Clinical Review

Physician-Patient Sexual Contact: Ethical and Legal Issues and Clinical Guidelines

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Although sexual relationships between mental health professionals and patients have been the subject of research, ethical writing, and legislation during recent years, there has been comparatively little attention given to this problem in primary care medicine. An estimated 11% of family physicians have had sexual contact with at least one of their patients. Recently, the American Medical Association presented ethical guidelines addressing this issue. Acceptable conditions under which a physician may become involved with a former patient are not well addressed by these guidelines. Although sexual involvement with patients appears to exist on an ethical continuum, it inevitably results in diminished patient autonomy. Sexual contact between patients and mental health professionals is now explicitly illegal in many states, but comparable legislation has not been enacted for nonpsychiatric physicians. There is evidence that when sexual contact between a physician and a patient occurs, the patient suffers long-term psychological consequences.

Key words. Physician-patients relations; primary care; sex; sexual partners; countertransference. (*J Fam Pract 1993; 36:647-653*)

Sexual involvement between physicians and their patients represents one of several ways in which the boundaries of the physician-patient relationship become blurred. Other examples of boundary breakdowns include economic (the physician who invests in a patient's business) and social (the physician who plays golf with a patient). Although these "dual relationships" are cautioned against in psychiatry, they are not explicitly forbidden for nonpsychiatric physicians. For family physicians, extraprofessional social involvement with patients is more likely to occur. Socializing with patients outside the office is particularly common among physicians practicing in small communities and rural areas.[1] In addition, family physicians are likely to have a closer relationship with their patients than other medical specialists. As Balint[2] suggests, many patients consider their primary care physician to be a family friend or similar to a distant relative. As a result, the physician-patient boundary is less clear than for mental health professionals.

In the past 10 years, sexual relationships between mental health professionals and their patients have been the focus of considerable legal and ethical attention.[3,4] However, this issue has only begun to be addressed among nonpsychiatric physicians.[1,5,6] Although data are limited, the prevalence of patient sexual contact, as well as the emotional sequelae for patients, appears similar among both primary care physicians and psychiatrists. Ethical and legal exploration of this issue, however, is still in the early stages.

This paper examines the ethical, legal, and psychosocial aspects of sexual contact between patients and physicians. Current trends suggest that in future these relationships will become a prominent ethical issue in primary care. At present, there are considerably fewer prevalence data available about sexual contact with patients for nonpsychiatric physicians as compared with mental health professionals. A recent survey suggests, however, that sexual contact with patients is as prevalent among family physicians as among mental health professionals.[6] Although family medicine has only begun to explore this issue, the more established body of mental

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health law and ethical writing is likely to have implications for primary medical care. Therefore, research and ethical writing on patient sexual involvement with psychiatrists and clinical psychologists will serve as a foundation for examining the implications of similar relationships in family medicine.

Contemporary Context

Recognition of Sexual Misconduct

Sexual contact between primary care physicians and patients is likely to become a prominent legal and ethical issue for several reasons. First, the growing consumer rights movement has contributed to a more critical and less passive public stance toward all professionals.[7] Two surveys of family physicians conducted almost 20 years apart suggest that the prevalence of sexual involvement with patients has not markedly increased during this time.[6,8] However, patients appear to be less protective of and less intimidated by physicians. This pattern is evident in other helping professions such as the ministry. Sexual harassment claims filed by parishioners against clergy have increased dramatically in recent years. Although the prevalence of sexual contact between pastors and members of their congregation has probably not increased, public protectiveness of the clergy has diminished markedly.[9]

Second, there is an increased awareness of sexual abuse, including sexual harassment, child abuse, and sex crimes such as date rape. An issue that is particularly important to family physicians is the recent rapid criminalization of sexual involvement between mental health professionals and current as well as former patients.[10,11] In a growing number of states, psychiatrists and psychologists can be criminally prosecuted for sexual contact with patients under statutes that resemble those for child sexual abuse in both content and intent. At present, psychiatrists are the only group of physicians who are specifically named in these statutes. Primary care physicians who provide psychiatric care such as counseling or psychotropic medication, however, are likely to be subject to these laws in the near future.

Third, the professions, including medicine, appear to have become more active in detecting and treating their own impaired members. The American Medical Association, as well as many regional medical organizations,[1] are increasingly attending to physicians at risk. Recently, the American Medical Association published a position paper on sexual misconduct in clinical practice.[5] This report highlighted the importance of including the topic of sexual misconduct in medical education as well as encouraging physicians to report offending colleagues to licensing boards.[5]

Table 1. Results of Two Surveys Assessing Prevalence of Sexual Involvement Between Physicians and Patients, by Specialty

Specialty	Prevalence, %	
	Gartrell et al (1992)[6]	Kardener et al (1973)[8]
Family (general) practice	11	14
Internal medicine	6	11
Obstetrics-gynecology	10	15
Surgery	9	7

Prevalence

If one generalizes from the reports of psychotherapists, sexual attraction to a patient is a very common experience.[12] Surveys of mental health professionals indicate that up to 80% report being sexually attracted to a patient at some point in their career. Overall, male therapists were somewhat more likely than their female colleagues to report being attracted to a patient. When age was controlled, however, as in the survey by Pope and Bouhoutsos,[12] there were no sex-based differences; only older female therapists were somewhat less likely to report being attracted to a patient. Although approximately 8% of psychotherapists in that survey had been sexually involved with a patient, nearly 20% had considered it.

At present, there is less known about the prevalence of sexual contact between nonpsychiatric physicians and their patients. The two physician surveys mentioned earlier[6,8] that span nearly 20 years have produced generally consistent findings, which are summarized in Table 1. In an anonymous mail survey conducted in 1990 by Gartrell and colleagues,[6] the percentage of physicians from four different specialties who acknowledged sexual contact with patients averaged approximately 9%. The majority of physicians who had sexual relationships with patients had been involved with only one patient; 42% had been involved with more than one patient. Most of these physician-patient relationships reportedly lasted less than 12 months. When the likelihood of underreporting this behavior is taken into account, physician-patient sexual involvements appear to be fairly common.

Thus, although formal legal charges of physician sexual misconduct are relatively rare, sexual contact is not. Current surveys of nonpsychiatric physicians would be of value in further clarifying the frequency and extent of this behavior.

Ethical Background

From an historical perspective, prohibition of physicians' sexual contact with patients dates to 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 relationships with both female and male persons, be they free or slaves."[13] However, the issue has received relatively little attention until recently. The development of primary and tertiary care specialties has led to physician-patient relationship issues and ethical dilemmas unique to each sector. Brody[14] distinguishes between the relational ethic governing primary care and the decisional ethic governing tertiary care. Decisional ethics often govern the time-limited physician-patient relationship that develops during an acute care episode involving subspecialists. After a focal decision is made and a procedure performed, there is no ongoing contact between the physician and patient. In primary care, however, decisions are made in the context of long-term physician-patient contact in which preservation of the relationship is an important dimension. In keeping with this relational emphasis, Brody[15] notes that a key goal in primary care ethics should be the enhancement of patient autonomy even when temporarily reduced by illness. Sexual contact with a patient is both an infringement on patient autonomy and an abrogation of the unspoken social contact that exists within the healing relationship.[14,15]

A fundamental issue in any dual relationship (whether social, financial, or sexual) between a physician and his or her patient is that both parties are rarely equals in the exchange. In the course of clinical encounters, psychological issues of authority, dependence, responsibility, and trust may be elicited, either directly or indirectly.[16] Patients may experience attraction to their physician but it is important to recognize that these feelings are often "transferential" and are not a reaction to the current "real life" situation. Instead, they represent past unresolved issues often associated with parental figures.[2,16] Because of the authority and caregiving dimensions of the physician's role and the simultaneous dependence and vulnerability frequently associated with the role of patient, these transferential dynamics are very likely to occur in clinical encounters. Furthermore, the physical and emotional vulnerability of patients in relation to their physicians makes it difficult for patients to provide truly informed consent to sexual involvement.[5] The emotional and interpersonal dynamics of this situation are similar to those in which childhood incest and sexual abuse occur.[1,5] Although physicians do not consciously provoke these reactions in their patients, the physician is responsible for monitoring these transferential dynamics and responding in a professional manner.

Similarly, physicians may have strong emotional reactions to patients. This "countertransference" may be manifested through physician attraction to a patient. Attraction to a patient appears to be a very common experience,[8,12] but most physicians are able to make the distinction between normal sexual feelings and inappropriate actions. Early indicators that the physician is not maintaining this distinction may not be readily apparent. Although special scheduling, seeing a patient outside the office when it is not necessary, or driving a patient home may be motivated by particular concern for a vulnerable patient, these behaviors should alert the physician to reflect upon his or her motives.[1] More subtle clues of possible countertransference include inquiring about a patient's sexual preferences and sexual performance, and obtaining a detailed sexual history when it is not relevant to the presenting complaint.[1]

The physician's own past family dynamics and current relationships are likely to contribute to these personalized, intense responses to patients. For physicians-in-training, Balint groups, which focus on physicians' emotional reactions to patients, provide a supportive context for examining these issues.[2,16] Balint groups encourage residents to label and understand feelings that arise during clinical encounters. Participation in a Balint group during training is likely to reduce physician countertransference in the physician-patient relationship. Balint training also encourages physicians to be more introspective and identify the interpersonal dynamics that occur in their interactions with patients.[2]

Relationships with Former Patients

If the family physician adopts the prohibition against sexual involvement with patients at any time during the course of professional contact, there remains the issue of when the physician-patient relationship ends.

Ethically, there is considerable ambiguity surrounding whether it is permissible to become sexually involved with a former patient. A recent survey found that 63% of physicians viewed sexual contact with a former patient as acceptable if treatment had ended.[6] However, the acceptable interval between ending the professional relationship and initiating the involvement has not been specified. For mental health professionals, some states recently have passed laws specifying a time frame after which a psychotherapist and a former patient may become involved without legal repercussions. Although some states, such as Florida, view the psychotherapist-patient relationship as "deemed to continue in perpetuity,"[11] California's law contains a 2-year period and Colorado

law refers to a 6-month period.[11] No comparable statutes have been enacted for nonpsychiatric physicians, but a 2-year period between the last episode of patient care and the initiation of the social relationship has been recommended.[6] During this 2-year interim, social and professional contact with the former patient is prohibited.[6]

The issue of post-therapy involvement with patients continues to be hotly debated by psychiatrists and psychologists. Many psychotherapists note that they are frequently recontacted by patients years after treatment has ended. Questions have been raised about whether it is ever ethically appropriate to become sexually involved with a former patient. Family physicians often know a great deal about a patient's personal history, as well as his or her current emotional status, and the physician may also treat family members.[1,5] It would be difficult for a physician not to use this knowledge in the course of a personal relationship with a former patient if one were to develop. Conversely, the family physician may not be aware of important psychosocial information about the patient, such as a history of childhood sexual abuse, that may render him or her vulnerable to sexual exploitation by an authority figure.[1,6] Research with psychotherapists has suggested that patients experience strong feelings toward their therapist for 5 to 10 years after treatment.[4,11,12] In the survey of physicians by Gartrell et al,[6] 37% opposed sexual relationships with former patients. The American Medical Association has stated: "Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the professional relationship."[5] It has been recommended that psychologists and psychiatrists consult with a colleague before initiating a sexual relationship with a former patient to obtain a more objective assessment of potential patient harm. For primary care physicians, a similar guideline has been suggested.[6] The consultant could be a physician colleague or mental health professional.

Psychosocial Dimensions of Physician-Patient Sexual Relationships

Reasons for Sexual Contact with Patients

It has been suggested that physicians who engage in sexual relationships with patients are younger and less experienced; available data, however, suggest that sexual contact is more prevalent among older, experienced physicians. In the survey of Kardener et al,[8] 42% of the respondents were between 40 and 49 years old and 33% between 50 and 59 years old; 67% had been in practice for over 10 years. Similar demographic data are reported for psychotherapists who become sexually involved with patients, with the modal therapist being 40 to 50 years of age and having considerable professional experience.[12,17]

Kardener and colleagues surveyed physicians' attitudes with the question, "Under what circumstances might erotic behavior be utilized in treatment?" In response, several physicians offered comments supporting sexual contact such as: to help patients' recognition of their sexual status; for specific sexual problems (by being a normal partner); to demonstrate there is no physical cause for absence of libido; for teaching sexual anatomy; especially in the case of a depressed middle-aged woman who feels undesirable; and to relieve frustration in a widow or divorcee who "hasn't yet re-engaged in dating."[8]

However, these rationales are not supported by the vast majority of physicians.[6] Over 95% of more than 1800 physicians recently surveyed indicated that sexual contact with a patient is not appropriate for treating sexual dysfunction, enhancing a patient's self-esteem, or changing his or her sexual orientation.[6] Little is currently known about the conditions under which physicians become sexually involved with patients. Among psychotherapists, however, there are suggestions that sexual exploitation is more likely to occur when the caregiver is experiencing a life crisis such as bereavement or divorce and is emotionally vulnerable.[17-19] In addition to feelings of loneliness and emotional neediness, substance abuse by the provider also appears to play a role in this behavior.[12,17] At the same time, there are suggestions that these providers rely on defenses such as denial and rationalization. This defensive pattern is compatible with reports that health care providers who become involved with patients minimize the impact of their actions on the patient's well-being.[17-20]

Educational Contexts

Sexual attraction and involvement with patients are issues that are typically not addressed in medical education.[1,5] The relatively nonthreatening classroom setting is a natural context for discussing the normal experience of being attracted to a patient and the unacceptable response of initiating sexual contact. There are suggestions, however, that sexual exploitation of patients may be behavior that was modeled by educators during professional training.

Surveys of psychology doctoral trainees conclude that between 10% and 20% have been subject to sexual overtures from one of their graduate instructors.[21,22] A survey of a Canadian medical school found that 46% of women and 19% of men had experienced sexual harass-

ment by an educator.[1] Based on a survey of fourth-year psychiatric residents, Gartrell and colleagues[23] concluded that about 6% of female residents and 4% of male residents had been sexually involved with a supervising psychiatrist during their residency. It was noted that female residents were an average of 15 years younger and male residents an average of 3 years younger than the psychiatrists with whom they were involved.

Psychological Sequelae for Patients

There is increasing evidence that sexual involvement between patients and health care providers has long-term adverse psychosocial impact similar to rape or incest.[12,17,24] The absence of truly informed consent by the patient, who is by definition vulnerable, has led a number of researchers to equate sexual involvement with assault or victimization. Feldman-Summers and Jones[24] interviewed and administered a number of psychological measures to women who had experienced sexual contact with both psychiatric and nonpsychiatric health care professionals. Common symptoms associated with the sexual contact included increased depression and psychosomatic symptoms, as well as greater anger and distrust toward men.[24] Other common symptoms may include drug and alcohol abuse, sexual confusion, and difficulty in trusting others.[1] The adverse impact for patients may be greater if the provider is married, possibly because of the guilt associated with an extramarital affair.[24]

Studies of psychotherapy patients have documented that the negative effects of sexual involvement with a therapist last for several years and include psychiatric hospitalization and marital deterioration.[12] Of these psychotherapy patients, 90% experienced serious adverse sequelae that resembled post-traumatic stress disorder including panic attacks, extreme guilt, flashbacks, and self-destructive feelings.[12] Recent state laws reflect the perception that sexual involvement with a health care provider is akin to childhood incest perpetrated by a parent.[1,12] Common to both situations is that a trusted authority figure engages in exploitative sexual contact with someone in a vulnerable, dependent position.

Legal Implications for Family Physicians

For psychiatrists and psychologists, sexual involvement constitutes one of the most common sources of malpractice litigation.[3,17] Many liability insurance policies for psychotherapists specifically place narrow limits on the extent of coverage for sexual misconduct.[3,17]

At least 20% of primary care clinic patients exhibit a psychiatric disorder.[25–27] Thus, family physicians are likely to treat far more psychiatric patients than many psychiatrists. While current laws in the United States apply only to psychiatrists, it is very likely that primary care patients could bring successful litigation against family physicians who were treating their psychiatric condition and became sexually involved with them over the course of treatment.[10] The rationale behind a successful legal suit would be that the family physician was the functional equivalent of a psychiatrist.

From a strictly legal perspective, primary care physicians should be aware that they may soon be held to a standard similar to that for their colleagues in psychiatry. Psychiatrists have consistently been found legally at fault when they have had sexual relationships with consenting adult patients outside the office during the period when the patients were in therapy.[10,12] As noted earlier, some states have enacted legislation specifying the time after the termination of treatment during which sexual contact is illegal.

While a lifetime prohibition against sexual involvement with a patient is not legally supported, family physicians should become aware of ethical, legal, and clinical information about the impact of sexual involvement on patients.

Table 2. Ethical Guidelines for Physician-Patient Sexual Involvement

- Sexual relationships with current patients are unethical.
- Sexual relationships with former patients may be unethical.
- Before becoming involved with a former patient, consider the possibility of undue influence, and psychological impact upon patient.
- An extended interval (eg, 2 years) should elapse before becoming involved with a former patient.
- If unsure about a relationship's impact on a former patient, consult with a colleague.

Conclusions and Recommendations

Ethical guidelines for physician-patient sexual involvement are summarized in Table 2. Sexual involvement with a patient currently in treatment is unethical and under certain circumstances may be illegal.[1,4] Terminating the physician-patient relationship for the specific purpose of initiating an immediate sexual relationship is also unethical. Sexual relationships with former patients may be unethical. Before becoming involved with a former patient, it is recommended that physicians consult with colleagues to determine whether undue influence derived from the previous relationship is a factor.[5]

Physician colleagues engaged in sexual misconduct should be reported to their local medical society or state licensing board. The survey by Gartrell and colleagues[6] found that 23% of physicians had at least one patient who had reported sexual contact with another physician. Surveys of psychiatrists found that, whereas 65% reported treating a patient who had been sexually involved with a previous therapist, only 8% formally reported the misconduct.[28] Similar to the intent of child abuse reporting laws, it has been recommended that physicians who report a colleague's sexual misconduct have the option to remain anonymous and be protected from legal repercussions.[5] Physicians should be encouraged, if not legally mandated, to report sexual misconduct.

It is likely that current attention to this issue will prompt reflection by physicians who in the past have been sexually involved with patients. Survey data suggest that the majority of physicians who have had sexual contact with their patients recognize the adverse psychological impact of these relationships.[6] There are also suggestions, however, that a substantial proportion of providers who have been sexually involved with one patient go on to become involved with multiple patients.[6,12] Research with psychologists suggests that providers who are sexually intimate with multiple patients are likely to be experiencing psychological distress.[12] Thus, it is recommended that physicians who have been sexually involved with more than one previous patient seek counseling or psychotherapy. Programs for distressed physicians operated by state or local medical societies may be an initial contact for these doctors.

For those physicians currently involved with a patient, several steps are recommended. First, the physician-patient relationship should be terminated and the patient referred to another physician for medical care. Second, the potential adverse effects of the dual relationship should be discussed only with the partner. Third, if the relationship is significant and both parties desire its continuation, it is recommended that the couple enter brief conjoint counseling to explore the issue with a neutral third party and resolve any emotional "carryover" from the previous physician-patient relationship.

Medical education and clinical training should include attention to the issue of sexual involvement with patients. While sexual attraction to patients is fairly common, acting on these feelings is inappropriate and harmful to patients. It has been suggested elsewhere, however, that denying or minimizing feelings of attraction to a patient increases the likelihood of sexual acting out.[19]

In comparison with other medical specialties, the family physician's role in relationships to patients has historically been a closer one. The potential for harming the physician-patient relationship by acting on such feelings of closeness is high; nevertheless, as recent survey data suggest, this frequently occurs. Balint training has been a useful method for family medicine residents to examine roles, boundaries, and their emotional reactions to patients. The context of teaching is also a good setting in which residents and medical students can reflectively examine this issue. Sexual misconduct by physicians and its impact on patients should be included in medical school curricula. This topic should also be part of continuing education programs for practicing physicians.

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