



Professional Services - Loss Prevention

[Seminars](#)
[Surveys](#)
[Online Advice](#)
[Publications](#)
[ABOUT MIEC GROUP](#)
[SERVICES](#)
[RATE CALCULATOR](#)
[APPLICATIONS & FORMS](#)
[RELATED RESOURCES](#)
[ACUPUNCTURE PROGRAM](#)
[HOME](#)

Special Report

MIEC Claims Alert

Number 37B

June 2006

Avoiding allegations of sexual misconduct

- [What's wrong?](#)
- [Sexual misconduct](#)
- [Special considerations for psychiatrists](#)
- [Physician/patient rapport and boundaries](#)
- [General recommendations](#)
- [PE recommendations](#)
- [Psychiatric recommendations](#)
- [Resources and bibliography](#)

What is wrong with these pictures?!

- *Dr. Adams sits on the edge of the exam table while his patient's feet are still in the stirrups. He's unaware of her discomfort.*
- *Dr. Benson insists upon a pelvic exam for each female patient, regardless of her complaint.*
- *Dr. Carson notices that her patient gets an erection during her examination, and jokingly says, "You must be really glad to see me!"*
- *Dr. Dwight and her psychotherapy patient sit side-by-side on the loveseat in the doctor's office and Dr. Dwight holds her patient's hand.*
- *Dr. England is doing a breast exam, and he tells his patient it would be a shame for those "beautiful babies" to experience any disease.*

Case # 1A patient seeking employment as a longshoreman came to Dr. Finch for a pre-employment physical examination. During the exam, Dr. Finch palpated the patient in the groin to check for signs of an inguinal hernia. The patient, unaware of the medical reason behind this action, became very uncomfortable and sued Dr. Finch for sexual battery. The case was found in favor of the defendant, but, had Dr. Finch explained the reason for the exam, the patient's discomfort and subsequent lawsuit might have been avoided. Defense costs for the case were unrecoverable.

Boundary violations between physicians and patients occur across all medical specialties and practice settings. These violations can be circumstances in which patients' erotic, emotional, financial, or other needs are exploited by their physicians, or they can be situations in which a physician's unwanted behavior negatively impacts the patient. The boundary violation most frequently alleged in medical malpractice claims and lawsuits is that of sexual misconduct. This

newsletter addresses the ways physicians in psychotherapeutic and medical settings can reduce risk, prevent allegations, avoid the appearance of sexual misconduct, and increase the strengths of a physician's defense in the event of a lawsuit that alleges such a violation.

Since Hippocrates first penned his Oath, physicians have been admonished not to engage in sexual relations with their patients, but it wasn't until 1989 that the American Medical Association (AMA) officially published its opinion declaring the same. There is little national data about sexual misconduct-related malpractice claims, disciplinary actions or professional sanctions. This may be a result of patients' reluctance to criticize a respected physician, a lack of interest on the part of those in a position to discipline physicians, or society's historical reluctance to tackle the issue of sexual abuse, in general. Sexual misconduct claims increased in frequency as taboos on the topic diminished and patients/consumers became more disposed to filing lawsuits against their physicians. Unfortunately, the emerging data indicates that sexual misconduct is not perpetrated only by a few bad physicians.

Studies show that geography, training, and specialty are not significant predictors of boundary violations that include sexual misconduct. Allegations are made more frequently against physicians over the age of 50; allegations are more frequent in the specialties of psychiatry and primary care; substance abuse has been known to play a role in some cases; perpetrators often commit violations while they are in the midst of their own personal crises; and abusers often abuse patients serially. Although the predominance of sexual misconduct claims are made by female patients about their male physicians, allegations occur in all gender configurations.

Case # 2 Dr. Gantry treated M. Jones for depression and anxiety. Dr. Gantry wrote the patient prescriptions, one for antidepressants and the other to advise the patient to engage in more frequent sexual relations. The patient took one prescription to a pharmacist, and the other to a Medical Board investigator. A time-consuming investigation followed, ultimately resulting in a letter of public reprimand against Dr. Gantry.

Sexual misconduct needn't be flagrant to do substantial harm, and patients have been known to allege injury from "covert" exploitation, which might include behaviors such as a physician's flirtations, revelations about his/her own personal or sex life, long, full-body hugs, or inappropriate comments about the patient's clothes or body.

Allegations of sexual misconduct in the medical setting may also arise when the patient misinterprets what is occurring during a routine, medically necessary examination. Settings in which such allegations arise vary widely, but can include the urgent care visit with an unfamiliar provider, examinations for conditions which are causing stress and anxiety for the patient (e.g., unusual vaginal discharge, STD's), exams where a part of the body the patient does not expect to be touched is touched (e.g., an inguinal hernia exam as described in Case #1, or when auscultation of the heart requires the practitioner to touch the patient's breast) or where a familiar and expected exam is conducted in a different manner than the patient has experienced in the past or by other providers (e.g., a brief pelvic exam

performed without stirrups from the patient’s side to check for an acute abnormality).

Plaintiffs’ attorneys are aware that most professional liability carriers may defend—but will not indemnify—physicians for an intentional wrongful act such as sex with a patient. Claims or lawsuits related to sexual misconduct are complicated by the fact that plaintiffs’ attorneys may not only allege medical negligence, but may also level other causes of action against the defendant physician, such as breach of fiduciary duty (in which a patient trusts a physician to provide appropriate care and treatment in return for an appropriate fee), negligent infliction of emotional distress, breach of contract, and/or spousal claims. In some cases, the physician’s employer may also be included in a lawsuit. These factors influence coverage questions, defense strategies, and the possibility of indemnification of the defendant physician. It usually takes considerable time, effort and expense to resolve these issues. Sexual misconduct charges may also result in disciplinary action against a physician’s license and/or additional civil or criminal actions.

Case # 3 Dr. Hsu treated I. King for many years, during which time the two developed a close, friendly relationship in which they sent each other Christmas cards, exchanged small gifts such as bath soaps, and hugged at the end of sessions. Dr. Hsu and the patient mutually decided that King no longer needed therapy and agreed to end their therapeutic relationship. Soon after, the former patient invited Dr. Hsu to lunch. After a pleasant lunch, the two decided to continue their conversation while going for a walk, which ended in a hug and a kiss. They soon developed a romantic relationship. On occasions when King’s depression resurfaced, Dr. Hsu prescribed medications “to help,” and King’s mood seemed to improve without therapy. After dating for seven months, Dr. Hsu decided to end the relationship. Dr. Hsu subsequently received a Summons and Complaint from King alleging that Dr. Hsu’s gift-giving and hugs in therapy had been deliberately seductive; that Dr. Hsu took advantage of King’s vulnerability as a patient to indulge selfish sexual and emotional desires; that King suffered a relapse of depression; and that Dr. Hsu prescribed habit-forming drugs to which King was now addicted while discouraging King from seeking treatment with another psychiatrist. King claimed damages of severe emotional trauma, recurrence of depression, inability to trust, dependence on drugs, and lost wages. The jury agreed that although the relationship had been consensual, it was Dr. Hsu’s responsibility as a professional to maintain appropriate boundaries. King was given a hefty award, which Dr. Hsu had to pay out-of-pocket.

In the past decade, MIEC has defended almost seventy cases of sexual misconduct. Even though MIEC successfully closed 80% of these claims without paying indemnity to the plaintiff, the defense costs alone came to nearly \$2 million. These costs were not recoverable. In most instances, physicians who lost their cases paid damages out of their own pockets to plaintiffs.

Sexual misconduct

The American Medical Association (AMA) Council on Ethical and Judicial Affairs (CEJA) issued an opinion defining sexual misconduct as any sexual contact between a physician and his or her patient, and relations with former patients in which the physician exploits the previous professional relationship. Opinion 8.14

reads:

Sexual conduct that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from 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, he or she should avoid 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 the 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

Allegations of sexual misconduct occur when a physician and patient engage in a romantic/sexual relationship or encounter, or when patient perceives that such a relationship or encounter has taken place. Allegations of sexual misconduct can be broken into two categories: allegations of a non-consensual relationship or encounter, usually in the context of an office visit or examination, and allegations of a consensual relationship or encounter which the patient recognizes after the fact as sexual misconduct.

Special considerations for psychiatrists

Psychiatrists represent 39% of sexual misconduct claims defended by MIEC in the past decade, exceeding any other specialty, with the largest indemnity awards and defense costs paid by or on behalf of psychiatrists. The American Psychiatric Association (APA) suspends or expels an average of twelve members per year for various forms of patient exploitation, most of them sexual. Psychiatrists are particularly at risk, in part, due to patients' "transference" and psychiatrists' failure to deal with transference and counter-transference appropriately.

In 1993, the APA Assembly adopted a position that sexual contact between a psychiatrist and former patient was considered sexual misconduct, with no time limit specified. The Federation of State Medical Boards lists psychiatric care as a mitigating factor warranting tougher sanctions in sexual misconduct investigations and disciplinary proceedings. In California, a patient may sue a psychiatrist for sexual misconduct if they engage in a romantic or sexual relationship within two years of termination of the physician/patient relationship. California psychiatrists are also required by law to give patients who disclose a past sexual relationship

with a mental health provider with a brochure that explains that sex should never be a part of therapy.

Maintaining physician/patient rapport while maintaining boundaries

Good rapport is essential to maintain an effective relationship with patients. There are many ways in which physicians and patients may interact that encourages such rapport without transgressing the boundaries of an appropriate physician-patient relationship. Occasionally accepting small gifts, such as baked goods or produce from a patient's garden, or attending patients' social events such as christenings and weddings, may not necessarily be perceived as a boundary violation. Physicians should use good judgment on a case-by-case basis to determine if accepting a particular gift or invitation may be a boundary violation. Similarly, it is acceptable in some cases for physicians to disclose personal experiences, with a particular illness, for example, so long as such disclosures are intended to enhance patient care, and not an opportunity for physicians to unburden themselves.

What can physicians do to protect themselves from over-stepping the boundaries that lead to perceptions or allegations of sexual misconduct, or an act of sexual misconduct? MIEC offers the following recommendations:

General recommendations

- Ask yourself, when contemplating a behavior or action, “Does the action exploit or appear to exploit the patient? Does it create an expectation from the patient of special treatment or romantic involvement? Does it create unnecessary discomfort for the patient?”
- If a patient requests, demands, provokes, or initiates a boundary violation, document the interaction.
- If a particular patient repeatedly presents boundary challenges, consider whether withdrawal from care is appropriate. When in doubt, seek consultation from an outside source; this may include a call to MIEC's Claims Department.
- Explain the relevance of sexual questions to care and treatment.
- Avoid flirtatious behavior toward patients and behaviors, gestures or expressions that are sexualized, seductive or sexually demeaning to patients.
- Avoid inappropriate and gratuitous comments or suggestions about or to the patient, including: sexual comments about the patient's body or clothing; comments about the patient's sexual orientation; sexual performance; and sexual fantasies. Such comments are acceptable only when they are relevant to the management of patients' medical or psychological problems for which you are providing treatment.
- Avoid suggestions of sexual involvement and/or sexual or romantic contact between the patient and you.
- Avoid inappropriate body contact, including hugging of a sexual nature.
- Self-monitor to ensure that barriers between normal sexual feelings and inappropriate behavior are maintained. If they are questionable, take

appropriate action to curb them immediately, such as consultation with appropriate colleagues, a therapist, or one of MIEC's Claims Representatives.

- Formally withdraw from care and refer a patient to another physician for future medical care prior to becoming sexually or romantically involved with a patient. Cease providing any medical services, including writing prescriptions, for any former patient with whom you share a social, sexual or romantic relationship.

Recommendations for physical examination

- See patients only during office hours, and when someone else is also on the premises.
- Ask questions about sexual history when the patient is fully clothed. Such questions should be asked during a pelvic exam or examination of the breasts or genitalia only if directly related to a physical finding.
- Communicate clearly with the patient about the reasons for and methods of examination. Obtain the patient's verbal consent prior to performing the exam if you sense the patient may be reluctant to proceed.
- Allow patients to disrobe and dress in private, and offer cover gowns and appropriate drapes.
- Position exam tables for maximum patient privacy.
- Have a chaperone in the room whenever possible, especially during breast, pelvic, and other exams of an intimate nature. Document that the chaperone was present, including the chaperone's name and title.
- Accommodate patient requests for a chaperone, regardless of the patient's gender; do not use a patient's family member as a chaperone unless specifically requested by the patient.
- Document a patient's request that a chaperone not be present during the examination, if such a request is made.
- Offer patients an opportunity to speak to you in private without the presence of a chaperone; patients should be clothed and no physical examination should be conducted at this time.
- Do not use sexually suggestive or denigrating language.
- Avoid examining, touching, or massaging any part of the body unless the action is within the standard of care for your specialty and is medically justifiable.
- Always wear gloves when performing a pelvic or anal-rectal examination or when touching the external genitalia.

Recommendations for psychiatrists

- Establish physical boundaries by ensuring that both doctor and patient remain in their respective chairs during therapy.
- Avoid contact with patients outside of the office.
- Keep your private life separate from the therapeutic relationship.

- **(California only)** If patients disclose a history of sexual and/or romantic experiences with a health care professional and you are a California psychiatrist, you must provide them with the “Professional Therapy Never Includes Sex” brochure (see **Resources and Bibliography**).

There is no defense for physician sexual misconduct, even if a patient is a willing participant. As Thomas Gutheil, MD, Professor of Psychiatry at Harvard Medical School states: “A patient can be seductive, threaten to kill herself if she doesn’t get what she wants, or take off her clothes in the session. She has no code to uphold, no standard of behavior to violate. Only the professional can be to blame.” [Please understand that this statement applies equally to male patients.] If you have any doubt whether a behavior is appropriate **don’t do it**. If you wonder if your behavior will precipitate an allegation of sexual misconduct against you, **don’t do it**. If you are considering an action you know might incriminate you, **don’t do it**. There are almost always methods to accomplish what is needed without jeopardizing yourself. Avoid the appearance of wrongdoing and save yourself the stress of defending yourself in court, potential financial hardship, and professional embarrassment.

MIEC’s legal consultant for this newsletter was Ann H. Larson, Esq., of McNamara, Dodge, Ney, Beatty, Slattery & Pfalzer, Walnut Creek, California.

How to reach MIEC

Oakland Office: 510/428-9411
Honolulu Office: 808/545-7231
Boise Office: 208/344-6378
Outside: 800/227-4527

Loss Prevention Fax: 510/420-7066
Main Oakland Fax: 510/654-4634
Honolulu Fax: 808/531-5224
Boise Fax: 208/344-7903

E-Mail: Lossprevention@miec.com
E-Mail: Underwriting@miec.com
E-Mail: Claims@miec.com

MIEC on the Internet: www.miec.com

Resources and Bibliography:

American Medical News: “Boards get tougher on physician sex offenses,” by

Damon Adams. December 19, 2005.

California Medical Association “CMA ON-CALL” document #0838, “[Sexual Relations with Patients: Sexual Misconduct.](#)”

Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process. Richard S. Epstein, MD, 1994, ISBN 0880486600.

REQUEST A PUBLICATION

“[Opinions of the Ethics Committee on The Principles of Medical Ethics: with Annotations Especially Applicable to Psychiatry.](#)” published by the American Psychiatric Association. Contains advice on specific questions pertaining to boundary violations.

Physician Sexual Misconduct, Edited by Joseph D. Bloom, MD, et al. 1999. ISBN 0880487062.

“Professional Therapy Never Includes Sex,” brochure, prepared by the California Department of Consumer Affairs, available in English and Spanish. To obtain a copy, call the Medical Board of California (916) 263-2466. The brochure is also available free online at www.medbd.ca.gov/publications.htm.

Psychology Today: Behind Closed Doors: Sex Therapists, by Carl Sherman. May/June 1993



6250 Claremont Avenue, Oakland, CA 94618 800.227.4527 Fax 510.654.4634

Copyright © 2005 Medical Insurance Exchange of CA