

### **9.1.1 Romantic or Sexual Relationships with Patients**

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient-physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's wellbeing.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

*AMA Principles of Medical Ethics: I, II, IV*

*Background report(s):*

CEJA Report A-I-90 Sexual misconduct in the practice of medicine

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In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, *nonclinical* contact with a patient may be perceived as or may lead to *romantic or sexual* contact should avoid such contact. [new content clarifies guidance]

***AMA Principles of Medical Ethics: I, II, IV***

## CEJA Report A – I-90 Sexual Misconduct in the Practice of Medicine

There is a long-standing consensus within the medical profession that sexual contact or sexual relations between physicians and patients are unethical. The prohibition against sexual relations with patients was incorporated into the Hippocratic oath:

I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons...<sup>2</sup>

Current ethical thought uniformly condemns sexual relations between patients and physicians.<sup>24-30</sup> In addition, the laws of many states prohibit sexual contact between psychiatrists or other physicians and their patients. The ban on physician-patient sexual contact is based on the recognition that such contact jeopardizes patients' medical care.

This report reviews relevant research on sexual misconduct in medicine and discusses the ethical implications of sexual contact between physicians and patients. The Council has made the following conclusions: (1) sexual contact or a romantic relationship with a patient concurrent with the physician-patient relationship is unethical; (2) sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship; (3) physicians who learn of sexual misconduct by a colleague must report the misconduct to either the local medical society, the state licensing board, or other appropriate authorities, with appropriate exceptions made to protect patient welfare, and (4) education on the issue of sexual attraction to patients and sexual misconduct should be included throughout all levels of medical training.

### PHYSICIAN-PATIENT SEXUAL CONTACT

#### *Incidence*

A number of studies have tried to establish the incidence of physician-patient sexual contact. Much of the research done on the prevalence of physician-patient sexual contact is based on self-reporting by physicians.<sup>4,10,12,16</sup> The general stigma attached to sexual contact with patients and the professional repercussions which may result from admitting to such contact have led most researchers to believe that the occurrence of patient-physician sexual contact is underreported.<sup>4,8,11</sup> Studies indicate that there is a small minority of physicians who have reported having sexual contact with patients.<sup>10</sup> Psychiatrists have been particularly diligent in examining and analyzing the occurrence of sexual contact with patient. Consequently, the majority of existing studies on physician-patient sexual contact examine sexual contact between psychiatrists and their patients. Studies of psychiatrists indicate that between 5-10% reported having sexual contact with patients.<sup>4,8,9,12,14,17</sup> Data for all specialties are not available but a 1976 study suggested that the percentages may be comparable for other specialties.<sup>10</sup> While much of the discussion in this report centers on sexual misconduct by psychiatrists, it is clear that sexual misconduct is a problem not confined to any particular specialty.

Sexual contact between physician and patient can occur in a variety of ways: (1) physicians may become involved in personal relationships with patients that are concurrent with but independent of treatment;<sup>4</sup> (2) some physicians may use their position to gain sexual access to their patients by representing sexual contact as part of care or treatment;<sup>1</sup> (3) others may assault patients by engaging in sexual contact with incompetent or unconscious patients. There seems to be little or no data indicating the prevalence of each type of sexual misconduct.

### *Physicians Who Engage in Sexual Contact with Patients*

There are some useful distinctions that can be drawn regarding physicians who engage in sexual contact with patients. For some physicians, sexual contact with a patient is a result of an isolated and temporary failure to constructively manage the complex emotions arising from the physician-patient relationship. Many physicians regret the sexual contact with their patients, recognizing the actual or potential harm that a sexual relationship poses to the patient.<sup>4,14</sup> In addition, many seek or are amenable to treatment rehabilitation that would preclude future misconduct.

However, it is also clear that for some other physicians, sexual misconduct is the conscious (and usually repeated) use of their professional positions in order to use or exploit their patients' vulnerabilities for their own gratification. Presumably, most physicians who represent sexual contact to patients as part of treatment would belong to this category. Certainly self-gratification is the only basis for the behavior of physicians' who engage in sexual contact with incompetent or unconscious patients.

### Sexual Misconduct Which Occurs as a Result of Temporary Failure to Properly Handle the Emotional Content of the Physician-Patient Relationship

The professional physician-patient relationship frequently evokes strong and complex emotions in both the physician and the patient.<sup>31,33,34</sup> It is not unusual for sexual attraction to be one of these emotions. Many commentators agree that sexual or romantic attraction to patients is not uncommon or abnormal.<sup>6,13,29</sup>

Recognition and consideration of a physician's emotional response to a patient may benefit the physician-patient interaction. As with other emotional responses to patients, identifying and analyzing sexual attraction to a patient may reveal information which can be used to improve the professional interaction. Awareness of the patient's psychological state may aid in diagnosing the patient's physiological or psychiatric problems.<sup>31,34</sup> For instance, sexual attraction to a patient may also be a response to a patient's loneliness or emotional needs. Sexual attraction to a patient may also, of course, be nothing more than a normal human reaction.

However, the emotion of sexual attraction to a patient, while not necessarily detrimental to the physician-patient relationship, could also lead to sexual contact or a sexual relationship between the patient and physician. The emotions of admiration, affection, and caring which, among others, are a part of the physician-patient relationship, can become particularly powerful when either party is experiencing intense pressures, or traumatic or major life events. Loneliness, divorce, death of a loved one, professional pressures etc., may exert a powerful effect on the emotional content of the physician-patient relationship.<sup>9</sup> These conflicts and problems may exacerbate other feelings a physician and patient have toward each other. The usual professional restraint exhibited by physicians may falter under such profound emotional influences, resulting in the transformation of sexual attraction into sexual contact.

Currently, the research on sexual misconduct is insufficient to determine how many sexual interactions between physicians and patients would fall into this category. Although figures vary widely, one nation wide study of psychiatrists showed that a significant number of psychiatrists who reported sexual contact with a patient, 66%, indicated that the contact occurred with only one patient.<sup>4</sup> This study showed that approximately 50% of psychiatrists who reported sexual contact with only one patient sought help or consultation for the matter.<sup>4</sup> In the same study, 75% of all psychiatrists who reported sexual contact with patients reported either regret or mixed feelings about the contact.

Engaging in sexual contact with a patient because of temporary impairment of proper judgment or perspective is not ethically excusable or condonable.

### Physician-Patient Sexual Contact Which Occurs Under Potentially Exploitative Conditions

Instances of sexual contact with patients occur most commonly where there is considerable disparity in power, status, and emotional vulnerability between physician and patient. The number of sexual relationships between physicians and patients which occur under these potentially exploitative circumstances raises concerns that some physicians use their professional position to exploit patients sexually.

In addition to pre-existing factors which may render the physician-patient interaction unequal, physicians who engage in sexual contact with patients are typically older and male, while patients are typically younger and female. Studies among psychiatrists indicate that approximately 85-90% of sexual contact involves a male psychiatrist and a female patient. In one study of psychiatrists, a majority admitted that sexual contact with a patient was for their own emotional or sexual gratification. In one study of male psychotherapists, a majority reported that they maintained the dominant role in the relationship even after sexual contact had been initiated, and a slightly smaller majority reported considering themselves as "father figures" for their patients.<sup>15</sup>

Other studies of patient-psychiatrist sexual contact showed that the patients who were involved in sexual contact with their psychiatrists were also the ones most likely to be particularly vulnerable emotionally. Such patients were more likely than other patients to consider exploitative relations with an authority figure to be normal. In fact, the most prevalent predictive factor for a patient becoming involved in a sexual relationship with a mental health professional is a prior sexual victimization, usually in the form of childhood incest. Other important risk factors include major psychiatric illness, such as borderline personality disorder and drug or alcohol problems. In addition, studies of patients who have engaged in sexual relationships with their psychiatrists have also shown that the patients usually tended to be experiencing some sort of life crisis at the time, such as divorce, and were particularly lonely and emotionally vulnerable.<sup>15,18</sup>

A significant amount of sexual contact with patients does not seem to be an isolated instance of mismanaging the emotions of the professional relationship. For instance, a substantial number (33%) of psychiatrists who reported sexual contact with patients also reported repeated instances of sexual contact with patients. Repeat offenders were the most likely of all psychiatrists to claim that their conduct was beneficial to patients, despite considerable evidence that the conduct was harmful. These repeat offenders were also the least likely to seek help or consultation regarding the sexual contact.

### *Effects of Sexual Contact Between Patients and Physicians*

Despite some early attempts to show that sexual contact between patient and physician is or could be beneficial to the patient,<sup>20,22</sup> most researchers agree that the effects of physician-patient contact are almost universally negative or damaging to the patient.<sup>1,3,7,11,18,19</sup> Similar to the reactions of women who have been sexually assaulted, female patients who had sexual contact with their physicians tended to feel abandoned, humiliated, or mistreated at the hands of their physician.<sup>3,19</sup> Many were angry and felt they had been exploited.<sup>8</sup> Victims have been reported to experience guilt, severe distrust of their own judgment, and many were left mistrustful of both men and physicians.<sup>11,15</sup> One researcher reported that patients who had been involved in therapist-patient sexual relationships suffered from depression, anxiety, psychosexual disorders, sleeping disorders, and were at risk for substance abuse.<sup>11</sup> Others report that

victims have an increased incidence of first time psychiatric hospitalization, and an increased risk of suicide.<sup>42</sup> Finally, a significant number of patients who have had sexual contact with a psychiatrist experience symptoms of post-traumatic stress syndrome.<sup>42</sup>

Most studies which have examined the effects of physician-patient sexual contact have focused on psychiatrists or therapists and their patients. Psychiatric therapy is of an intensely intimate and personal nature. The intimate and emotional nature of therapy would seem to render the patient particularly susceptible to harm from the effects of sexual contact with the psychiatrist. However, it would be erroneous to assume that sexual contact between patients and practitioners other than mental health professionals poses less of a risk to patient well-being. One study found that the psychological impact of physician-patient sexual contact was negative for the patient regardless of the type of practitioner involved.<sup>3</sup> The study suggests that it is, at least in part, the betrayal of the patient's trust in the physician which produces negative psychological consequences for the patient. In addition, the risks posed to patient well-being due to loss of professional objectivity are equal regardless of the physician's specialty.

Surveys among psychiatrists and psychotherapists show that they almost uniformly consider (approximately 95-98%) sexual contact with patients as potentially or actually harmful to the patient.<sup>4,7,12,27</sup> The only psychiatrists who profess that sexual contact with patients may be therapeutically beneficial or at least harmless are those who engage in it. These psychiatrists in general were likely to believe that their patients had experienced the contact as predominantly beneficial. However, evidence suggests that psychiatrists who engage in sexual contact with patients are poor assessors of the actual effect of the contact on their patients. Eighty-five to ninety percent of patients experience such sexual contact as damaging.<sup>32</sup>

## SEXUAL CONTACT WITHIN THE PHYSICIAN-PATIENT RELATIONSHIP: ETHICAL CONSIDERATIONS

### *Serving the Needs of the Patient*

The satisfaction or gratification which a physician derives from treating patients is a fortunate benefit of the physician-patient alliance. However, the physician's professional obligation to serve the needs of the patient means that the physician's own needs or gratification cannot become a consideration in decisions about the patient's medical care. Regard for the physician's needs or gratifications may interfere with efforts to address the needs of the patient. At the very least, the emotional factors which accompany sexual involvement may affect or obscure the physician's medical judgement, thus jeopardizing the patient's diagnosis or treatment. Sexual contact or relationships between patient and physician are unethical because the physician's gratification inappropriately becomes part of the professional relationship.<sup>3,14,23</sup>

### *Trust Integral to the Physician-Patient Relationship*

From ancient times, members of the medical profession have accepted the special responsibility that is accorded them by virtue of their unique skills of healing. The degree of knowledge, training, and expertise required to practice the art of medicine is highly sophisticated and complex. Physicians recognize that the health of individuals and society depends on their willingness to employ their knowledge, expertise and influence solely for the welfare of patients. Patients who seek medical care must, in turn, be able to trust in the physician's dedication to the patient's welfare in order for the physician-patient alliance to succeed.<sup>9</sup>

A physician who engages in sexual contact with a patient seriously compromises the patient's welfare. The patient's trust that the physician will work only for the patient's welfare is violated. Consequently, sexual contact and sexual relationships between physicians and their patients are unethical.

### *Comparison of Sexual Misconduct to Sexual Assault and Incest*

Several researchers have been prompted to compare the occurrence of sexual misconduct to sexual assault and incest.<sup>1,3,7,9,11</sup> Masters and Johnson advocated that therapists who exploit their power in order to have sexual intercourse with their patients should be charged with rape.<sup>13</sup> Four states classify sexual exploitation by a psychotherapist as sex offenses under criminal statutes.<sup>35,36,39,40</sup>

Several elements of the physician-patient relationship can combine to give the physician disproportionate influence over the patient. Within the physician-patient relationship, the physician possesses considerable knowledge, expertise, and status. A person is often most vulnerable, both physically and emotionally, when seeking medical care.<sup>2,9</sup> When a physician acts in a way which is not to the patient's benefit, the relative position of the patient within the professional relationship is such that it is difficult for the patient to give meaningful consent to such behavior, including sexual contact or sexual relations.<sup>9,11</sup> It is the lack of reliable or true consent on the part of the patient which has led researchers to compare physician-patient sexual contact to other sexually exploitative situations such as sexual assault and incest.<sup>7,11</sup> It is noteworthy that several states specify that consent of the patient or client cannot be used as a defense to charges of sexual misconduct.<sup>21,35-40</sup> The comparison to sexual assault is easily understood when physician represents sexual contact to the patient as being an appropriate medical or therapeutic procedure. In such situations, a physician uses his or her status as a physician to influence or coerce the patient into accepting sexual contact. For instance, one researcher examined the responses of 16 women who had been sexually molested during routine gynecological examinations by the same physician.<sup>1</sup> The majority of the women did not stop the physician even after becoming uncomfortable with the length and nature of his examination since they trusted that, as a physician, he would not conduct an unethical examination.<sup>1</sup> In addition, the reactions of all 16 of these women were similar to those of women who have been sexually assaulted.<sup>1,3,11</sup>

### *Ethical Implications of Non-Sexual Physical Contact with Patients*

The ethical prohibition against romantic relationships or sexual contact with patients is not meant to be a bar to other kinds of non-sexual touching of patients by physicians. In addition to its role in physical examination, non-sexual touching may be therapeutic or comforting to patients. However, even non sexual contact with patients (beyond the appropriate touching of the physical examination) should be approached with caution. It may be difficult to identify a strict boundary between non-sexual and sexual touching. Either the patient or the physician may misinterpret the touching behavior of the other.<sup>32</sup> For instance, a patient with borderline personality disorder may readily mistake a hug meant to provide comfort as a sexual advance from a physician.<sup>6</sup> There is also some concern that what may begin as benign, non-sexual contact may eventually lead to sexual contact.<sup>10,12</sup>

If a physician feels that a patient may misinterpret the nature of physical contact, or if a physician has some doubt about whether his or her non-sexual touching behavior may be leading to sexual contact, then he or she should avoid the non-sexual contact.

*Physician-Patient Sexual or Romantic Relationships Necessitate Termination of the Professional Relationship*

It is of course possible for a physician and a patient to be genuinely attracted to or have genuine romantic affection for each other. However, any relationship in which a physician is (or risks) taking advantage of the patient's emotional or psychological vulnerability would be unethical. Therefore, before initiating a dating, romantic, or sexual relationship with a patient a physician's *minimum* duty would be to terminate his or her professional relationship with the patient.<sup>14</sup> In addition, it would be advisable for physician to seek consultation with a colleague before initiating a relationship with the former patient. Termination of the professional relationship would also be appropriate if a sexual or romantic attraction to (as opposed to contact with) a patient threatens to interfere with the judgment of the physician or to jeopardize the patient's care.

SEXUAL RELATIONSHIPS WHICH OCCUR AFTER THE TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

*Post - Termination Relationship May Also Be Unethical*

Termination of the physician-patient relationship does not eliminate the possibility that sexual contact between a physician and a former patient might be unethical. Sexual contact between a physician and a patient with whom professional relations have been terminated would be unethical if the sexual contact occurred as a result of the use or exploitation of trust, knowledge, influence or emotions derived from the former professional relationship. The ethical propriety of a sexual relationship between a physician and a former patient, then, may depend substantially on the nature and context of the former relationship.

In most patient-psychiatrist relationships, the intense and emotional nature of treatment makes it difficult for a romantic relationship between a psychiatrist and a former patient not to be affected by the previous professional relationship. The American Psychiatric Association has accordingly stated that "sexual involvement with one's former patients generally exploits emotions deriving from treatment and is therefore almost always unethical."<sup>29</sup>

Relationships between patients and other types of physicians may also include considerable trust, intimacy, or emotional dependence. The length of the former professional relationship, the extent to which the patient has confided personal or private information to the physician, the nature of the patient's medical problem, and the degree of emotional dependence that the patient has on the physician, all may contribute to the intimacy of the relationship. In addition, the extent of the physician's general knowledge about the patient, i.e., the patient's past, the patient's family situation, and the patient's current emotional state are all factors which may render a sexual or romantic relationship with a former patient unethical.

*Prohibiting Sexual Contact with Former Patients for a Fixed Period of Time after Termination of the Professional Relationship*

Some commentators have suggested that the amount of time Which has elapsed since the termination of the professional relationship and the initiation of the sexual or romantic relationship may be pertinent to the ethical propriety of relationships between physicians and former patients.<sup>7</sup> It may be that a sexual or romantic relationship which immediately follows the termination of the physician-patient relationship may be more suspect than one which occurs after considerable time has passed yet, some emotions and dependencies that were created during the professional relationship may not disappear even after a considerable amount of time has passed. Research on psychotherapists has shown that patients experience strong feelings about their therapist for 5-10 years after the termination of treatment.<sup>32</sup>

For these reasons, it would not be useful to decide the appropriateness of a sexual relationship between a physician and a former patient based on the amount of time that has elapsed since the termination of the professional relationship. Rather, the relevant standard is the potential for misuse of emotions, trust, knowledge or influence derived from the former professional relationship.

## PREVENTION AND DISCIPLINE OF SEXUAL MISCONDUCT

### *Education*

There is evidence that the issue of sexual misconduct and sexual or romantic attraction to patients is not adequately covered in many medical training programs.<sup>13,28</sup> Although the reasons for lack of comprehensive education on sexual attraction to and sexual contact with patients vary, almost all commentators agree that the issues surrounding sexual misconduct need attention during medical education.<sup>5,6,13,15</sup>

Education may serve to distinguish sexual or romantic attraction to patients, which is a common and normal experience, from inappropriate behavior such as acting on the attraction or allowing the attraction to jeopardize the care of the patient. Education may also promote responses to sexual attraction to patients that would prevent the jeopardizing of patient care. For example, evidence suggests that psychotherapists who have had some sort of graduate level training regarding sexual attraction to patients are more likely than those who have had no such training to seek consultation or supervision when specific instances of attraction to patients arise.<sup>13</sup> Obviously, education about sexual misconduct would also inform physicians and medical students about the ethical implications of physician-patient sexual contact as well as the potential harm to patient well-being.

### *Detection and Reporting of Sexual Misconduct of Colleagues*

Sexual misconduct is unlikely to be brought to the attention of the proper authorities by many of the usual means of exposing deficiencies in the practice of medicine. Other transgressions can be detected through the analysis of records, or may be brought to the attention of the authorities by hospital staff or peer review processes. However, the discovery and investigation of sexual misconduct is unlikely unless victims of sexual misconduct initiate and pursue disciplinary or ethical review procedures.<sup>7</sup> Unfortunately, patients who have had sexual contact with their physicians may be hindered from reporting the misconduct. There is some evidence that offenders tend to refer patients to colleagues whom they know to be sympathetic to their actions.<sup>16</sup> Patients may thus be discouraged from reporting instances of sexual misconduct. In addition, many psychiatrists have reported that disciplinary actions tended to be infrequent, ineffective, and substantially weighted in favor of the accused.<sup>16</sup>

Further, some patients may not be able emotionally to report instances of sexual misconduct, or to undergo the process of review and investigation required to discipline an offending physician. When the sexual relationship was a result of the physician's mishandling of the emotional influences of the professional relationship, the patient may not be able to recognize that the physician's behavior was improper, or inappropriately motivated.<sup>5</sup> Victims of sexual misconduct through medical deception may be incapable of reporting the offense because of the emotions of shame, humiliation, degradation, and self-blame which also often make it difficult for victims of sexual assault to report their assaults.

One of the few remaining avenues for identifying offending physicians is reporting by colleagues. Consequently, reporting of transgressions by peers is especially important in the case of sexual misconduct. Unfortunately, physicians are often reluctant to report instances of sexual transgression by

their colleagues. A 1987 survey of 1,423 practicing psychiatrists revealed that although 65% of them reported treating patients who had been sexually involved with previous therapists, and 87% of those psychiatrists believed that the previous involvement was harmful to the patient, only 8% of them reported their colleagues' behavior to a professional organization or legal authority.<sup>5</sup>

Literature which has studied the reporting practices of physicians indicates that reluctance to report may involve concerns about confidentiality, either in the physician-patient relationship or among colleagues. Reluctance to take action contrary to a patient's wishes or concern that a patient's recovery process may be damaged also may affect the reporting practices. Some physicians may also regard the patient's allegations as hearsay, and therefore unreportable.<sup>5,6</sup>

The AMA includes among its Principles of Medical Ethics the standard that "[a] physician shall...strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." Because the nature of sexual misconduct is such that most victims are rendered reluctant or unable to report the misconduct on their own, physicians should be particularly vigilant in exposing colleagues who commit sexual misconduct. Presently, four states have mandatory reporting laws specific to the reporting of sexual misconduct by colleagues.<sup>32</sup> The Council on Ethical and Judicial Affairs believes that physicians who learn of sexual misconduct by a colleague must report the misconduct to either the local medical society, the state licensing board or other appropriate authorities. Exception may be made if a physician learns of the misconduct while treating the offending physician for it, provided that the offending physician is not continuing the misconduct and does not resume the misconduct in the future. An exception may also be made in cases in which a patient will not consent to reporting or in cases where the treating physician believes that reporting would significantly harm the patient's treatment.

### *Discipline*

Some commentators have expressed concern that existing disciplinary bodies have not been sufficiently effective in dealing with sexual misconduct.<sup>5</sup> While the frequency of false accusations of sexual misconduct seems to be extremely low,<sup>6,41</sup> the rate at which practitioners are disciplined for ethical violations of this kind does not seem commensurate with the number of accusations.<sup>5,25</sup> There may be myriad concerns which limit the efficiency of investigative and disciplinary bodies, including the difficulties inherent in ensuring procedural fairness to the accused physician while remaining sensitive to the needs of the patient who reports physician sexual misconduct.

There are some ways, however, to structure disciplinary bodies that would maximize both effectiveness in detecting and disciplining offenders and sensitivity to patients who report sexual misconduct. For instance, some research has shown that women who experienced sexual contact with male psychotherapists showed an increased distrust both of men and psychotherapists.<sup>5</sup> In addition, patients who have had sexual contact with a physician may be reluctant to discuss the contact, especially given the sensitive issues which are implicated by sexual contact. Patients should therefore be given the option of a preliminary interview with a member of the disciplinary board with whom or with whose gender they feel most comfortable. In addition, it is important that disciplinary panels hearing sexual misconduct charges have equal gender distribution among its members.

Members of disciplinary bodies that deal with reports of sexual misconduct should undergo training and education specific to the problems patients may face greater obstacles in reporting and pursuing legal action in the case of sexual misconduct than with other medical transgressions. Some institutions may consider establishing a special disciplinary body to handle allegations of sexual misconduct, one whose members are educated and sensitized to the particular difficulties facing victims of sexual misconduct.<sup>37</sup>

Alternatively, an institution might establish special procedures for handling sexual misconduct complaints.

Finally, physicians who commit sexual misconduct must be able to get help. Physicians are subject to many pressures and influences in their professional lives, including attraction to patients, the emotional influences of the physician-patient interaction and the effect of their own emotional problems or conflicts. Many physicians who commit sexual misconduct may benefit from treatment for their problem. Currently, there is virtually no research regarding the efficacy of therapy for physicians who engage in sexual misconduct. However, programs similar to those which help other kinds of physician impairments, such as alcohol and drug addiction, should be developed and made available for sexual misconduct offenders.<sup>13,15</sup>

Education on the issue of sexual misconduct and profession therapy for impaired physicians will deter or prevent sexual misconduct by many physicians. However, strong steps must be taken so that any physician who jeopardizes patient well-being can be disciplined appropriately.

## CONCLUSION

The Council on Ethical and Judicial Affairs concludes that:

1. Sexual contact or a romantic relationship with a patient concurrent with the physician-patient relationship is unethical.
2. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship.
3. Education on the issue of sexual attraction to patients and sexual misconduct should be included throughout all levels of medical training.
4. Disciplinary bodies must be structured to maximize effectiveness in dealing with the problem of sexual misconduct.
5. Physicians who learn of sexual misconduct by a colleague must report the misconduct to either the local medical society, the state licensing board or other appropriate authorities. Exceptions to reporting may be made in order to protect patient welfare.
6. It should be noted that many states have legal prohibitions against relationships between physicians and current or former patients.

## REFERENCES

1. Burgess A. Physician sexual misconduct and patients' responses. *Am J Psychiatr.* 1981;138:1335-42.
2. Campbell M. The oath: an investigation of the injunction prohibiting physician- patient sexual relations. *Persp in Bio and Med.* 1989;32:300-308.
3. Feldman-Summers S, Jones G. Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. *J Consult & Clin Psychol.* 1984;52:1054-61.
4. Gartrell N, Herman J, Olarte S, et al. Psychiatrist-patient sexual contact: Results of a national survey, t: prevalence. *Am J Psychiatr.* 1986;143:1126-31.
5. Gartrell N, Herman J, Olarte S, et al. Reporting practices of psychiatrists who knew of sexual misconduct by colleagues. *Am J Orthopsychiatr.* 1987;57:287-295.
6. Gutheil TG. Borderline personality disorder, boundary violations, and patient-therapist sex: Medicolegal pitfalls. *Am J Psychiatr.* 1989;146:597-602.
7. Herman JL, Gartrell N, Olarte S, et al. Psychiatrist-patient sexual contact results of a national survey. II: psychiatrists' attitudes. *Am J Psychiatr.* 1987;144:164-16
8. Holroyd JC & Brodsky AM. Psychologists' attitudes and practices regarding erotic and nonerotic physical contact with patients. *Am Psychologist.* 1977;oct:843-8 9.
9. Kardener SH. Sex and the physician-patient relationship. *Am J Psychiatr.* 1974;131:1134-1 ~36.
10. Kardener SH, Fuller M, Mensh IN. Characteristics of "erotic" practitioners. *Am J Psychiatr.* 1976;133:1324-25.
11. Kluff RP. Treating the patient who has been exploited by a previous the therapist. *Psychiatr Clin NA.* 1989;12:483-500.
12. Perry JA. Physicians' erotic and nonerotic physical involvement with patients. *Am J Psychiatr.* 1976;133:838-840.
13. Pope KS, Keith-Spiegel P, Tabachnick BC. Sexual attraction to clients: the human therapist and (sometimes) inhuman training system. *Am Psychologist.* 1986;41 147-158.
14. Rapp MS. Sexual misconduct. *Can Med Assn J.* 1987;137:193-94.
15. Zelen SL. Sexualization of therapeutic relationships: the dual vulnerability of patient and therapist. *Psychotherapy.* 1985;22: 178-185.
16. Kardener S.H., Fuller M & Mensh IN. A survey of physicians' attitudes and practices regarding erotic and nonerotic contact of patients. *Am J Psychiatr.* 178; 130:1077-81.
17. Derosis H, Hamilton J, Morrison E, Strauss M. More on psychiatrist- patient sexual contact. *Am J Psychiatr.* 1987; 144:687-88.
18. Belote B. Sexual intimacy between female clients and male psycho the apists: mas- ochistic sabotage. Unpublished doctoral dissertation, California School of Professional Psychology, San Francisco (1974).
19. Bouhoutsos J, Holroyd J, Lerman H, et al. Sexual intimacy between psychotherapists and patients. *Professional Psychol: Res & Pract.* 1983; 14:185-196.
20. McCartney J. Overt transference. *J Sex Rsrch.* 1966; 2:227-37.
21. Appelbaum PS. Statutes Regulating Patient-Therapist Sex. *Hosp & C m. Psychiatr.* 1990;41;15-16.
22. Shepard M. *The love treatment: Sexual Intimacy between patients and psychotherapists.* NY: Wyden (1971).
23. Seeman MV. Sexual misconduct [letter]. *Can. Med. Assoc. J.* 1987; 137: 9-700
24. American Psychiatric Association. The Principles of Medical Ethics with annotations especially applicable to psychiatry. Washington, D.C. APA, 1989.
25. Moore, RA. Ethics in the practice of psychiatry: update on the results f Enforcement of the Code. *Am J Psychiatr.* 1985; 142:1043-46.
26. Ill. ALS 1254 (1988).
27. F.A.C. 21U-15.004

28. Glaser RD & Thorpe JS. Unethical intimacy: a survey of sexual contact and advances between psychology educators and female graduate students. *Am Psychol* 1986; 41:43-51.
29. Gartrell N, Herman J, Olarte S., et al. Psychiatric residents' sexual contact with educators and patients: Results of a national survey. *Am J Psychiatr.* 1988; 15:690-94.
30. Council on Ethical and Judicial Affairs, American Medical Association *Current Opinions of the Council on Ethical and Judicial Affairs* 1991, Opinion 8.14. Chicago, Illinois.
31. Zinn WM. Doctors have feelings too. *JAMA* 1988;259:3296-3298.
32. Bemann KC & Goodwin J. New laws about sexual misconduct by therapists: knowledge and attitudes among Wisconsin psychiatrists. *Wisc Med J* 1989;8 (5):11-16
33. Groves JE. Taking care of the hateful patient. *N Eng J Med* 1978;298:8 -887.
34. Gorlin R, Zucker HD. Physicians' reactions to patients. *N Eng J Med* 1983;308;1059-1063.
35. Wis Stat §940.22 (1986)
36. Minn Stat Ann §609.344 (1990)
37. SD Codified Laws Ann §36-4-30(1989)
38. Fla Stat §458.331 (1988)
39. Colo Rev Stat §18-3-405.5 (1989)
40. ND Cent Code § 12.1-20-06.1 (1988)
41. Bass A. Sexual abuse-the tide is turning. Boston Globe, Health Science Section. June 18, 1990, p.29-30, col. 3.
42. California Legislature. Report of the California Senate Task Force on Psychotherapist and Patients Sexual Relations. Prepared for the California Senate Rules Committee. March 1987.