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Committee on Ethics
This Committee Opinion was developed by the American College of Obstetrician and Gynecologists’ Committee on Ethics in collaboration with committee member David I. Shalowitz, MD, MSHP.

Sexual Misconduct

ABSTRACT: The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The patient–physician 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 by physicians is an abuse of professional power and a violation of patient trust. Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients.

Recommendations and Conclusions

On the basis of the principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Sexual misconduct by an obstetrician–gynecologist is an abuse of power and a violation of patients’ trust. Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution.
- It is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient.
- Physical examinations should be explained appropriately, undertaken only with the patient’s consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients’ exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination.
- It is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing.
- Obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault.
- Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care.
- Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct.
Introduction

The practice of obstetrics and gynecology includes interaction in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The relationship between obstetrician–gynecologists and their patients therefore requires a high level of trust and professional responsibility. The patient–physician 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 by an obstetrician–gynecologist is an abuse of power and a violation of patients’ trust (1).

Although sexual misconduct is uncommon in clinical care, even one episode is unacceptable. The ethical prohibition of sexual misconduct is forceful, and its application in medical practice is essential (2). This Committee Opinion has been revised to incorporate current data on the prevalence of physician sexual misconduct, to delineate ACOG’s expectations for obstetrician–gynecologists’ interactions with their patients to ensure that all patients are cared for safely and professionally (2), and to provide clinical best practice recommendations to support obstetrician–gynecologists’ mission to provide the highest quality health care to their patients.

Background

Definition

The Federation of State Medical Boards categorizes the range of behaviors that constitute sexual misconduct into “sexual impropriety” (behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient) and “sexual violation” (physical sexual contact between a physician and patient, whether or not initiated or consented to by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual) (Box 1) (3). Examination of the breast or genitals without appropriate consent from a patient or surrogate decision maker qualifies as sexual misconduct under both of these categories. Sexual misconduct may be grounds for disciplinary action, and sexual misconduct that falls under the category of sexual violation also may meet the criteria for criminal prosecution (eg, sexual assault). The U.S. Department of Justice defines sexual assault as “any nonconsensual sexual act proscribed by Federal, tribal, or State law, including when the victim lacks capacity to consent” (4). Sexual assault encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to rape (5, 6).

Scope of the Problem

It is difficult to estimate accurately the incidence of sexual misconduct. Available data rely heavily on patient reporting, and it is estimated that less than 10% of patients subjected to sexual misconduct report their experience (7). One prominent report by The Atlanta Journal-Constitution identified 3,100 individual physicians named in sexual misconduct reports brought to state medical boards between 1999 and 2016. The Atlanta Journal-Constitution identified an additional 450 physicians from allegations during 2016 and 2017 (8). Additionally, between 2003 and 2013, 1,039 physicians had at least one sexual misconduct-related report filed with the National Practitioner Data Bank by hospitals, state medical boards, or other eligible entities (9). A review of cases brought to the American Medical Association (AMA) Council on Ethical and Judicial Affairs between 2004 and 2008 found that 32 of 298 cases were related to possible sexual misconduct (10). However, this number may be an underestimate because sanctions related to sexual misconduct may not be identified as such (11).

Limited data suggest that the greatest number of reported allegations of sexual misconduct involves physicians who practice family medicine, psychiatry, internal medicine, and obstetrics and gynecology (12, 13). An analysis of 101 cases of sexual abuse of patients by physicians revealed a strong, consistent association with male physician gender (100% of cases), age more than 39 years (92%), lack of board certification (72% of cases involving “nonconsensual sex”), consistent examination of patients without a chaperone (85%), and practice in nonacademic medical settings (94%) (14).

Sexual misconduct by clinicians during labor and delivery may be more prevalent than previously thought. A large survey of U.S. and Canadian obstetric support personnel raised concern that clinicians may at times use sexually degrading language with laboring women or perform genital examinations or procedures without appropriate consent or despite the patient’s refusal (15). Again, although sexual misconduct during obstetric care likely is uncommon, the experience of sexual violation during childbirth may be associated with long-lasting consequences for patients’ mental health. Intimate examinations and procedures performed without consent or under circumstances perceived by the patient to be coercive are associated with psychological trauma during childbirth (16, 17). Likewise, patients may find being physically exposed to more personnel than necessary for their clinical care during childbirth to be a dehumanizing and traumatic experience (16). Patients who experience childbirth as a traumatic event are at high risk of developing depression and posttraumatic stress disorder in the postpartum period (18). Although the interpretation and generalizability of these data are limited by the studies’ methods, patients’ vulnerability to perceived sexual violation during childbirth deserves special consideration, especially given the sometimes intensive and acute nature of intrapartum care.
Ethical and Professional Guidelines

Romantic or Sexual Relationships With Current Patients

Sexual or romantic interaction between an obstetrician–gynecologist and a current patient is always unethical, is grounds for investigation and sanction, and in some cases should be considered for criminal prosecution. Such interactions may exploit patients’ vulnerability, compromise physicians’ ability to make objective judgments about patients’ health care, and ultimately be detrimental to patients’ long-term health (19, 20). Furthermore, an uncomfortable or traumatic experience in a physician’s office may become a major barrier to seeking needed health care in the future.

Box 1. Examples of Physician Sexual Misconduct From the Federation of State Medical Boards

Sexual Impropriety

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient that may include, but are not limited to, the following:

- Neglecting to employ disrobing or draping practices respecting the patient’s privacy, or deliberately watching a patient dress or undress
- Performing an intimate examination or consultation without clinical justification or appropriate consent
- Subjecting a patient to an intimate examination in the presence of medical students or other parties without the patient’s informed consent or in the event such informed consent has been withdrawn
- Examination or touching of genital mucosal areas without the use of gloves
- Inappropriate comments about or to the patient, including but not limited to, making sexual comments about a patient’s body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient’s sexual orientation, making nonclinically relevant comments about potential sexual performance during an examination
- Using the patient–physician relationship to solicit a date or romantic relationship
- Initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation

Sexual Violation

Sexual violation may include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any contact with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to the following:

- Sexual intercourse, genital-to-genital contact
- Oral-to-genital contact
- Oral-to-anal contact, genital-to-anal contact
- Kissing in a romantic or sexual manner
- Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or when the patient has refused or has withdrawn consent
- Encouraging the patient to masturbate in the presence of the physician*

Box 1. Examples of Physician Sexual Misconduct From the Federation of State Medical Boards (continued)

- Masturbation by the physician while the patient is present
- Offering to provide practice-related services, such as drugs, in exchange for sexual favors

*ACOG recognizes the value of physician-guided sexual health counseling in the proper clinical context by an appropriately trained provider.

physician may be a manifestation of a transference reaction related to gratitude for clinical care (22, 23). For these reasons, a patient’s apparent consent to enter into a romantic or sexual relationship with a treating physician does not make the relationship permissible.

**Romantic or Sexual Relationships With Former Patients**

Consensual romantic or sexual relationships between physicians and former patients are ethically challenging because of the potential for these relationships to be unduly influenced by the power dynamic accompanying the former patient–physician relationship. The Committee on Ethics agrees with the AMA that it is unethical for obstetrician–gynecologists to misuse the trust, knowledge, or influence from a professional relationship in pursuing a sexual or romantic relationship with a former patient (21). For example, it would be unethical for an obstetrician–gynecologist to coerce a former patient into a romantic or sexual relationship under the threat of disclosing private information obtained during treatment. Treating a person who is not a current patient, but with whom the obstetrician–gynecologist has a current romantic or sexual relationship, may not be sexual misconduct but instead may violate ethical prescriptions against treating family members (24).

**Obligation to Report Misconduct**

In addition to involving harm to the victim, an episode of sexual misconduct may not be isolated and could indicate a history of misconduct toward other patients or a risk of future misconduct. Furthermore, physician misconduct damages public trust in medical professionals. The ACOG Code of Professional Ethics states that “obstetrician–gynecologists should strive to address through the appropriate procedures the status of those physicians who demonstrate questionable competence, impairment, or unethical or illegal behavior. In addition, the obstetrician–gynecologist should cooperate with appropriate authorities to prevent the continuation of such behavior” (1). Therefore, to protect patients and colleagues, obstetrician–gynecologists are obligated ethically and professionally to report sexual misconduct or suspected sexual misconduct by any health care professional to appropriate authorities, such as supervisors, department chairs or other institutional officials, peer review organizations, and professional licensing boards. Law enforcement should be involved in cases of sexual or physical assault (see the “Definition” section earlier in this document). Additional guidance on reporting unethical behavior by colleagues is available from the AMA and the Federation of State Medical Boards (25–27).

**Best Practices for Clinical Care**

The American College of Obstetricians and Gynecologists is invested in ensuring that the standards for an obstetrician–gynecologist’s behavior in a clinical encounter are transparent. In some situations, patients may have experienced sexual misconduct as part of an obstetric or gynecologic encounter but not recognized or reported it as such. Conversely, patients may perceive an interaction as sexual or romantic when in fact there was no such intent on the part of the obstetrician–gynecologist. The following clinical best practices are recommended to decrease the risk of misunderstandings related to the provision of appropriate clinical care and to increase patients’ ability to recognize and report inappropriate interactions in the clinical setting.

**Maintaining Appropriate Boundaries**

Regardless of intent, any clinical or nonclinical contact with a patient that may be perceived as a romantic or sexual overtone should be avoided. For example, clinical evaluation of a patient outside of a usual clinical setting may blur the boundaries between professional and nonprofessional interactions and, therefore, is discouraged; however, exceptions may include emergency care or a medically indicated home visit. Likewise, obstetrician–gynecologists should strictly avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks in professional settings. Nonclinical communication with current patients, including interactions by telephone, e-mail, text-messaging, or social media, should be approached with caution, and professional boundaries should be maintained at all times (28).

Under some circumstances, limited physical contact between physician and patient (eg, hugging or holding a patient’s hand) may be a valuable, therapeutic expression of support. However, obstetrician–gynecologists should be careful to ensure that patients are open to such contact and that its duration is appropriately limited. If inappropriate contact is initiated by a patient, obstetrician–gynecologists should feel empowered to separate themselves from the patient, reinforce professional boundaries, and request assistance if needed.

**Physical Examinations**

Physical examinations should be explained appropriately, undertaken only with the patient’s consent, and performed with the minimum amount of physical contact required to obtain data for diagnosis and treatment. Draping should be used to minimize patients’ exposure during examinations. Patients should be offered the opportunity to ask questions or raise concerns about any element of the examination. The Committee on Ethics re-emphasizes that patients capable of decision making must provide consent for all procedures, and that patients have the right to refuse any and all examinations and procedures (29). Best practices for physical examination also apply to diagnostic tests involving instrumentation of the genital, urinary, or lower gastrointestinal tracts, such as transvaginal ultrasonography or urodynamics.
Photography and Video Recordings

Patients must consent to any photograph or video taken of them, and consent should be documented in the medical record. Photographs of pathology and unclothed or internal anatomy must be de-identified to the extent possible and used only for clinical documentation or academic purposes, including education of colleagues and trainees and publication in peer-reviewed medical literature. Identifiable images should be stored and sent (if necessary) in a secure manner, and images no longer being used for the above purposes should be destroyed securely.

Trauma-Informed Care

For some patients with a history of sexual trauma, even commonly used gestures and language may trigger memories of past physical or sexual abuse and may cause discomfort or fear during a clinical encounter. Because trauma often involves an experience of powerlessness, it is important to refrain from behaviors that a patient may perceive as overpowering or threatening (30–33). Common triggers include leaning over a patient during a discussion or pelvic examination, using commands such as “try to relax” before an internal examination, and exposing or touching parts of a patient’s body during a physical examination without adequate warning (32, 33). All obstetrician–gynecologists should become familiar with the principles of trauma-informed care and seek to integrate them into general practice (34). Issues related to the care of survivors of sexual abuse, intimate partner violence, and reproductive and sexual coercion are detailed in other ACOG documents (35–37).

Chaperones

The presence of a third party, or “chaperone,” in the examination room can provide reassurance to the patient about the professional context and content of the examination and the intent of the obstetrician–gynecologist. The chaperone also serves as a witness to the events taking place should there be any misunderstanding or concern for misconduct. In the obstetric setting, chaperones may decrease the risk of patient-perceived trauma during childbirth by advocating for patients and serving as a deterrent to potentially inappropriate behavior. The American College of Obstetricians and Gynecologists previously recommended an “opt-in” approach regarding the presence of chaperones, in which a chaperone was required if mandated by a clinical practice’s policy or if requested by the patient or obstetrician–gynecologist. Given the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone, ACOG now believes that the routine use of chaperones is needed for the protection of patients and obstetrician–gynecologists. Therefore, it is recommended that a chaperone be present for all breast, genital, and rectal examinations. The need for a chaperone is irrespective of the sex or gender of the person performing the examination and applies to examinations performed in the outpatient and inpatient settings, including labor and delivery, as well as during diagnostic studies such as transvaginal ultrasonography and urodynamic testing. Chaperones currently are required by the U.S. Veterans Health Administration health care system, and routine use of chaperones is considered essential by the Royal College of Obstetricians and Gynaecologists (38, 39).

Exceptions should be made in circumstances in which it is likely that failure to examine the patient would result in significant and imminent harm to the patient, such as during a medical emergency. If a patient declines a chaperone, it should be explained that the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible. If, after counseling, the patient refuses the chaperone, this decision should be respected and documented in the medical record. Under such circumstances, obstetrician–gynecologists may defer breast, genital, or rectal examinations for the protection of the patient and the physician. If an unchaperoned examination is performed, the rationale for proceeding should be documented. This approach allows patients to opt out of a chaperoned examination if they feel strongly but does not compel physicians to examine the patient without the protection of a chaperone, except in the case of a medical emergency, as discussed previously.

Chaperones should clearly understand their responsibilities to protect patients’ privacy and the confidentiality of health information. Obstetrician–gynecologists also should ensure that an opportunity exists for private conversation with patients so that the presence of a chaperone does not inhibit the communication of information important to the clinical encounter. Although chaperones may deter or discourage sexual misconduct by physicians (14), sexual misconduct still can occur in their presence. Chaperones should, therefore, be trained in the requirements of best clinical practices as stated previously and empowered to report concerning behavior through a process independent of the health care provider being chaperoned. Family members should not be used as chaperones and should be present for physical examination only if requested by the patient (40). Use of trainees (eg, medical students or residents) as chaperones generally is discouraged unless they are trained in appropriate clinical practices and empowered to report concerns about the health care provider’s behavior during an examination.

Implementation of Routine Chaperoning

The Committee on Ethics recognizes that recommending the routine use of chaperones for obstetric, gynecologic, and diagnostic examinations may require some practices
to adjust staffing procedures. There also may be concern about the time and resources needed to implement changes and their potential effect on patient care. Although these concerns merit study, there is robust evidence of the detrimental effects of sexual misconduct on patients’ well-being, the patient–physician relationship, and public perception of the medical profession. Therefore, there is a need for obstetrician–gynecologists and clinical practices to institute routine chaperoning as an ethical best practice measure to reduce the risk of sexual misconduct (41). Steps taken to prioritize patients’ safety and comfort likely will improve public trust in obstetric and gynecologic care and may thereby improve patients’ willingness to seek care when indicated.

Institutional Responsibilities

Examination areas should protect patients’ privacy, and staffing should be adequate to permit routine use of chaperones for physical examination and procedures. Institutions and clinical practices also should consider providing patients with a “what to expect” guide before obstetric or gynecologic appointments so that patients are prepared for their clinical encounters and better able to recognize deviations from proper medical practice. For example, see ACOG’s related patient education resource, Your First Gynecologic Visit (42).

Institutions should have clear guidelines that allow clinical staff to report sexual misconduct or suspected sexual misconduct without concern for retaliation. Patients, family members, and loved ones should have the opportunity to express concerns about interactions with clinical staff without fear of adversely affecting clinical care. All such reports should be promptly and thoroughly investigated, and appropriate disciplinary or remedial action, or both, should be taken.

Medical Education

Teaching physicians are expected to be exemplars of appropriate behavior for trainees; likewise, residents and fellows-in-training should model best practices for medical students and other trainees. Relevant elements of the clinical examination should be highlighted specifically when appropriate (eg, draping methods, explanation of examination to patient, use of trauma-sensitive language, appropriate use of chaperones, and solicitation of questions and permission to proceed with an examination). Trainees taking part in patient care should be introduced, and the patient should be given the opportunity to agree to the participation. Breast, genital, and rectal examinations (including examinations under anesthesia) that are for educational purposes only may not be performed without patients’ specific informed consent (43).

Medical students and trainees in obstetrics and gynecology should be educated about the inherent power imbalance in the patient–physician relationship, avoidance of sexually offensive or denigrating language, risk factors for sexual misconduct, and procedures for reporting suspected misconduct (44–47). Although education may not eliminate the possibility of misconduct, formalized clinical and didactic training will help to make best clinical practices routine and may assist obstetrician–gynecologists in managing the boundaries between clinical care and inappropriate behavior and in identifying and reporting when these boundaries have been crossed by others.

Conclusion

Sexual misconduct by physicians is an abuse of professional power and a violation of patient trust. Such behavior jeopardizes the well-being of patients and carries immense potential for harm. Obstetrician–gynecologists should implement best clinical practices to ensure that patients are afforded a safe environment for their health care. Routine use of chaperones, in addition to the other best practices outlined in this Committee Opinion, will help assure patients and the public that obstetrician–gynecologists are maximizing efforts to create a safe environment for all patients. Obstetrician–gynecologists are ethically obligated to model responsible clinical practices and to report sexual misconduct or suspected sexual misconduct. Health care institutions, likewise, should provide resources to support best clinical practices and to ensure that patients are protected to the greatest extent possible.

References


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