Patient–physician sexual involvement: a Canadian survey of obstetrician-gynecologists

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Objective: To determine obstetrician-gynecologists' (ob-gyns') awareness of and experience with sexual abuse of patients and former patients and their opinions about appropriate consequences.
Design: Mailed survey.
Setting: Canada.
Participants: All 792 members of the Society of Obstetricians and Gynaecologists of Canada (SOGC); 618 (78%) responded. Approximately half of all ob-gyns in Canada belong to the SOGC.
Main outcome measures: Knowledge of sexual involvement by an ob-gyn colleague with a patient or former patient (as defined by the respondents and by the College of Physicians and Surgeons of Ontario [CPSO]), self-report of such involvement, attitudes toward physician sexual abuse, desirable length of time a physician should wait before seeing a former patient in a situation that could lead to a sexual encounter, suggested consequences of sexual abuse.
Results: Overall, 10% of the respondents indicated that they knew about another ob-gyn who at some time had been sexually involved with a patient. In all, 3% of the male respondents and 1% of the female respondents reported sexual involvement with a patient; the corresponding proportions of those who reported having been accused of sexual abuse by a patient were 4% and 2%. Significantly more of the female ob-gyns than of their male counterparts (37% v. 19%) reported awareness of a colleague's sexual involvement with a patient that would meet the CPSO's definition of sexual impropriety, transgression or violation. Most of the respondents felt that the consequence of proven sexual impropriety should be a reprimand and fine (chosen by 33%) or rehabilitation without loss of licence (28%). Most of the physicians supported loss of licence for proven sexual transgression (57%) or proven sexual violation (74%), but fewer felt that loss of licence should be permanent for these types of abuse (4% and 24% respectively). The female ob-gyns supported stronger sanctions against sexual transgression and sexual violation than the male ob-gyns. A wide range of opinion was seen regarding the propriety of sexual relationships with former patients.
Conclusions: Ob-gyns have varied opinions about how sexual abuse of patients should be defined and how it should be sanctioned. There is a discrepancy between proposed public policy and the beliefs of physicians to whom the policy is to be applied.

Objectif : Déterminer la sensibilisation des obstétriciens-gynécologues aux abus sexuels à l'égard de patientes et d'anciennes patientes, leur expérience à cet égard et leur avis sur les sanctions appropriées.
Conception : Enquête postale.
Contexte : Canada.
Participants : Les 792 membres de la Société des obstétriciens et gynécologues du Canada

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(SOGC) dont 618 (78 %) ont répondu. Environ la moitié des obstétriciens-gynécologues du Canada sont membres de la SOGC.

Principales mesures de résultats : Connaissance d'une relation de nature sexuelle entre un collègue obstétricien-gynécologue et une patiente ou une ancienne patiente (au sens entendu par les répondants et le Collège des médecins et chirurgiens de l'Ontario [CMCO]), autodéclaration d'une telle relation, attitudes à l'égard des abus sexuels commis par les médecins, durée souhaitable de la période qui devrait s'écouler avant qu'un médecin commence à rencontrer une ancienne patiente dans une situation qui pourrait entraîner une rencontre sexuelle, sanctions suggérées en cas d'abus sexuels.

Résultats : Dans l'ensemble, 10 % des répondants ont dit connaître un autre obstétricien-gynécologue qui a été impliqué sexuellement à un moment donné avec une patiente. Au total, 3 % des répondants et 1 % des répondantes ont déclaré avoir été impliqués sexuellement avec une patiente; les proportions correspondantes d'obstétriciens-gynécologues qui ont déclaré avoir été accusés d'abus sexuels par une patiente étaient de 4 % et 2 %. Beaucoup plus d'obstétriciennes-gynécologues que leurs collègues masculins (37 % c. 19 %) ont déclaré avoir été au courant de l'implication sexuelle d'un collègue avec une patiente qui serait conforme à la définition de l'inconvenance, de la faute ou de l'infraction sexuelles selon le CMCO. La plupart des répondants étaient d'avis qu'une inconvenance sexuelle démontrée devrait entraîner une réprimande et une amende (choix de 33 %) ou une réadaptation sans perte de permis d'exercice (28 %). La plupart des médecins appuient une perte de permis d'exercice en cas de faute sexuelle démontrée (57 %) ou d'infraction sexuelle démontrée (74 %), mais ceux qui soutiennent que la perte de permis d'exercice devrait être permanente dans de tels cas d'abus sont moins nombreux (4 % et 24 % respectivement). Les obstétriciennes-gynécologues préconisent des sanctions plus sévères dans les cas de faute et d'infraction sexuelles que leurs collègues masculins. On a constaté un large éventail d'opinions au sujet de la convenance des relations sexuelles avec d'anciennes patientes.

Conclusions : Les obstétriciens-gynécologues ont des avis variés au sujet de la définition de l'abus sexuel des patientes et des sanctions qu'il devrait entraîner. Il y a un écart entre la politique publique proposée et ce que pensent les médecins auxquels elle s'appliquera.

Although concern about the potential harm of physician–patient sexual involvement has a long history,[1–5] the 1991 report by the Task Force on Sexual Abuse of Patients,[6] commissioned by the College of Physicians and Surgeons of Ontario (CPSO), has focused the attention of Canadian physicians on the issue of physician–patient sexual involvement. In Ontario strict guidelines for reporting such activity and disciplining physicians have been enacted.[7] The licensing bodies in several provinces and many voluntary professional medical organizations have been studying the CPSO task force report.[8–10] Projects have been launched in several provinces to consider how the issues raised in the report will affect the profession and how risk to physicians will be managed during their dealing with sexuality and physical examination of patients.

Although the CPSO task force recommended that two levels of sexual abuse of patients by physicians (sexual impropriety and sexual violation) be recognized, the CPSO itself subsequently defined three levels and proposed somewhat different penalties for each level.[11]

- Sexual impropriety: any behaviour such as gestures and expressions that are sexually demeaning to a patient or that demonstrate a lack of respect for the patient's privacy.
- Sexual transgression: any inappropriate touching of a patient, short of sexual violation, that is of a sexual nature.
- Sexual violation: sex between a physician and a patient, regardless of who initiated it, including but not limited to sexual intercourse, genital–genital contact, oral–genital contact, oral–anal contact and genital–anal contact.

We surveyed members of the Society of Obstetricians and Gynaecologists of Canada (SOGC), a voluntary professional organization that represents approximately 50% of Canadian obstetrician-gynecologists (ob-gyns). The survey explored issues related to physician–patient sexual contact according to first the physician's definition of sexual involvement and then the CPSO's definitions.

Methods

In mid-October 1992 we mailed a questionnaire to members of the SOGC residing in Canada; a membership list was provided by the society. The questionnaire was developed in English. It underwent extensive pretesting, which included review by colleagues with expertise in questionnaire design and probing of the content by local ob-gyns to establish face validity. The SOGC's French translation services were used to translate the questionnaire. (Copies of the questionnaires are available from the authors upon request.)

Questions were included on the following types of information, arranged in the order presented to respondents: (a) sociodemographic information, (b) knowledge of sexual contacts between ob-gyns and their patients or

former patients (according to the physician's implicit definitions), (c) personal sexual contact with patients and former patients, (d) attitudes toward sexual contact between physicians and patients, (e) knowledge of sexual impropriety, transgression or violation (according to the CPSO's definitions) between ob-gyns and patients or former patients, and (f) support for various suggested penalties by type of misconduct (impropriety, transgression or violation). Most of the questions were close-ended or partially close-ended, although the physicians were also invited to comment on their answers.

The purpose of the survey was first described to members of the SOGC in the society's newsletter *The Bulletin*. We then mailed the questionnaire to all members with a covering letter from the society's president requesting cooperation. A brief note was included from us that emphasized the importance of responding. Two weeks after the initial mailing a thank-you note or reminder was mailed. The questionnaire was sent a second time, 3 weeks after the initial mailing, to members who had not returned the questionnaire yet. The second cover letter was again signed by the president and highlighted the procedures used to protect the confidentiality and anonymity of respondents. The data were collected up to mid-January 1993.

Measures were taken to ensure the anonymity of respondents. An identification number appeared on the cover of the survey to monitor its returns. Once the questionnaire was returned the number was removed and another one assigned for data analysis. No link was maintained with the identity of the respondents.

All data were analysed with the use of SPSSX-PC (SPSS Inc., Chicago, 1988) and BMDP (BMDP Statistical Software Inc., Los Angeles, 1990). Initial analyses were descriptive (frequency distributions of responses to categoric items; means, medians and standard deviations of continuous variables such as age). Cross-tabulations were done by sex of respondent. The statistical significance of associations was tested with the χ^2 test or the Fisher's exact test, depending on the underlying distribution of the data. Given that multiple challenges of the data were done, associations with a p value of 0.01 or less were considered significant.

Results

Physician characteristics

Of the 792 members of the SOGC 618 (78%) returned the questionnaire. Over 98% of the respondents answered all of the questions. The response rate varied from 75% (in Quebec and Saskatchewan) to 100% (in Prince Edward Island). Men and women were equally likely to respond. The mean age of the respondents was 47.3 (standard deviation [SD] 9.7) years and ranged from 28 to 76. Most of the respondents were men (80%), were graduates of Canadian medical schools (75%) and had had 4 or more years of postgraduate training in Canada (83%). The length of time in practice ranged from 0.5 to 47 (mean 16.8 [SD 10.3]) years. In all, 70% practised in large communities (population of more than 100 000), 15% in medium-sized communities (50 000 to 99 999) and 14% in small centres (less than 50 000). Approximately 40% of the respondents were in solo practice, 25% were in academic geographic full-time positions, and 20% were in group practice; the remainder reported a combination of practice types.

No recent published data were available regarding the characteristics of ob-gyns in general in Canada. Thus, unpublished information was provided by the CMA on the age and sex distribution of ob-gyns who responded to the 1990 Physician Resource Questionnaire. After exclusion of the respondents who were 65 years of age or over in 1990 (since they likely no longer were in practice in 1992), the age distribution of male and female respondents to the two surveys were quite similar (Table 1). The slightly younger profile of the respondents to our questionnaire was likely due to new entrants between 1990 and 1992. However, if the proportion of women responding to the CMA survey was representative of all female ob-gyns, these data suggest that a higher proportion of female than of male ob-gyns in Canada belong to the SOGC. Thus, it is important to view the responses to our questionnaire provided by men and women separately. Combined data likely overestimate the contribution made by the female respondents and cannot be readily generalized to all ob-gyns.

Colleagues' sexual involvement

When asked whether they were aware of a colleague in obstetrics and gynecology who had been involved in a sexual encounter with a patient or former patient (no definitions about sexual involvement were offered at this point) 17% said Yes: 10% knew of such

Table 1: Age distribution of obstetrician-gynecologists (ob-gyns) who responded to the CMA's 1990 Physician Resource Questionnaire and those who responded to the 1992 survey of the Society of Obstetricians and Gynaecologists of Canada (SOGC)

	Survey; no. (and %) of respondents			
	SOGC survey		CMA survey	
Age, yr	Male	Female	Male	Female
≤ 44	175 (35)	91 (75)	280 (34)	100 (69)
45–54	164 (33)	23 (19)	268 (32)	27 (19)
55–64	127 (26)	6 (5)	285 (34)	18 (12)
≥ 65	25 (5)	1 (1)	[301]*	[14]*
Unknown	6 (1)	0	2 (0.2)	0
All	497	121	1136	159

*Not considered in calculation of percentages because they were unlikely to be in practice in 1992.

an encounter with a patient, and 7% knew of one with a former patient (Table 2). Less than 1% knew of such encounters with both patients and former patients. More of the female respondents than of the male respondents knew of contacts between colleagues and patients.

Personal sexual involvement

The proportion of respondents who had had a sexual encounter with a patient or a former patient was 3% (Table 2). Fewer than 1% reported both types of encounters. In each case the physician was asked with how many patients or former patients they had had encounters. Of those who reported an encounter with a patient 62% stated that it had been with only 1, and 88% reported that 2 or fewer patients were involved (range 1 to 15 patients). Of those who reported a sexual encounter with a former patient 72% stated that it had been with only one patient (range one to four patients). Fewer female than male ob-gyns reported sexual contact with a patient or former patient (Table 2).

Sexual impropriety, transgression and violation

When asked if they were aware of an ob-gyn colleague who had had a sexual encounter with a patient that met one of the three CPSO definitions, 23% said Yes, and 8% chose not to answer. Significantly more of the female respondents than of the male respondents knew of such an encounter (Table 2). When asked whether they personally had been accused of sexual impropriety, transgression or violation by a patient 4% answered Yes, and 1% chose not to reply; the difference between the female and male respondents was not significant.

Consequences for sexual impropriety, transgression and violation

Because controversy exists about the appropriate penalties for sexual abuse and the extent to which different consequences should be applied for sexual impropriety, transgression and violation, the respondents were asked about the types of sanctions that they considered appropriate for each type of sexual abuse (Table 3). Most (61%) of the respondents felt that physicians found guilty of sexual impropriety should be allowed to continue practising. Of the 33% who thought that a reprimand and fine was the appropriate penalty, 53% felt that the fine should be $500 or less. The "other" category usually included multicategoric responses (e.g., rehabilitation and fine) or ones in which the respondent recommended that the penalty increase with subsequent offences.

Fewer physicians endorsed a reprimand and fine for proven sexual transgression than for sexual impropriety (Table 3); the size of the fine recommended by most (78%) was higher, at $1000 or more. Rehabilitation was the consequence chosen by 62% of the respondents, and loss of license during rehabilitation or for an indeterminate period was endorsed by 53%. Of the respondents who chose other responses 7% gave a multicategoric response, and 3% indicated that they were unwilling to choose a consequence category because the penalty should increase with subsequent offences.

More respondents endorsed severe consequences

Table 2: Questions regarding physician–patient sexual involvement

Question	% of respondents who answered Yes* Female (n = 121)	Male (n = 497)	Total
Do you know of an ob-gyn colleague who has had sexual involvement			
With a patient?	17 (0)	8 (0.4)	10‡ (0)
With a former patient?	10 (0)	6 (0.4)	7 (0)
Have you ever had sexual involvement			
With a patient?	1 (2)	3 (0.4)	3 (1)
With a former patient?	1 (2)	3 (1)	3 (1)
Are you aware of a colleague whose behaviour with a patient would be viewed as sexual impropriety, transgression or violation?†	37 (7)	19 (8)	23§ (8)
Have you ever been accused of sexual impropriety, transgression or violation† by a patient?	2 (0)	4 (1)	4 (1)

*Percentages in brackets refer to the proportion of respondents who did not respond.
†According to definitions of the College of Physicians and Surgeons of Ontario.[11]
‡Fisher's exact test 7.45; $p = 0.03$.
§Fisher's exact test 18.69; $p < 0.01$.

for proven sexual violation than for the other two types of sexual abuse (Table 3). In total, 5% endorsed options that would allow physicians to continue to practise, and a few commented that the license should be restricted to avoid patient contact. Again, some of the respondents chose other sanctions and often wrote in multicategoric options or suggested that the penalty be increased with subsequent offences.

More of the female respondents than of the male respondents assigned stiffer penalties for sexual impropriety (Table 3), although many of each sex commented that sexual impropriety was such a subjective category that it was difficult to answer the question. The women were significantly more likely than the men to assign stiffer sanctions for sexual transgression and violation ($p = 0.002$).

Attitudes toward sexual contact

Most (97%) of the respondents indicated that sexual involvement with patients is never therapeutic. Only 58% always saw sexual involvement with patients as an abuse of power, and 60% supported zero tolerance of it. No statistically significant difference in these attitudes was observed between the male and female respondents, although somewhat more of the women than of the men always saw it as an abuse of power (62% v. 56%) and supported zero tolerance (65% v. 58%).

The responses to the question about how long physicians should wait before beginning to see a former patient in a situation that could lead to a sexual encounter (e.g., dating) are in Table 4.

Discussion

The response rate to our survey was higher than has been typically reported in the literature for surveys of this type.[1-5,12] The CPSO task force found that in studies with response rates substantially below 50% the prevalence of physician–patient contact ranged from 7% to 13%, which was translated into a likely 10% contact rate.[6] In our survey 10% of the respondents were aware of a colleague's sexual contact with a patient (according to their own definition). Such a prevalence cannot be used to establish a rate of physician–patient sexual involvement, because it does not take into account the probability that several physicians may be aware of the same colleague's behaviour. When self-reports of physician–patient sexual contact were considered, our findings suggested a much lower prevalence (3% overall). This overall estimate is similar to the one of 4% (74% response rate) recently obtained by Wilbers and associates.[13] It also approximates the prevalence of 3.8% found in a survey with a 69.5% response rate done in British Columbia.[14] It appears that prevalence estimates drop as the response rates to such surveys increase.

As we expected, the physicians' definitions of what constitutes physician–patient sexual involvement were more limited in scope than the definitions recently adopted by the CPSO. Overall, 23% indicated an awareness of sexual involvement by a fellow ob-gyn that would currently be viewed as sexual impropriety, trans-

Table 4: Respondents' opinions on how long a physician should wait before beginning to see a former patient in a situation that could lead to a sexual encounter

Waiting period	No. (and %) of respondents
None or until public termination of professional relationship	70 (11)
≤ 6 mo	120 (19)
7–12 mo	142 (23)
> 1 yr	71 (11)
Depends on the circumstances	44 (7)
Such a relationship should never occur	87 (14)
No response	84 (14)

Table 3: Suggested penalties by type of sexual abuse

	Type of sexual abuse; % of respondents who agreed*								
	Impropriety			Transgression			Violation		
Penalty	Male	Female	All	Male	Female	All	Male	Female	All
Reprimand and fine	35	27	33	9	5	8	1	0	1
Rehabilitation without loss of licence	26	35	28	19	12	18	4	1	4
Loss of licence									
During rehabilitation	18	17	18	43	46	44	29	20	27
For indeterminate period	1	2	1	8	12	9	24	19	23
Permanent	1	3	2	3	11	4	21	39	24
Other	17	15	17	15	13	15	18	20	18
No response	3	1	2	3	1	2	3	2	3

*χ^2 values (with 5 degrees of freedom) for comparisons between the male and female responders for impropriety, transgression and violation were 8.36 ($p = 0.13$), 18.90 ($p = 0.002$) and 18.24 ($p = 0.002$) respectively.

gression or violation, as compared with 10% who reported knowing of a colleague who had been involved in a sexual encounter of their own definition. It appears likely that personal definitions do not include much of the behaviour that is now labelled sexual impropriety. Also, the respondents chose lesser sanctions for sexual impropriety, most suggesting that the physician be allowed to continue to practise.

Over one third of the female respondents were aware of some form of sexual abuse of patients (CSPO definitions) by their colleagues. Twice as many female as male respondents reported knowing of such contact, regardless of whether they used their own definitions or those of the CPSO. Because we did not ask how they found out about their colleagues' behaviour we can only speculate on why such a difference in awareness existed. Female patients who were sexually abused by a male ob-gyn may have been more likely to seek out a female than a male ob-gyn for further care. Previously abused women, regardless of whether they preferentially sought care from a female ob-gyn, may have been more likely to mention an episode of previous abuse to a female physician than to a male physician. The female ob-gyns may have been more likely than the male ob-gyns to report their knowledge of a colleague's sexual involvement. Finally, the physicians' definitions of what constitutes sexually inappropriate behaviour may have been different for the female respondents than for their male counterparts.

Sexual encounters with former patients are seen as an abuse of power by the CPSO task force.[6] The task force suggested that at least 2 years elapse between the end of the professional relationship and any sexual involvement with a former patient. Most of the respondents disagreed with this recommendation. Although 14% thought that such contact should never occur, most felt that it was not improper if handled appropriately, which usually involved either a period of waiting or a public declaration that the professional relationship had ended. If reporting of such contact becomes mandatory, it will likely be strongly resisted by SOGC members.

Less than 25% of the respondents favoured permanent loss of licence for physicians found guilty of sexual violation; almost twice as many female respondents as male respondents advocated such a consequence. Most of the physicians favoured temporary loss of licence either during rehabilitation or for an indeterminate period. This may have been because most of the physicians who admitted having had sexual contact with patients indicated that it had occurred only with one or two patients. Some flexibility in assigning penalties seems to be advocated by many of the respondents, who commented that the penalty should depend on the individual's previous behaviour or circumstances. How physicians might react to legislation for mandatory reporting of physician–patient sexual involvement was not directly probed. However, our results indicate that many may be reluctant to report an incident if the consequence is permanent loss of licence.

We found no significant difference in the attitudes toward and self-reporting of sexual contact with patients between the male and female respondents. Yet, considerably more physicians, especially women, would have to be surveyed to allow significant differences to be detected. Four times as many male respondents as female respondents reported sexual contact with a patient and more than twice as many reported that they had been accused of sexual abuse by a patient. Since all patients of ob-gyns are female, this difference may be because lesbian orientation is considerably less frequent than heterosexual orientation. Yet, the low rate of sexual contact with patients reported by the female ob-gyns matches rates in previous reports,[2,4,5,12–14] which suggests that women are less likely than men to become sexually involved with their patients.

Our study has several methodologic limitations. Despite a response rate of 78% and no difference in the response rate between the female and male physicians, a sizeable minority of ob-gyns chose not to return the questionnaire. Women were overrepresented in the survey sample, since more female ob-gyns than male ob-gyns in Canada are members of the SOGC. We cannot validate the responses obtained to key questions with information from external sources and thus cannot estimate the extent of over- or underreporting. Yet, it appears that a broad cross-section of SOGC members were willing to answer our sometimes intrusive questions. We can be most confident of our comparison between the men and women, because equal proportions of each group participated. Here, a question on how the respondents found out about their colleagues' sexual involvement with a patient would have been helpful to our understanding of why more women than men reported knowing about such contact.

Conclusion

The findings of this survey of SOGC members suggest that overall 10% of ob-gyns know about another ob-gyn who at some time was sexually involved with a patient. The prevalence of self-reporting of sexual involvement with a patient (recent or remote) is estimated to be less than 4%. Physicians' personal definitions of sexual abuse are narrower in scope than the definitions suggested by the CPSO task force. Although most physicians support temporary loss of licence for proven sexual transgression or violation, fewer support permanent loss of licence, even for proven sexual violation. Most ob-gyns think that the sanctions for sexual impropriety should be a reprimand and fine or rehabilitation. There is no agreement on the propriety of sexual relationships with former patients. The range of opinions among ob-gyns about how sexual abuse of patients should be defined and punished point to a discrepancy

between proposed public policy and the beliefs of physicians to whom the policy will be applied. More female ob-gyns than male ob-gyns reported knowing of physician–patient sexual abuse and supported stiffer penalties for sexual transgression and violation. If mandatory reporting is legislated, and these findings reflect actual differences in likelihood of such awareness, female ob-gyns may be more likely to confront situations in which they must decide whether to report on a colleague's sexual involvement with a patient.

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Du 17 au 21 sept. 1994 : 10e Congrès international sur les soins aux malades en phase terminale
Montréal
Susan Garin, directrice de la programmation, Secrétariat du 10e Congrès international, Les Services de congrès GEMS, 100–4260, ave. Girouard, Montréal, QC H4A 3C9; tél (514) 485-0855, fax (514) 487-6725

Sept. 17–21, 1994: 10th International Congress on Care of the Terminally Ill
Montreal
Susan Garin, director, program department, 10th International Congress Secretariat, GEMS Conference and Consulting Services, 100–4260 Girouard Ave., Montreal, PQ H4A 3C9; tel (514) 485-0855, fax (514) 487-6725

Sept. 18–23, 1994: 12th International Congress of Neuropathology (in conjunction with the annual meetings of the Canadian Association of Neuropathologists and the American Association of Neuropathologists)
Toronto
Dr. J.J. Gilbert, Department of Pathology, Victoria Hospital, PO Box 5375, London, ON N6A 4G5; tel (519) 667-6649, fax (519) 667-6749

Sept. 23–24, 1994: 3rd Annual International Sports Medicine Symposium — Instabilities: a Global Approach (presented with the Sports Medicine Council of Alberta)
Edmonton
Dr. Lisa Stevenson, Glen Sather Sports Medicine Clinic, E-05 Van Vliet Centre, University of Alberta, Edmonton, AB T6G 2H9; tel (403) 492-4752, fax (403) 492-1637

Du 29 sept. au 1er oct. 1994 : Conférence internationale sur les effets préventifs et thérapeutiques des suppléments nutritionnels dans le traitement des maladies chroniques
Toronto
Secrétariat de la conférence sur les suppléments nutritionnels, a/s Association des hôpitaux du Canada, 100–17, rue York, Ottawa, ON K1N 9J6; tél (613) 241-8005, fax (613) 241-5055

Sept. 29–Oct. 1, 1994: International Conference on Adjuvant Nutrition and Chronic Disease: Preventive and Therapeutic Effects
Toronto
Adjuvant Nutrition Conference Secretariat, c/o Canadian Hospital Association, 100–17 York St., Ottawa, ON K1N 9J6; tel (613) 241-8005, fax (613) 241-5055

October 1994: 2nd International Forum of Medical Cooperative Health Care
Brasilia, Brazil
Unimed do Brasil, Confederação Nacional das Cooperativas Médicas, Alameda Santos, 1827–15° andar, CEP 01419-002, São Paulo, Brazil; tel 011-55-11-253-6633, fax 011-55-11-253-6656

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