

Report on Sexual Boundary Issues

By The

Ad Hoc Committee on Physician Impairment

The Federation of State Medical Boards of the US, Inc., accepted this Report on Sexual Boundary Issues as policy in April 1996.

Section I. Opening Statement

In 1993, the Ad Hoc Committee on Physician Impairment was established to evaluate current concepts regarding physician impairment and to develop strategies for state medical boards for the regulation and management of such physicians. This report was finalized and disseminated to all state medical boards.

In 1994, the committee's charge was expanded to include examination of sexual boundary issues. In accepting this new charge, the committee recognized that sexual misconduct by physicians is a form of behavior that adversely affects the public welfare and agreed that an entirely separate report should be developed. Therefore, the committee has issued this report in an attempt to provide medical boards with recommended guidelines regarding the handling of sexual misconduct cases. As defined later in this report, physician sexual misconduct exploits the physician-patient relationship, is a violation of the public's trust, and causes immeasurable harm, both mentally and physically, to the patient. Sexual misconduct is an issue that affects all medical boards and is not a geographical problem. It is the medical board's primary responsibility to protect the safety and welfare of the public it serves. In doing so, it is the medical board's responsibility to inform its licensees that sexual misconduct, in any form, will not be tolerated and, when sexual boundary violations do occur, to take prompt and decisive action against all such physicians.

As state medical boards are required to respond to an increasing number of complaints, it becomes imperative that medical boards use standardized guidelines for dealing with sexual boundary issues and take measures to educate their licensees about sexual boundary issues.

In addressing the issue of whether sexual misconduct is a form of impairment, the committee does not view it as such, but, instead, as a violation of the public's trust. It should be noted that although a mental disorder may be a basis for sexual misconduct, the committee finds that sexual misconduct usually is not caused by physical/mental impairment. While sexual addiction is a frequently used phrase, it is not recognized as a disease in the Diagnostic and Statistical Manual of Psychiatric Disorders, Version IV (DSM IV).

The following report defines physician sexual misconduct and provides specific recommendations to assist medical boards with the investigation process, preparation for formal hearings, appropriate disciplinary options available, physician monitoring, and physician education.

Section II. Definitions

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. This behavior is non-diagnostic and non-therapeutic, may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual.

The committee believes that there are primarily two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action by a state medical board if the board finds that the behavior was an exploitation of the physician-patient relationship.

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

1. sexual intercourse, genital to genital contact
2. oral to genital contact
3. oral to anal contact, genital to anal contact
4. kissing in a romantic or sexual manner
5. touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent
6. encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present
7. offering to provide practice-related services, such as drugs, in exchange for sexual favors.

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient, including but not limited to:

1. disrobing or draping practices that reflect a lack of respect for the patient's privacy, deliberately watching a patient dress or undress, instead of providing privacy for disrobing
2. subjecting a patient to an intimate examination in the presence of medical students or other parties without the explicit consent of the patient or when consent has been withdrawn
3. examination or touching of genitals without the use of gloves
4. 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 (homosexual, heterosexual, or bisexual), making comments about potential sexual performance during an examination or consultation except when the examination or consultation is pertinent to the issue of sexual function or dysfunction, requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation
5. using the physician-patient relationship to solicit a date
6. initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician
7. examining the patient intimately without consent.

Section III. Guidelines for State Medical Boards: Investigations

Board Authority

The committee recommends that state medical boards have the authority to investigate reported allegations of sexual misconduct. The purpose of the investigation is to determine whether the report can be substantiated and if intervention is warranted. If the state medical board's investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate steps to ensure the protection of the public.

Patient Sensitivity

Furthermore, boards should recognize that each case tends to be unique and should be evaluated on an individual basis. The board should be careful of preconceived notions and should be objective in its assessment in all such complaints. Recognizing that many of the complaints will be made by members of the public and that the nature of the complaint is a delicate matter, boards should have proper procedures

for dealing sensitively with the patient. The committee recommends that the investigation and subsequent intervention be conducted by professionals who are appropriately trained in the area of sexual misconduct. At times, boards may have to provide specialized training for investigators. Boards also should consider using female investigators when dealing with complaints from female patients. In those instances when patients express a desire to "tell their side of the story," the board should afford the complainants the opportunity to appear before a board subcommittee or the board itself.

Identifying Patterns of Behavior

During the investigation process, the committee recommends that medical boards determine whether the complaint is an isolated case or if the complaint represents a part of a pattern of behavior. While some complaints may be isolated, it is the committee's experience that most physicians who are brought before the medical board on charges of sexual misconduct have previously exhibited patterns of behavior which may be characteristic of predatory behavior or other boundary violations. The committee recommends that each complaint be seriously investigated on its own merits and that the board may find it beneficial to have the physician undergo a comprehensive psychological evaluation to determine whether a pattern of behavior exists, because evaluations usually bring to light additional facts that investigators are unable to discover and that may establish predatory behavior.

The committee distinguished predatory behavior from non-predatory behavior as any behavior(s) exhibited by the physician in which multiple patients were violated. A pattern of behavior also may be detected by a thorough review of the board's complaint file, including review of any malpractice settlements, to discover whether previous complaints have been made against the physician. Often, following a thorough investigation by the board, it still may be unclear whether sexual misconduct actually occurred. The committee also recommends that, in all instances, both the patient and physician should be interviewed by the investigator.

Comprehensive Psychological Evaluation

Although most state medical boards may believe that evaluations may be best used for health professionals who may have an impairment, the committee has determined that the use of similar evaluations when dealing with a complaint regarding sexual misconduct also provides additional significant information that may not surface during the initial phase of the investigation. This information will assist the state medical board in determining if sexual misconduct occurred and if so, to what extent.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing. The committee offers the following specific recommendations in regard to the evaluation of physicians who have had a sexual misconduct complaint lodged against them:

1. The committee recommends that providers performing evaluations have demonstrable expertise in the recognition of the unique characteristics of physicians who have violated the sexual boundaries of their patients.
2. The evaluation of the physician should be conducted by an independent evaluator to avoid the appearance of conflict of interest.
3. Former sexual misconduct offenders should not be allowed to conduct the evaluation.
4. Evaluation of a physician for sexual misconduct should be contingent upon agreement by the independent evaluator to release to the state medical board all records pertaining to the identity, diagnosis, prognosis, and treatment of such physician. Such records should include but not be limited to those records maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research. Upon completion of the evaluation, results must be released to the medical board.
5. The physician may undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate urine and blood drug screens.

6. The psychiatric history and mental status examination should be performed by a psychiatrist knowledgeable in the evaluation of physicians suspected of sexual boundary violations. The examination may include neuropsychological testing.

Section IV. Guidelines for State Medical Boards: Hearings

Following investigation and evaluation, the board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled. This section will discuss issues encountered by boards when preparing for an administrative hearing and will provide specific recommendations regarding those issues.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a formal hearing. The committee recommends that a board have the authority to amend its formal charges to include additional complainants identified prior to the conclusion of the hearing process.

Open vs. Closed Hearings

If boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. The committee recommends that boards have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient's identity so that patients are not discouraged from coming forward with legitimate complaints against physicians. The boards should have statutory authority to ensure nondisclosure of the patient's identity to the public. This authority should include the ability to delete from final public orders any information that would identify patients.

Expert Testimony

Sexual misconduct cases involve complex issues, including boundaries and transference. Therefore, the committee recommends that boards use expert witnesses to provide testimony on these issues for the record. Expert witnesses may provide detailed assessments about the level of harm incurred by the patient as a result of the physician's actions, especially when the patient involved was undergoing treatment for a psychiatric illness.

Other Issues

1. The committee recommends that hearings involving sexual misconduct use the rules of evidence applicable in other administrative hearings.
2. Patient consent should not be viewed as a legal defense.

Section V. Guidelines for State Medical Boards: Disciplinary Options

Disciplinary responses are designed to protect the public. The committee strongly recommends that, on a finding of sexual misconduct, the board should invoke an appropriate disciplinary response. This response should reflect the severity of the violation.

Sexual Violation

While findings of sexual violations usually are egregious enough to warrant revocation of a physician's medical license, boards may, at times, find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation.

Sexual Impropriety

While findings of sexual impropriety generally will result in a somewhat less severe sanction by the medical board than findings of sexual violation, special consideration should be given to the following when determining an appropriate response:

1. patient harm
2. severity of impropriety
3. culpability of licensee
4. psychotherapeutic relationship
5. inappropriate termination of physician-patient relationship
6. age of patient (minor)
7. number of times behavior occurred
8. number of patients involved
9. period of time relationship existed
10. evaluation/assessment results

Disciplinary Actions

Although boards may have different language to describe the same action, most boards use the following categories:

Emergency Suspension: The suspension by a state medical board of the health professional's license prior to a formal hearing. This type of suspension should be only used if there is egregious behavior with imminent danger to the public and the behavior is likely to continue. This is a protective action, not a punitive action.

Revocation: The revocation by a state medical board of the health professional's license, thereby prohibiting the practice of medicine in said state following a formal hearing.

Suspension: The suspension by a state medical board of the health professional's license, thereby prohibiting the practice of medicine. Usually, the license is suspended for a definite period of time, and license reinstatement is available.

Probation/Limitations: The physician is placed on probation by the state medical board for a period of time determined by the board. Terms of probation may include license restrictions, practice limitations (e.g., no female patients, chaperones), preapproved practice site, training regarding boundary issues, and mandated treatment.

Other Disciplinary Options: Actions usually less severe than those above taken by a state medical board against the physician. These options may include a letter of concern, fine, formal reprimand, and/or appropriate remedial medical education.

License Reinstatement

In the event a physician applies for license reinstatement, any petition for reinstatement should include the

stipulation that additional evaluations be required prior to the medical board's review for reinstatement to ensure the continuing protection of the public.

Section VI. Guidelines for State Medical Boards: Monitoring

The committee believes that there is a need for appropriate monitoring of the physician after a finding of sexual misconduct and recommends that each case be handled on an individual basis. The committee believes that if a diagnosis of mental illness is made during the initial evaluation/assessment, the monitoring of that physician should be the same as for any other mental impairment. If there is not a diagnosis of mental impairment, the committee recommends that monitoring procedures should be the same as those for other types of violations of the medical practice act. Monitoring procedures may include but are not limited to:

1. Supervision of the physician in the workplace by a supervisory physician
2. Requirement that chaperones sign the medical record attesting to their attendance during examination
3. Periodic on-site review by board investigator
4. Practice limitations, including but not limited to
 - a. prohibition of pelvic/breast examinations
 - b. prohibition of opposite sex (same sex) examinations
5. Regular interviews with the board required to assess status of probation
6. Regular reports from a qualified practitioner conducting board-mandated counseling.

Section VII. Physician Education

Recognizing that physician sexual misconduct frequently has been inadequately addressed during a physician's medical training, medical boards should take a proactive stance to educate their licensees about sexual misconduct. Because of lack of education/awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary violations. The committee believes that only through improvement in the education of physicians about what is acceptable behavior in regard to sexual boundary issues will there be a significant reduction in the frequency of physician sexual misconduct.

Boards should develop cooperative relationships with state medical societies, hospital medical staffs, other organized physician groups, and medical schools to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what physician actions constitute boundary violations, and the potential consequences of these violations. Physicians also should be educated about the degree of harm patients can experience when sexual boundary violations occur.

Information about physician sexual misconduct should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public.

Section VIII. Conclusion

The Committee recognizes that it is impossible to address in this report the many gray areas that medical boards may encounter during their investigations into complaints regarding sexual misconduct. However, it should be noted that they do exist and that it is the board's responsibility to determine the motivation and circumstances behind the complaint. The committee has worked vigorously to provide medical boards with

recommended guidelines and to detail strategies to assist them in determining whether a complaint is valid and, if so, how to effectively deal with the physician found guilty of sexual misconduct. The committee has provided a definition of sexual misconduct as well as recommending two levels of severity. Although many boards already have developed position statements regarding physician sexual misconduct, it is the committee's desire that all boards review their current policies regarding sexual misconduct and incorporate the recommendations outlined in this report.

Section IX. Bibliography

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