing treatment without their written consent (knowing the risks associated with this), then he or she should put in writing that they are aware of the *Standards'* requirements, risks associated with not complying with the *Standards*, and that they wish for treatment of sensitive areas to continue in light of this information (this consent would be included in the client record).

Will the new written consent process take time away from treatments?

Written consent for treatment of sensitive areas is only one part of the broader informed consent process and is not intended to take a significant amount of time away from treatment. It is intended to be part of the comprehensive, informed consent discussion that RMTs should already be having with their clients.

CMTO recommends that RMTs discuss any sensitive area to be treated as part of the existing informed consent discussion/process. A thorough informed consent process should take less

than few minutes in normal circumstances and includes the following six components of informed consent:

1) Nature of the treatment.
2) Expected benefits of the treatment.
3) Material risks of the treatment.
4) Material side effects of the treatment.
5) Alternative courses of action.
6) Likely consequence of not having the treatment.

What do I do if a client is physically unable to sign?

In the situation where the client is cognitively capable of providing consent but is physically unable to sign the form, another person may sign as a "witness." The witness does not need to be a substitute decision maker or power of attorney. It can be anyone who can confirm the client is providing his or her own consent. It can be another healthcare provider, a family member/friend, etc. The witness needs to indicate that they are signing on behalf of the client. The RMT should then document all of this thoroughly in the chart. Alternatively, a client can be video-taped providing the consent, however, the RMT must ensure this recording is secured according to privacy and confidentiality rules, and is to be included in the health record.

Is the list of clinical indications exhaustive?

The list of clinical indications is exhaustive. RMTs are welcome to make CMTO aware of clinical indications that may be absent from the list, and the College will review them (to ensure they are evidence-informed and fall within the Scope of Practice for Massage Therapy) prior to their inclusion in future versions of the *Standards*.

How did CMTO determine "sensitive areas"?

The Government of Ontario's *Protecting Patients Act, 2017*, broadened mandatory revocation provisions to include touching of a sexual nature of the client's genitals, anus, breasts or buttocks.

CMTO already provided a list of sensitive areas in previous guidance to RMTs, and *defined* "sensitive areas," as the upper inner thighs, gluteal muscles (buttocks), breasts, and anterior chest wall. These areas align with amendments made to the RHPA by the *Protecting Patients Act, 2017.*

My clients want their sensitive areas massaged as part of a relaxation massage. Why can't I continue to do this?

Relaxation massage or "full body massage" does not, in and of itself, justify treatment of the sensitive areas.

RMTs must do an assessment to determine if there is a clinical reason to treat the area. For example, athletes may request massage to their pectoral muscles (part of the chest wall) to address impaired muscle performance and function – even on a maintenance treatment plan. The gluteal region can be treated for maintenance purposes to address "soft tissue impairments in the gluteal and posterior hip regions that have been identified as significant and relevant to the achievement of treatment plan goals" (as stated in the *Standards*) – particularly if the goal is to prevent injury or maintain flexibility of the hip. The sensitive areas can only be treated if there is a clinical indication (as outlined in the *Standards.*)

Do the new *Standards* limit the provision of healthcare since treatment of a sensitive area cannot begin mid-treatment if written consent before treatment is now required?

The intention of the new *Standards* is not in any way to limit the provision of healthcare. There are several approaches an RMT could take. Proactively, RMTs could discuss possible areas to include in the treatment prior to starting treatment, such as predicting that the gluteal region may be involved when the client is a runner, or is complaining of back pain and accordingly, obtaining written consent to treat the gluteal area. If it turns out that after commencing treatment, the gluteal region is not actually treated, a note in the health record can reflect why consent was obtained, but why that area was not ultimately treated. It is anticipated that this approach will address the vast majorities of these scenarios.

Alternatively, the RMT could explain to the client during treatment, when it is identified that a treating a sensitive area may be beneficial and that this area can be addressed during the next visit. Should the RMT determine that the risk of waiting to the next visit to treat the area would have a greater negative impact on the client, the RMT can treat the area (by obtaining verbal consent before treating the area) and fully documenting their rationale, verbal consent process, and identifying the risk(s) of harm and benefit(s) to the client, following the treatment session. The RMT must also document their clinical rationale for deviating from the *Standards*. RMTs should be aware, however, that if the client subsequently complains that their sensitive areas were treated without consent, the RMT will have a more difficult time responding to the complaint than they would have if they had obtained written consent prior to the treatment.

As with all Standards of Practice, RMTs must use clinical judgment and decision-making in situations which are not addressed in the *Standards* and document their rationale fully in the client record.

My clients do not consider their breasts, gluteals, upper inner thighs or chest wall to be sensitive areas – can I circumvent the requirement for written consent?

The term "sensitive areas" is simply shorthand for the list of body areas which include breasts, anterior chest wall, gluteal muscles (buttocks), and upper inner thigh, where misunderstandings about touching are more likely to arise. It is not meant to imply that it is sensitive to touch or that it is innately sexual. It is intended as providing a list of body areas, which also align with the *Protecting Patients Act, 2017*, for which the treatment requires different consent rules to improve client safety and ensure accountability of RMTs to the public. Clients may have different areas of the body that they consider "sensitive". Asking if there is a part of the body that the client wishes to not have touched can be addressed as part of the informed consent discussion. For the sensitive areas of the body that are outlined in the *Standards on Maintaining Professional Boundaries and Preventing Sexual Abuse* (the breasts, anterior chest wall, gluteal muscles (buttocks), and upper inner thigh), written consent must be obtained.

In the scenario where a client has come in to have their gluteal muscles treated, and the written consent form is completed, do other RMTs treating the client under the same treatment plan need to also obtain written consent?

With any written consent for gluteal muscles (buttocks) that an RMT obtains from a client who is subsequently treated by another RMT, the second RMT will need to confirm verbal consent for treatment, but would not need to obtain a second written consent. Only if there is a change to the treatment plan would either RMT need another written consent completed.