

## SEXUAL MISCONDUCT IN THE PHYSICIAN/PATIENT RELATIONSHIP

### A. BACKGROUND

The primary ethical principle is "Remember first the well being of the patient". This principle guides the conduct of the physician in all professional decisions.

### B. THE FIDUCIARY RELATIONSHIP

The physician/patient relationship is a fiduciary<sup>1</sup> relationship. The dynamics of the physician/patient relationship include:

1. The relationship is one where there is a power imbalance. The patient depends upon the physician's knowledge and training to provide care. To receive care, patients provide personal information and/or allow the physician to conduct intimate physical examinations. The transfer of information and the physical examination is one-sided, from patient to physician. Often patients are particularly vulnerable because they are unwell, in pain or fearful of being ill. Furthermore, within society physicians are respected for their knowledge and the service they provide. All of these factors create an imbalance of power in the physician/patient relationship.
2. The relationship is based on trust. A patient reposes trust and confidence in the physician and the physician assumes responsibility for the relationship because the physician holds the more powerful position in the relationship. The physician is obligated to act in the best interests of the patient, and to use the therapeutic relationship to further those interests. The therapeutic relationship must not be used to further the physician's own interests.

The well being of the patient must be considered in its fullest sense. The quality of the fiduciary relationship is a direct measure of the extent to which the physician strives to preserve this well being.

### C. IMPORTANT ASPECTS OF WELL BEING

- (a) Self worth: Healthy individuals have a realistic view of themselves and their capabilities and this optimal state should be supported. Comments or activities which disparage this view or urge the individual to assume inappropriate relationships are harmful. The ethical physician must be aware of the variation in ethno-cultural norms as they relate to such issues as appearance and communication skills.

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<sup>1</sup> A fiduciary means a person holding the character analogous to that of a trustee, in respect to the trust and confidence involved in it and the scrupulous good faith and candor which it requires. As a fiduciary, the physician has the duty to act primarily for the benefit of the patient.

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(b) Family and community: The individual exists as part of an immediate and large community. Relationships in these communities can be very important and influence the individual's behaviour.

(c) Sexuality: This is a comprehensive term which includes all of one's sexual behaviour and thoughts. It is a part of one's natural makeup that enters into and affects all interactions and relationships. Each individual has boundaries that are intended to limit the closeness of others. An ethical physician will be aware and respect such boundaries

### College Policy on Sexual Misconduct in the Physician/Patient Relationship

Sexual misconduct is a spectrum encompassing the whole range of inappropriate physician-patient interactions of a sexual nature, including but not limited to:

- any behavior, gesture or expression that is sexualized, seductive or sexually demeaning to a patient
- inappropriate comments about or to the patient including:
  - sexual comments about the patient's body or clothing
  - comments about the patient's sexual orientation
  - comments about the patient's sexual performance, unless the patient consultation is for the purpose of addressing issues of sexual function or dysfunction and the comments are relevant to the management of the patient's problems
  - initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the patient, *unless the patient consultation is for the purpose of addressing such issues and the comments are relevant to the management of the patient's problems*
  - initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the physician
  - requesting details of sexual history or preference unless this is relevant to the patient consultation
  - suggestions of sexual involvement and/or sexual or romantic contact between the physician and the patient
- inappropriate examinations, including:
  - examination of the breasts, genitals or anus without appropriate patient consent
  - examination, touching or massaging of the breasts, genitals or anus when the procedure is not standard and not justifiable
  - performing a pelvic examination, an anal-rectal examination or examination of the external genitalia without wearing gloves
- inappropriate body contact, including hugging of a sexual nature and kissing
- dating
- sex and any conduct with a patient that is sexual or may be reasonably interpreted as sexual
- a failure on the part of the physician to show reasonable sensitivity for a patient's need for privacy/territoriality.

This list is not exhaustive.

### **Current Patient**

There are no circumstances in which sexual misconduct in the current physician/patient relationship is acceptable. Therefore:

- A physician must not initiate any form of sexual advance to a patient. It is the ethical responsibility of the physician to avoid using the physician/patient relationship to gratify inappropriately his/her own needs.
- A physician must not respond sexually to any form of sexual advance by a patient. It is never appropriate for a physician to attempt to meet a patient's sexual needs. Sexualizing the physician/patient relationship has no therapeutic value.
- Physician/patient sexual contact is abusive regardless of whether the physician believes that the patient consents. Patient consent is never an acceptable rationalization.

It is the physician's responsibility to set and control appropriate boundaries in the physician/patient relationship.

### **Former Patient**

The dynamics of the physician/patient relationship do not necessarily end with the completion of treatment or the transfer of patient care. There is a risk of abuse of power on the part of the physician since, whether intentionally or not, he/she may use or exploit the trust, the confidential information, the emotions or the power created during the professional relationship.

In any sexualized conduct with a former patient, the physician has a duty to ensure there is no exploitation by the physician of the power imbalance between the parties resulting from the earlier physician/patient relationship.

It is not acceptable to terminate a physician/patient relationship with the intent of engaging in a sexual relationship. The physician's ethical obligation not to exploit the physician/patient relationship for the physician's personal advantage applies whenever a physician considers termination of the physician/patient relationship to pursue a personal relationship. The physician must recognize the risk of abuse in any such circumstance, and must realistically assess the emotional dependence of the patient. Where a physician/patient relationship is terminated with the intent of entering a personal relationship, the physician is accountable for any exploitation.

Factors to be considered in assessing whether sexualized contact with a former patient is appropriate include but are not limited to:

- The type and duration of the therapeutic relationship.
- The physician's understanding of the dynamics of the physician/patient relationship.
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- The physician's understanding of the boundaries involved in a physician/patient relationship.
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- The circumstances surrounding the termination of the physician/patient relationship.
- The physician's knowledge of the concept of transference.
- The patient's degree of vulnerability. (For example, patients undergoing psychotherapy may be particularly vulnerable, as may be those with certain psychological, physical or character traits.)

Given the very special nature of the psychotherapeutic relationship, it is rare for personal relationships to be established between physicians and their former psychotherapy patients in which the previous physician/patient relationship is not exploited in some way.

A physician who is considering a personal relationship with a former patient is encouraged to:

- act cautiously, allowing adequate time for consideration of the potentially complex issues, including:
  - the vulnerability of the former patient, including factors such as the maturity of the individual, whether the individual has an illness or condition likely to impair decision-making ability,
  - the potential for the physician to exploit the trust, knowledge and dependence that developed during the physician/patient relationship
- ensure that the former patient has a good understanding of the dynamics of the physician/patient relationship and the boundaries applicable to that relationship, both through direct discussion and consultation with an independent third party,
- consult with colleagues and/or the College before embarking on the relationship.

### D. WHEN DOES A PHYSICIAN/PATIENT RELATIONSHIP EXIST?

*When the physician first attends a patient, a doctor/patient relationship is formed. The duration of the relationship is measured on the individual facts of each case. Factors which will be taken into account include:*

- (1) **Dependency:** Physicians must accept that the patient is always vulnerable and this arises from the fact that the patient is the dependent party in the relationship. This quality of dependence can be very deep as in the case of the psychotherapeutic relationship or it may be marginal as in the case of a single episode of medical care for a minor medical emergency or for a consultant opinion.
- (2) **Termination of Care:** This may be explicitly stated by either party or may be implied by the patient seeking out and attending an alternative continuing source of care. As of that date, the physician is no longer attending.

The quality of the psychosocial bond is very important in assessing termination of dependency in the physician/patient relationship. Generally, it can be said that the more that dependency is a feature, the longer will the relationship be said to exist **even after** termination might otherwise appear to have occurred. The Canadian Psychiatric Association states that in the case of psychotherapy, there should be no social/sexual/romantic relationship while emotional dependence exists and no earlier than 2 years after the termination of care.

*Where a Social/Sexual Relationship Pre-dates the Physician/Patient Relationship: Where a social/sexual relationship pre-dates the physician/patient relationship, physicians should have regard to the ethical precept that physicians will provide only minor or emergency services to themselves and their immediate family members.<sup>2</sup>*

#### **E. EXAMINATIONS: RESPECTING PRIVACY**

Physicians must be aware of the patient's need for preservation of self dignity. Accordingly, reasonable practice should be followed with the use of gowns, sheets, modesty screens, etc.

There is a heightened sensitivity of a patient when close territoriality is to be invaded. Increased apprehension can be expected in examinations such as examinations of the rectum, pelvis, breasts and genitalia. Physicians should assess the quality of the patient's comfort with such procedures before proceeding. Whether or not an attendant should be present depends on the preference of the patient and the discretion of the physician. A rectal/pelvic examination should not be performed if an attendant is not readily available for assistance.

An ethical precept is that a physician will practise in a fashion that is above reproach and will take neither physical, emotional nor financial advantage of the patient. This ethical requirement implies that a physician respects a patient's need for privacy and right to be treated with dignity. Accordingly, the physician will avoid actions or comments which have a harmful effect in either respect.

The extent to which a physician would be assessed as deficient in clinical practice depends on the extent to which patient expectations have been evaluated. The need for evaluation increases in situations where:

- the emotional maturity of the patient is in question, ie. very young or emotionally immature;
- there is increased patient vulnerability (whether due to stress factors or illness);
- the discussion/examination has sexual connotations;
- the patient contact is new;
- the patient is distressed about the reason for the visit;
- the patient is asked to assume a state of undress or position which seems unusual for the examination involved or to which the patient stated an objection;
- the patient makes a specific request or places conditions on the examination;
- there is no availability of an attendant when requested or indicated.

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**A guideline is practice generally recommended.**

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<sup>2</sup> See Statement S15, "Prescribing and Treatment: Self and Family"