ACOG COMMITTEE OPINION

Number 373 • August 2007

Sexual Misconduct*

Committee on Ethics

Reaffirmed 2016

ABSTRACT: The physician–patient relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual contact or a romantic relationship between a physician and a current patient is always unethical, and sexual contact or a romantic relationship between a physician and a former patient also may be unethical. The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated regardless of the physician's sex. If a chaperone is present during the physical examination, the physician should provide a separate opportunity for private conversation. Physicians aware of instances of sexual misconduct have an obligation to report such situations to appropriate authorities.

The privilege of caring for patients, often over a long period, can yield considerable professional satisfaction. The obstetrician–gynecologist may fill many roles for patients, including primary physician, technology expert, prevention specialist, counselor, and confidante. Privy to both birth and death, obstetrician–gynecologists assist women as they pass through adolescence; grow into maturity; make choices about sexuality, partnership, and family; experience the sorrows of reproductive loss, infertility, and illness; and adapt to the transitions of midlife and aging. The practice of obstetrics and gynecology includes interaction at times of intense emotion and vulnerability for the patient and involves both sensitive physical examinations and medically necessary disclosure of especially private information about symptoms and experiences. The relationship between the physician and patient, therefore, requires a high level of trust and professional responsibility.

Trust of this sort cannot be maintained without a basic understanding of the limits and responsibilities of the professional's role. Physician sexual misconduct is an example of abuse of limits and failure of responsibility. The valued human experience of the physician–patient relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm.

Sexual misconduct is of particular concern in today's environment of shifting roles for women and men, greater sexual freedom, and critical evaluation of power relations in society (1–4). Prohibitions against sexual contact between patient and physician are not new; they can be found in the earliest guidelines in western antiquity. From the beginning, physicians were enjoined to "do no harm" and specifically avoid sexual contact with patients (5). In the intervening centuries, as the study of medical ethics has evolved, attention has been focused on respect for individual rights, the problem of unequal power in relationships between professionals and patients, and the potential for abuse of that power (6).

In this context, the American Medical Association's Council on Ethical and Judicial Affairs developed a report, "Sexual Misconduct in the Practice of Medicine," condemning sexual relations between physicians and current patients (7). It raises serious questions about the ethics of romantic relationships with former patients. It is summarized as follows (8):

> Sexual contact that occurs concurrent with the physician–patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physi-

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

*Update of "Sexual Misconduct" in *Ethics in Obstetrics and Gynecology,* Second Edition, 2004.

> cians and patients detract from the goals of the physician–patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.
>
> If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician–patient relationship before initiating a dating, romantic, or sexual relationship with a patient.
>
> 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.

The Council provides clear guidelines (7):

- Mere mutual consent is rejected as a justification for sexual relations with patients because the disparity in power, status, vulnerability, and need make it difficult for a patient to give meaningful consent to sexual contact or sexual relations.
- Sexual contact or a romantic relationship concurrent with the physician–patient relationship is unethical.
- Sexual contact or a romantic relationship with a former patient may be unethical under certain circumstances (9). The relevant standard is the potential for misuse of physician power and exploitation of patient emotions derived from the former relationship.
- Education on ethical issues involved in sexual misconduct should be included throughout all levels of medical training (10–13).
- Physicians have a responsibility to report offending colleagues to disciplinary boards.

The Society of Obstetricians and Gynaecologists of Canada has adopted a similar statement that "acknowledges and deplores the fact that incidents of physicians abusing patients do occur" and finds that "these incidents include 'sexual impropriety' due to poor clinical skills, chauvinism, or abuse of the power relationship, and outright systematic sexual abuse" (14). The Society also supports the right to "informed, safe, and gender-sensitive" care and the right of victims of abuse to receive "prompt treatment." "Identification, discipline, and, where possible, rehabilitation of the perpetrators" is recommended.

Although much discussion of sexual misconduct by health care professionals has centered around the particular vulnerability that exists within the relationship a woman has with her mental health care professional (15, 16), sexual contact between patients and obstetrician–gynecologists also has been documented (3, 4). Physicians themselves acknowledge that there is a problem, but the extent of the problem is difficult to determine because information relies on self-reporting, which carries the potential for bias in response.

The Committee on Ethics of the American College of Obstetricians and Gynecologists endorses the ethical principles expressed by the American Medical Association and the Society of Obstetricians and Gynaecologists of Canada and affirms the following statements:

- Sexual contact or a romantic relationship between a physician and a current patient is always unethical.
- Sexual contact or a romantic relationship between a physician and a former patient also may be unethical. Potential risks to both parties should be considered carefully. Such risks may stem from length of time and intensity of the previous professional relationship; age differences; the length of time since cessation of the professional relationship; the former patient's residual feelings of dependency, obligation, or gratitude; the former patient's vulnerability to manipulation as a result of private information disclosed during treatment; or physician vulnerability if a relationship initiated with a former patient breaks down.
- Physicians should be careful not to mix roles that are ordinarily in conflict. For example, they should not perform breast or pelvic examinations on their own minor children unless an urgent indication exists. Children and adolescents are particularly vulnerable to emotional conflict and damage to their developing sense of identity and sexuality when roles and role boundaries with trusted adults are confused. It is essential to ensure the young individual's privacy and prevent subtly coercive violations from occurring.
- The request by either a patient or a physician to have a chaperone present during a physical examination should be accommodated regardless of the physician's sex. Local practices and expectations differ with regard to the use of chaperones, but the presence of a third party in the examination room can confer benefits for both patient and physician, regardless of the sex of the chaperone. Chaperones can provide reassurance to the patient about the professional context and content of the examination and the intention of the physician and offer witness to the actual events taking place should there be any misunderstanding. The presence of a third party in the room may, however, cause some embarrassment to the patient and limit her willingness to talk openly with the physician because of concerns about confidentiality. If a chaperone is present, the physician should provide a separate opportunity for private

conversation. If the chaperone is an employee of the practice, the physician must establish clear rules about respect for privacy and confidentiality. In addition, some patients (especially, but not limited to, adolescents) may consider the presence of a family member as an intrusion. Family members should not be used as chaperones unless specifically requested by the patient and then only in the presence of an additional chaperone who is not a family member.

- Examinations should be performed with only the necessary amount of physical contact required to obtain data for diagnosis and treatment. Appropriate explanation should accompany all examination procedures.
- Physicians should avoid sexual innuendo and sexually provocative remarks.
- When physicians have questions and concerns about their sexual feelings and behavior, they should seek advice from mentors or appropriate professional organizations (16, 17).
- It is important for physicians to self-monitor for any early indications that the barrier between normal sexual feelings and inappropriate behavior is not being maintained (4, 16, 18). These indicators might include special scheduling, seeing a patient outside normal office hours or outside the office, driving a patient home, or making sexually explicit comments about patients.
- Physicians involved in medical education should actively work to include as part of the basic curriculum information about both physician and patient vulnerability, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting and rehabilitation.
- Physicians aware of instances of sexual misconduct on the part of any health professional have an obligation to report such situations to appropriate authorities, such as institutional committee chairs, department chairs, peer review organizations, supervisors, or professional licensing boards.
- Physicians with administrative responsibilities in hospitals, other medical institutions, and licensing boards should develop clear and public guidelines for reporting instances of sexual misconduct, prompt investigation of all complaints, and appropriate disciplinary and remedial action (19).

Sexual misconduct on the part of physicians is an abuse of professional power and a violation of patient trust. It jeopardizes the well-being of patients and carries an immense potential for harm. The ethical prohibition against physician sexual misconduct is ancient and forceful, and its application to contemporary medical practice is essential.

References

1. Gabbard GO, Nadelson C. Professional boundaries in the physician-patient relationship [published erratum appears in JAMA 1995;274:1346]. JAMA 1995;273:1445–9.
2. Gawande A. Naked. N Engl J Med 2005;353:645–8.
3. Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. JAMA 1998;279:1883–8.
4. Enbom JA, Parshley P, Kollath J. A follow-up evaluation of sexual misconduct complaints: the Oregon Board of Medical Examiners, 1998 through 2002. Am J Obstet Gynecol 2004;190:1642–50; discussion 1650–3; 6A.
5. Campbell ML. The Oath: an investigation of the injunction prohibiting physician–patient sexual relations. Perspect Biol Med 1989;32:300–8.
6. Beauchamp TL, Childress JF. Principles of biomedical ethics. 5th ed. New York (NY): Oxford University Press; 2001.
7. Sexual misconduct in the practice of medicine. Council on Ethical and Judicial Affairs, American Medical Association. JAMA 1991;266:2741–5.
8. American Medical Association. Sexual misconduct in the practice of medicine. In: Code of medical ethics of the American Medical Association: current opinions with annotations. 2006–2007 ed. Chicago (IL): AMA; 2006. p. 255–8.
9. Hall KH. Sexualization of the doctor-patient relationship: is it ever ethically permissible? Fam Pract 2001;18:511–5.
10. Goldie J, Schwartz L, Morrison J. Sex and the surgery: students' attitudes and potential behaviour as they pass through a modern medical curriculum. J Med Ethics 2004; 30:480–6.
11. White GE. Setting and maintaining professional role boundaries: an educational strategy. Med Educ 2004;38: 903–10.
12. White GE. Medical students' learning needs about setting and maintaining social and sexual boundaries: a report. Med Educ 2003;37:1017–9.
13. Spickard A, Swiggart WH, Manley G, Dodd D. A continuing education course for physicians who cross sexual boundaries. Sex Addict Compulsivity 2002;9:33–42.
14. Sexual abuse by physicians. SOGC Policy Statement No. 134. Society of Obstetricians and Gynaecologists of Canada. J Obstet Gynaecol Can 2003;25:862.
15. Gabbard GO, editor. Sexual exploitation in professional relationships. Washington, DC: American Psychiatric Press; 1989.
16. Simon RI. Therapist–patient sex. From boundary violations to sexual misconduct. Psychiatr Clin North Am 1999; 22:31–47.
17. Crausman RS. Sexual boundary violations in the physician-patient relationship. Med Health R I 2004;87:255–6.
18. Searight HR, Campbell DC. Physician–patient sexual contact: ethical and legal issues and clinical guidelines. J Fam Pract 1993;36:647–53.
19. Federation of State Medical Boards. Addressing sexual boundaries: guidelines for state medical boards. Dallas (TX): FSMB; 2006. Available at: http://www.fsmb.org/pdf/GRPOL _Sexual%20Boundaries.pdf. Retrieved January 23, 2007.

Sexual misconduct. ACOG Committee Opinion No. 373. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007; 110:441–4.

ISSN 1074-861X