Perspective

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Can we be complacent about sexual misconduct in the medical profession?

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"Whatever houses I may visit, 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". Hippocratic Oath (4th century BC)

The sexual relationship between teacher and student, employer and employee, subordinate and superior, or therapist and client, irrespective of the consensuality, will inevitably be sexual misconduct as there is a breach of trust and power imbalance (1). Similarly, if a doctor concurs sexually with their patient, it is ethically transgressional due to the breach of trust and power imbalance (2,3). In Sri Lanka, sexual harassment is a criminal offence under Section 345 of the Penal Code (4), and occasionally, sexual misconduct committed by a doctor can be legally contested as sexual harassment (5). Thus, as sexual misconduct ensues serious legal implications and impacts on the profession, this article will review the available scientific evidence on the prevalence, complications, and factors that contribute to the sexual relationship between doctors and their patients, and how psychiatrists are vulnerable to this misdemeanour.

Defining sexual misconduct

Any behaviour that exploits the doctor-patient relationship in a sexual way (verbally, physically, virtually, or any behaviour involving the expression of thoughts, feelings, or gestures that are sexual) or if a patient or surrogate (the patient's immediate family member or bystander) is reasonably construed as sexual, is an act of sexual misconduct (6,7). In addition, 'gift-giving', special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient's trust and acquiescence to subsequent abuse, are subtle forms of sexual misconduct (7).

Sexual misconduct and breach of ethical principles

The unique relationship between doctor and patient serves as a basis for the provision of medical care (8). This relationship typifies inequality (i.e., imbalance of power) as the patient has to depend on and be bestowed upon the knowledge and expertise of the doctor for their health status (8). In other words, the patient is deemed to trust the doctor. Of note, beneficence, nonmaleficence, and autonomy are three ethical principles intricately associated with trust (i.e., in addition to power balance and consent), and hence, if a doctor engages sexually with a patient, the aforementioned ethical principles will be inevitably violated regardless of the consensuality (3,7).

Sexual contact with former patients and family members

The Council on Ethical and Judicial Affairs of the American Medical Association (AMA) proscribes sexual or romantic relationships with former patients (9). However, the ethical codes to determine the propriety of sexual relationships with former patients differ across various governing bodies for professional conduct (2,10), and are based upon the maturity and decision-making capacity of the patient, the amount of time that elapsed since the cessation of the therapeutic relationship, the nature and intensity of the service, and most importantly, the potential for the physician to exploit the trust, knowledge and dependence that developed during the professional relationship (11,12).

The definition of sexual misconduct extends to the relationship between a doctor and family members or others whose involvement in the treatment and welfare of a patient (e.g., a mother seeking medical advice from her child's physician (11). Family members or others directly involved with the patients should be considered as patients too, and hence, all ethical principles applied to patients will be applied to them as well (13).

Prevalence of sexual encounters with patients

An accurate estimate of the prevalence of doctor-patient sexual relationships is unattainable due to the high number of doctors declining to take part in self-reported surveys (14), nevertheless, the prevalence of sexual encounters between doctors and patients revealed by such anonymous surveys is remarkable. The US studies conducted in 1973, 1992 and 1996, portray the prevalence rates of doctor-patient sexual contacts as 7.2%, 9.3% and 3.3% respectively (15,16,17). In a Dutch study, 3.6% of gynaecologists and 3.5% of otolaryngologists reported sexual contact with patients (18). In Israel, 14.5% of doctors admitted sexual engagements with patients (19). In New Zealand, a study revealed, that 3.8% of the sample of general practitioners reported sexual contact with a patient (20). Finally, in the Netherlands, a randomised sample of 1250 general practitioners, of whom 977 responded, 3.3% admitted to having a sexual relationship with a patient, and out of them, 34% had at least two or more sexual engagements (21). It is noteworthy, that among the cases disciplined by the state medical boards due to sexual misconduct, male doctors, gynaecologists and psychiatrists were overrepresented (22,23,24,25,26). Furthermore, most of the accused were over 39 years old and repeatedly involved with multiple patients for over a year (21,27,28).

Complications

Incidents and severity of harm to victims of sexual misconduct by health professionals have been a matter of opinion and often, objectively immeasurable (29). Nevertheless, the empirical evidence affirms that 90% of cases of sexual encounters with health caregivers perceived it negatively, and in some, lasting psychological repercussions were observed (30,31,32). Depression, post-traumatic stress disorder, multiple disruptions to significant relationships and daily functioning, mistrust and intractable anger outbursts were some of the psychological repercussions victims underwent following sexual misconduct (23,28,33). Furthermore, victims manifested emotional injury as feelings of exploitation and betrayal (10,16, 23), impairing future relationships with other doctors and health staffers (26). Notably, the harm is not only confined to the victimised patient but also the transgressed doctor due to the consequent reputational damage, financial losses, revocation of license to practice, and occasionally subject to criminal charges and eventual imprisonment (13). Finally, such misdemeanours will harm the medical profession at large due to the degradation of the perceived legitimacy of the profession each time such misdemeanours are committed by doctors (13).

Attributing factors of sexual misconduct

Attributable factors that can lead to sexual misconduct can be explicated in terms of the characteristics of the doctor, the patient and the nature of the medical speciality.

Apart from older age and male sex as aforestated, concordant to the empirical evidence, attitude (such as consensual sexual relationship with patients is permissible, patient seduces and initiates into sex, sexual relationship is therapeutic, and feeling positive after the act) (16,20,34,35), personality disorders (mixed, and narcissistic personality with antisocial features) (2,28,32,36), life difficulties and life transitions (e.g., marital and family problems, midlife or late middle life stage-of-life crisis and burnout) (2,13), health conditions that interfere with judgement (2), hypomanic episodes (37), alcohol and or/ substance abuse disorders and paraphilias (13) were depicted as characteristics of doctors who involved sexually with patients. Explicably, an unconscious process known as countertransference (i.e., idealizing the patient as a lover) is psychoanalytically implicated in seeding the sexual or romantic drives in doctors towards patients (35).

Characteristically, victimised patients were, demographically in younger ages (which includes minors) and females (10,23), diagnosed with personality disorders (e.g., borderline, dependent, and submissive personalities that make patients oblivious in differentiating between social and professional boundaries) (2,26,37), history of sexual abuse (32,37), history of sexual contact with a professional (16,26), and more ordinary adverse life circumstances (e.g., loneliness) (2). From a psychoanalytical perspective, according to Devereux (2010), the patient can go through an unconscious process known as "idealizing transference", where the patient can feel bonded to a professional through their disclosure, which can turn to dependency, blurring the lines of what is and is not appropriate behaviour, desensitizing the victim from the warning signs of abuse and exploitation (26).

Any specialty that involves prolonged contact with patients, particularly, in psychiatry and gynaecology, increases the liability for sexual misconduct (2,22,23,38). Further, the provision of intimate information, and medical procedures that allow for violating bodily integrity enhance trust and respect in the caring doctor, which paves the way to dependence and intimacy in the doctor-patient relationship that might lead to an eventual sexual misdemeanour (16). Moreover, in an intimate and dependent relationship, the needs and fantasies will increase while weakening the objectivity and control necessary to preserve the professional boundary (10).

Prevention of sexual misconduct

Strikingly, studies revealed that many doctors were not educated or had a standard education on sexual misconduct during their medical student period (16, 39). Moreover, some doctors who committed such violations were ignorant of professional standards (27,40). Hence,

as a primary preventive measure, the literature suggests incorporating topics on professional ethics and sexual misconduct in the medical education curriculum and as a major component of the continuous medical education programmes (27,39,41,42). Further, early recognition of disruptive behaviour and providing formal peer feedback will enable the doctor to understand and correct the misdemeaned conduct (13,32,36), preventing recidivism. In addition, the risk associated with workplace settings should be deliberated, particularly, where patients are alone with individual healthcare professionals, especially during examinations with lots of physical contact, examinations of intimate body zones and long-lasting treatment relationships characterized by high intimacy, and in situations where patients might feel unsafe or uncomfortable (10). Seemingly, assessing patients in the presence of a chaperone would be the best preventive measure in the aforementioned vulnerable workplace settings, yet, a study revealed that 19% of cases of sodomy occurred in the presence of a chaperone, parent, or nurse, (28). Thus, this underscores the importance of chaperones being trained on how to respect privacy while providing appropriate oversight, and how to speak up when behaviour appears to be inappropriate (28).

Finally, to prevent patients from falling victim to sexual misconduct they should be empowered when dealing with situations that are routinely experienced as disempowering (28), which can be achieved by raising the public awareness to recognize and stand against the unprofessional practices of doctors (27).

Conclusion and recommendations

This article emphasizes that a doctor concurring sexually with a patient is a serious professional misconduct that can give rise to dire repercussions for the patient, the doctor, and the medical fraternity by and large. Moreover, although statistically, the prevalence of such a transgression is not high on the surface, it should be seriously cogitated, as there can be many unreported subtle incidences, particularly among psychiatrists, gynaecologists, and general practitioners.

Without indulging in emergent erotic feelings, one should fathom the limits of the professional relationship, and if overwhelming, these feelings should be brought into conscious awareness and modified cognitively, failing which, the patient should be handed over to a colleague (13) (43). If the patient directly expresses sexual feelings or overtures, he or she should be made aware that the relationship is professional and consists of strict limitations or if the expressions are more indirect, the same message should be made implicit by being more formal with the patient (43). All in all, every healthcare provider should be able to recognize inappropriate behaviours and not act inappropriately due to their emotional attraction to patients, hence, in addition to professional ethics, topics on emotional regulations, transference, and countertransference should be taught in medical schools, postgraduate training and in courses meant for professional development.

The Sri Lanka Medical Council in concert with academic bodies of all medical specialties should conduct awareness-raising programmes for the medical fraternity and the general public regarding professional ethics and boundary violations, creating a culture that infringes on sexual misconduct (10). In addition, academic bodies of various medical specialities should implement formal ethical committees to conduct peer feedback to help doctors reflect upon their potential misconduct and restore professional etiquette. Yet, doctor-patient sexual relationships could occur despite professional ethical prohibitions (16), hence, as a deterrent, the Sri Lanka Medical Council and the other relevant legal bodies should adhere to zero tolerance of such serious professional misconduct and observe strict punitive actions.

The medical profession is known to be at a critical juncture not only in terms of abuse against patients but also in sexual harassment of colleagues and trainees (26). The UK and the US health authorities have considered the latter seriously and even have implemented programmes such as “Active bystander training” to empower potential victims to stand against it (44). Although sexual harassment of colleagues and trainees in the medical profession is beyond the scope of this article, it should be an area to be pondered seriously for the well-being of our medical profession and fraternity as a whole.

References

1. Zelas K. Sex and the doctor-patient relationship. N Z Med J [Internet]. 1997; 110(1038): 60-2. Available from: https://pubmed.ncbi.nlm.nih.gov/9076289/

2. Surgenor LJ, Diesfeld K, Rychert M. Consensual Sexual Relationships between Health Practitioners and Their Patients: An Analysis of Disciplinary Cases from New Zealand. Psychiatry, Psychol Law [Internet]. 2019; 26(5): 766-82. Available from: https://doi.org/10.1080/13218719.2019.1640801

3. Cullen RM. Arguments for zero tolerance of sexual contact between doctors and patients. J Med Ethics. 1999; 25(6): 482-6.

4. Of offences affecting the human human body of offences affective human life. In: Penal Code Ordinance of Sri Lanaka [Internet]. Sri Lanak; 1995. p. 166. Available from: http://hrlibrary.umn.edu/research/srilanka/statutes/Penal_Code.pdf

5. Ost S. Breaching the sexual boundaries in the doctor-patient relationship: Should english law recognise fiduciary duties? Med Law Rev. 2016; 24(2): 206-33.

6. Capule R V. Physician Sexual Misconduct. Phillippine J Intern Med. 2023; 61(2).

7. Sindhu KK, Schaffer AC, Cohen IG, Allensworth RH, Adashi EY. Honoring the public trust: Curbing the bane of physician sexual misconduct. J Law Biosci. 2022; 9(1): 1-17.
8. Kaba R, Sooriakumaran P. The evolution of the doctor-patient relationship. Int J Surg. 2007; 5(1): 57-65.
9. Sexual misconduct in the practice of medicine. Council on Ethical and Judicial Affairs, American Medical Association. JAMA. 1991; 266(19): 2741-5.
10. Clemens V, Brähler E, Fegert JM. # patientstoo –- Professional sexual misconduct by healthcare professionals towards patients?: a representative study. Epidemiol Psychiatr Sci. 2021; 1-8.
11. The patient – physician relationship. Can Med Assoc J. 1994; 150(11): 1884A-E.
12. Ferris LE. Patient protection laws and the issue of consensual sexual relationships with physicians. C Can Med Assoc J. 2004; 170(1): 34-5.
13. Skipper GE, Schenthal S. Sexual misconduct by professionals: A new paradigm of understanding. Mo Med. 2012; 109(3): 184-6.
14. Sansone RA, Sansone LA. Crossing the line: Sexual boundary violations by physicians. Psychiatry (Edgemont). 2009; 6(6): 45-8.
15. Kardener SH, Fuller M, Mensh IN. A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients. Am J Psychiatry. 1973; 130: 1077-81.
16. Gartrell NK, Milliken N, Goodson WH, Thiemann S, Lo B. Physician-patient sexual contact – Prevalence and problems. West J Med. 1992; 157(2): 139-43.
17. Bayer T, Coverdale J, Chiang E. A national survey of physicians' behaviors regarding sexual contact with patients. South Med J. 1996; 89(10): 977-82.
18. Wilbers D, Veenstra G, Van De Wiel HBM, Weijmar Schultz WCM. Sexual contact in the doctor-patient relationship in the Netherlands. Br Med J. 1992; 304(6841): 1531-4.
19. Rubin SS, Dror O. Professional ethics of psychologists and physicians: Morality, confidentiality, and sexuality in Israel. Ethics Behav. 1996; 6(3): 213-28.
20. Coverdale JH, Thomson AN, White GE. Social and sexual contact between general practitioners and patients in New Zealand: Attitudes and prevalence. Br J Gen Pract. 1995; 45(394): 245-7.
21. Leusink PM, Mokkink HG, Rietmeijer CB. [Sexual contact between general practitioner and patient in the Netherlands: prevalence and risk factors]. Ned Tijdschr Geneeskd [Internet]. 2004;148(23):778-82. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15211975%5Cnhttp://www.ncbi.nlm.nih.gov/pubmed/15129567
22. Alam A, Kurdyak P, Klemensberg J, Griesman J, Bell CM. The characteristics of physicians Disciplined by Professional Colleges in Canada. PLoS One. 2012; 7(11): 166-72.
23. Favero M, Gomes V, Campo A Del, Moreira D, Sousa-Gomes V. Sexual violence perpetrated by health professionals. Front Psychol. 2022; 13(April): 1-9.
24. Bismark MM, Studdert DM, Morton K, Paterson R, Spittal MJ, Taouk Y. Sexual misconduct by health professionals in Australia, 2011-2016: a retrospective analysis of notifications to health regulators. Med J Aust. 2020; 213(5): 218-24.
25. Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1991 to 1995. Am J Obstet Gynecol. 1997; 176(6): 1340-8.
26. Mulvihill N. Professional authority and sexual coercion: A paradigmatic case study of doctor abuse. Soc Sci Med [Internet]. 2022;305(May): 115093. Available from: https://doi.org/10.1016/j.socscimed.2022.115093
27. DuBois JM, Anderson EE, Chibnall JT, Mozersky J, Walsh HA. Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States From 2008-2016. Am J Bioeth. 2019; 19(1): 16-34.
28. DuBois JM, Walsh HA, Chibnall JT, Anderson EE, Eggers MR, Fowose M, et al. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. Sex Abus J Res Treat. 2019; 31(5): 503-23.
29. Rapp MS. Sexual misconduct. CMAJ. 1987; 137: 193-4.
30. Bouhoutsos J, et al. Sexual intimacy between psychotherapists and patients. Prof Psychol Res Pract. 1983; 14(2): 185-96.
31. Burgess AW. Physician sexual misconduct and patient's responses. Am J Psychiatry. 1981; 138(10): 1335-42.
32. Alpert JL, Steinberg AL. Sexual boundary violations: A century of violations and a time to analyze. Psychoanal Psychol. 2017; 34(2): 144-50.
33. Halter M, Brown H, Stone J. Sexual boundary violations by health professionals – an overview of the published empirical literature. Counc Healthc Regul Excell [Internet]. 2007;(April). Available from: http://scholar.google.com/holar?hl=en&btnG=Search&q=intitle:Sexual+Boundary+Violations+by+Health+Professionals+?+an+overview+of+the+published+empirical+literature#0
34. Wilbers D, Veenstra G, Van De Wiel HB, Weijmar Schultz WCM. Sexual contact in the doctor-patient relationship in the Netherlands. Obstet Gynecol Surv. 1992; 47(10): 722-4.
35. Gabbard GO. Transference and counter transference in psychotherapy in therapists charged with sexual misconduct. J Psychother Pr Res. 1995; 4: 10-7.
36. Reid Finlayson A, Dietrich M, Ron Neufeld BS, et al. Restoring professionalism: the physician fitness-for-duty evaluation. Gen Hosp Psychiatry. 2013; 35(6): 659-63.

37. Fahy T, Fisher N. Sexual contact between doctors and patients. BMJ 1992; 304: 1519-20.

38. Gerritse FL, Duvivier RJ. Disciplinary complaints concerning transgressive behaviour by healthcare professionals: An analysis of 5 years jurisprudence in the Netherlands. BMJ Open. 2021; 11(10).

39. Dowling T, Steele S. Is sexual misconduct training sufficient in the UK's medical schools: Results of a cross-sectional survey and opportunities for improvement. JRSM Open. 2023; 14(9): 1-7.

40. Robinson GE, Stewart DE. A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment part 1: Content. C Can Med Assoc J. 1996; 154(5): 643-9.

41. Robinson GE, Stewart DE. A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment part 2: Teaching method. C Can Med Assoc J. 1996; 154(7): 1021-5.

42. Dekker H, Snoek JW, Schönrock-Adema J, van der Molen T, Cohen-Schotanus J. Medical students' and teachers' perceptions of sexual misconduct in the student-teacher relationship. Perspect Med Educ. 2013; 2(5-6): 276-89.

43. Golden GA, Brennan M. Managing erotic feelings in the physician-patient relationship. C Can Med Assoc J. 1995; 153(9): 1241-5.

44. Robertson A, Steele S. A cross-sectional survey of English NHS Trusts on their uptake and provision of active bystander training including to address sexual harassment. JRSM Open. 2023; 14(4): 205427042311666.