Family Practice
Vol. 18, No. 5

Printed in Great Britain

Sexualization of the doctor–patient relationship: is it *ever* ethically permissible?

Katherine H Hall

Hall KH. Sexualization of the doctor–patient relationship: is it *ever* ethically permissible? *Family Practice* 2001; **18:** 511–515.

Abstract. Whilst having sexual relationships with current patients is clearly unethical, the ethics of such a relationship between a doctor and former patient is more debatable. In this review of the current evidence, based on major articles listed in Medline and Bioethicsline in the past 15 years, the argument is made here that such relationships are almost always unethical due to the persistence of transference, the unequal power distribution in the original doctor–patient relationship and the ethical implications that arise from both these factors especially with respect to the patient's autonomy and ability to consent, even when a former patient. Only in very particular circumstances could such relationships be ethically permissible.

Keywords. Morality, physician–patient relationship, sex offences, social dominance, standards.

Introduction

All codes of ethics set up by medical professional bodies prohibit sexual relationships between a doctor and a current patient. For example, the New Zealand Medical Council[1] adopted the policy of 'zero tolerance' of sexual relationships between doctor and patient in 1994. Although this stance initially provoked a degree of controversy within the country,[2–6] the deleterious effects of such relationships upon patients have become increasingly recognized and condemned by the medical community. However, some areas of debate do still remain. One such area is whether sexual relationships with *former* patients are ever ethically permissible and, if so, under what circumstances. Two years after the zero tolerance policy was adopted, the New Zealand Medical Council released a further policy statement in which it stated that whilst complaints regarding sexual relations with former patients will be considered individually, it will be presumed to be unethical if the "doctor–patient relationship involved psychotherapy, or long-term counselling and support; the patient suffered a disorder likely to impair judgement or hinder decision-making; the doctor knew that the patient had been sexually abused in the past; [or] the patient was under the age of 20 when the doctor–patient relationship ended".[7]

This paper presents evidence from international medical and ethical literature to examine the validity of this position taken by the New Zealand Medical Council regarding the sexualization of relationships with former patients. First, the concepts of boundaries and transference are discussed and a profile of the medical practitioner at risk of offending is drawn. Secondly, three aspects of the doctor–patient relationship are explored: the general characteristics which promote health care; the importance of trust and the fiduciary relationship; and the role of power and authority in the relationship. Thirdly, a discussion of the role of autonomous choice and consent is presented. On the basis of this evidence, it is argued that the circumstances in which such relationships are ethically permissible are extremely limited and that official 'sanctioning' of these relationships should be very much the exception, not the rule.

Boundaries and boundary violations

Many boundaries exist in the doctor–patient relationship. These include boundaries of role, time, place and space, money, gifts and services, clothing, language and physical contact.[8] Sexual misconduct usually commences with violations of more minor boundaries:

> "The road to therapist–patient sex is paved with progressive boundary violations. Except when a patient is raped, the therapist who eventually sexually abuses a patient follows a remarkably predictable 'natural history' of sexual misconduct."[9]

Not all stages will take place in any one relationship, but the general stages include: gradual erosion of therapist neutrality; socialization of therapy; the patient is treated as 'special'; doctor's self-disclosures begin; physical contact begins (e.g. hugs, kissing); extratherapeutic

Received 8 December 2000; Accepted 4 May 2001.
Department of General Practice, Dunedin School of Medicine, University of Otago, PO Box 913, Dunedin, New Zealand.

contacts occur; dating begins; sexual intercourse occurs.[9] The long-term emotional consequences for the patient of being sexually involved with a doctor have been likened to rape or incest.[10] This has been documented extensively in the literature, with no counteracting reports of successful relationships and non-abusive consequences being published. This does not mean that no such type of relationship may exist, but it has not been researched. This suggests that the overwhelming outcome for most, if not all, patients is negative.

However, the crossing of boundaries *per se* does not necessarily mean that an unethical act occurred: after all, the crossing or erosion of boundaries is a normal part of the evolution of intimate relationships between human beings. Nor do all boundary transgressions between doctor and patient ultimately lead to sexual misconduct. As Gutheil and Gabbard write, ". . . the specific impact of a particular boundary crossing can only be assessed by careful attention to clinical context".[8] To decide whether any instance of a boundary crossing is a boundary *violation*, the analysis has to examine other factors. Clues as to what these other factors should be can be gleaned from examining the profiles of offending doctors.

Profiles of doctors who violate boundaries

A key factor in the identification of doctors at risk of violating boundaries is the enhanced vulnerability of a doctor to the transference–counter-transference dyad which occurs in varying degrees in every doctor–patient relationship. Transference is "the unconscious assignment to others of feelings and attitudes that were originally associated with important figures" by the patient onto the doctor.[11] Counter-transference is the doctor's reaction to this process and this can include erotic feelings. Doctors can mistake the feelings of love that arise in a therapeutic relationship as being the same as love that arises elsewhere; it is not. 'Love in the supermarket', as opposed to 'love transference', is based more in reality and not propelled to an artificial intensity by an unequal power structure.[12] Nor is love in the supermarket based upon a fiduciary relationship (see later discussion). In addition, 'love transference' can be extremely capricious, often hiding a destructive hate transference that frighteningly erupts and engulfs the therapist and patient.[9]

Even skilled and experienced doctors are not immune to rationalizing their behaviour and convincing themselves that a patient is 'very special' and 'truly an exception'.[9] Doctors are more vulnerable to counter-transference when the doctor unconsciously or subconsciously overidentifies with the patient's situation, so much so that one author comments:

> "The power of the subconsciously driven counter-transference to create rationalisations that the sexual relationship with the patient is 'special and the exception' to the usual rules of professional conduct should never be underestimated."[9]

Such 'overidentifiers' are often 'situational reactors' who are responding to particular triggers such as marital discord, loss of important relationships and a professional crisis in their own lives.[9] Particularly vulnerable are socially isolated, middle-aged men experiencing a mid-life crisis,[13] and who are eminent in their field.[14] The risk of sexual misconduct increases with age[15] by a risk ratio of 1.44 with every increasing decade.[16] Psychiatrists, gynaecologists and GPs are significantly more likely to offend than those in other specialities.[15–17] Whilst situational reactors are certainly an at-risk group, unlike other categories of doctors who offend (e.g. personality disordered doctors), this group is very unlikely to re-offend with appropriate treatment.[9]

Therefore, unmet emotional needs of the doctor, overidentification with the patient and particularly intimate areas of medicine associated with long-term professional relationships with patients can all potentially enhance the strength of the transference–counter-transference relationship between doctor and patient. Transferences *per se*, as with boundary crossings, also occur in normal love relationships,[12] and therefore are also a necessary but not sufficient condition for ethical unacceptability. However, it is the existence and persistence of this *type* of transference, linked with the fiduciary relationship and unequal power structure, which makes most relationships with former patients ethically unacceptable (see following sections).

The doctor–patient relationship

It is important in the doctor–patient relationship that a 'neutral, safe space' is established which allows a therapeutic alliance to grow.[9] This is recognized within professional codes, for example by the New Zealand Medical Council which states that "the ethical doctor–patient relationship depends upon the doctor creating an environment of mutual respect and trust in which the patient can have confidence and safety".[1]

The fiduciary relationship (relationship of trust) is a crucial aspect of the doctor–patient relationship.[18] It has been defined as ". . . [the] special confidence reposed in one who in equity and good conscience is bound to act in good faith and with due regard to the interests of one reposing the confidence".[19] Three salient features describe the circumstances in which this type of relationship occurs: there is an expectation of trustworthiness, an unequal power relationship exists and the interaction occurs under conditions of privacy.[19] It is an underlying principle of the concept of boundaries and it has been argued that it is the doctor's breach of fiduciary trust, not the patient's consent, which is the central issue regarding sexual misconduct.[9,12] To create the necessary conditions

of a safe, therapeutic haven for a patient, a strong fiduciary relationship has to be built. In turn, to build such a relationship, the unequal power distribution between doctor and patient has to be acknowledged and contained in an ethically correct manner. The onus of responsibility for this last task falls on the person who has the most power in the relationship which, as I will argue, is always the doctor.

To explain why this is always the case, even with former patients, it is useful to consider the sources of medical power in light of a framework suggested by family practitioner and ethicist, Howard Brody. In his book *The Healer's Power*,[20] Brody outlines three sources of medical power: Aesculapian, Charismatic and Social. Aesculapian power is ". . . the power that a physician possesses by virtue of her training in the discipline and the art or craft of medicine". Charismatic power is based on ". . . the personality characteristics of the physician independent of the disciplinary knowledge and skill that give rise to Aesculapian power". Social power is that which ". . . arises from the social status of the physician". It has also been suggested that another source of power —Hierarchical power, the power inherent by one's position in a medical hierarchy (e.g. specialist versus generalist)—be added.[21]

To help understand these four types of power, and the relationships between each type, consider the following incident from my personal experience as a first year house surgeon in Australia in the mid-1980s. Although it does not involve the sexualization of the doctor–patient relationship, it clearly illustrates the importance of recognizing all four types of power, and, in particular, the prominence of Hierarchical power:

> A consultant specialist was admitted to hospital with a severe multi-system disease causing severe renal impairment. After 6 weeks in hospital, on the day of his planned discharge, he was accidentally given another patient's medication. Instead of receiving his azathioprine and corticosteroids, he was given a high dose of frusemide and captopril. As attempts were made to rapidly infuse intravenous fluids and rescue his remaining renal function, the specialist cried 'I realized that they were the wrong pills but *I just wanted to be a good patient*!'

Despite having the Aesculapian power of a doctor, and the Social power of a hospital specialist, in addition to considerable Charismatic power (he was a well-liked and respected colleague), none of these were sufficient to counteract his lack of Hierarchical power by being a patient. Simply by the sheer nature of taking on the role of patient, regardless of any other type of power, there is *always* an unequal power differential between the doctor and patient. (This applies in both general practice and hospital-based medicine, although it may be accentuated by the latter's institutional culture. However, there is also the question of whether this type of power would be accentuated further in a fee-for-service situation, as exists in general practice in Australasia, as opposed to free public hospital treatment.)

This differential is exacerbated further by any imbalances arising from the other three sources of power. Usually a patient also has less Aesculapian power even if well versed in medical knowledge (unless the patient is themselves a doctor, as in this case, or an unusual situation exists such as the parents in the film 'Lorenzo's Oil'). Charismatic power may not always be less on the patient's side depending on the personalities of patient and doctor. Equally, Social power may vary in doctor–patient relationships depending on the social status of the individuals. (This may also relate to the gender roles of the patient and doctor. The large majority of cases of sexualization occur between female patients and male doctors.) Therefore, the onus of responsibility for controlling the power imbalance in an ethically correct manner is always on the doctor.

However, what is the relevance of this analysis to relationships with former, not current patients? Several points can be made. First, any privileged knowledge gained under the conditions of the original power imbalance of doctor and patient cannot be 'unlearnt' or forgotten, and this can continue as an unfair advantage for the doctor. Information gained in such a power imbalance can be artificially intimate—one does not normally begin to discuss details of sexual function within a few minutes of meeting a stranger, for example, but this frequently happens in general practice consultations. Secondly, given the strength of Hierarchical power in determining one's overall power in the doctor–patient relationship (as illustrated by the case history), it is hard to see how a relationship of equals could develop from such unequal beginnings.

Autonomous choice and consent

How should a claim be judged that a former patient gave his or her free consent before entering into the relationship? There is little disagreement that a current patient cannot validly consent to have sexual intercourse with his/her doctor.[9,18] A lack of competence due to the presence of transference (of which the patient is usually unaware and/or lacking insight into its significance[18]) is the most common and strongest basis for this claim.[9] Gutheil prefers a model of 'undue influence' rather than claiming such patients are necessarily incompetent.[9] The New Zealand Medical Council recognizes that ". . . patient consent cannot be a defence in disciplinary hearings of sexual abuse . . .".[1] It may, however, be an issue in consideration of the penalty.

The validity of consent of a former patient, as opposed to a current one, is a little more debated, but evidence is against that being a former patient materially alters the situation. Transferences can persist indefinitely and with it the perpetuation of the potential or real incompetence of the patient to recognize these feelings for their true

nature (and the same for doctors with respect to counter-transference):[22] for psychiatrists at least, the view is generally held 'once a patient, always a patient'.[9] Legally, the shortest permissible gap is a 2-year period with no patient contact (of any sort) which is acceptable only in Californian courts.[23] However, any *legal* statute of limitations does not mean such behaviour is or becomes *ethical*. Indeed, despite the Californian courts' position, the American Psychiatric Association itself has clearly stated that "sexual activity with a current *or former* patient is unethical", with no qualifications.[24]

There is no empirical research to demonstrate that transference disappears for the patient or even simply decreases with cessation of the doctor–patient relationship (or counter-transference for the doctor although this is less studied):

> "the concept of a supposed 'waiting period' after termination before sexual intimacies is naïve because it does not take into account the timeless nature of the subconscious . . . there have been no published studies demonstrating or even suggesting that therapist–patient sexual involvement becomes safe at a point 3 months or even 3 years after termination."[22]

Not all authors condemn sexual relationships with previous patients however. Zelas is a little less prohibitive. She writes:

> "No rule of thumb regarding a suitable time period of restraint nor regarding the specific nature of the doctor–patient involvement can be offered . . . a reasonable guideline is that if the sexual attraction and desire for a relationship commenced in the context of the doctor–patient relationship then it is unlikely to be well-founded at any time in the future."[18]

Even with this broad guideline, however, Zelas also states that:

> "[t]here seems to be widespread agreement that when a patient has been in long term psychotherapy or counselling with the doctor then an ordinary social relationship can *never* [emphasis added] be established . . ."[18]

In the earlier discussion, it was argued that the power imbalance of the doctor–patient relationship would continue into the sexualized relationship. Meaningful consent to a sexualized relationship cannot be given in a situation of unequal power: "even if consent can be given, exploitation can nevertheless be argued if the fiduciary has acquired information about the client's vulnerabilities that otherwise would remain concealed".[19] The Council of Ethical and Judicial Affairs of 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 previous professional relationship".[25]

Other arguments support the idea that meaningful consent is an impossibility in this situation. Traditional teaching of informed consent emphasizes the importance of autonomous choice, i.e. choice where all relevant information has been provided, with the person having the necessary capacities to comprehend that information whilst not acting under any form of coercion. Leaving aside the provision of information (presumably such information should include a review of the current known research in this area, although this apparently rarely, if ever, happens[12]), this discussion will concentrate on coercion and impaired capacity. Coercion can arise from imposed restraints on any or all of three types of autonomy: autonomy of thought or the ability to think for oneself, autonomy of will or the freedom to make a choice based on one's own deliberations, and autonomy of action or the freedom to enact one's choice physically.[26] The persistence of transference (as argued above) can exert a coercive effect on one's autonomy of thought and/or will. However, an alternative definition of autonomy which centres upon the importance of one's social relationships demonstrates a more subtle source of coercion. Nedelsky writes:

> "If we ask ourselves what actually enables people to be autonomous, the answer is not isolation but relationships . . . that provide the support and guidance necessary for the development and experience of autonomy."[27]

Brody argues that the distinguishing characteristic of general practice ethics, as opposed to hospital-based ethics (which involves a time-limited decisional focus), is the longitudinal relationship which develops between doctor and patient.[28] This 'relational ethic' is grounded in the goal of enhancing the patient's autonomy by and through this relationship. From both these arguments, then, it can be seen that attention to relationship is particularly important when considering general practice ethics. It could be argued, therefore, that general practice has a *particular duty* of fostering the autonomy of the patient and that a GP's actions should be evaluated in the light of this duty. Sexual misconduct with a former patient does not, by any established evidence, foster patient autonomy, and a doctor participating in such a relationship is thus breaching this duty.

Conclusion

It would be the minority of consultations, especially in general practice, where the above conditions of persistent transference and power imbalance did not exist. Certainly the onus of proof, in any disciplinary hearing, would lie with the doctor to demonstrate how these ethical issues were of minimal impact in the subsequent sexualized relationship. Only in situations where there

was a minimal potential for transference–counter-transference to arise, together with an unusual equality of power, could the former patient be in a position to exercise true autonomy and choice when entering into a sexualized relationship with the doctor.

In general, the criteria by which the New Zealand Medical Council will judge the ethical acceptability of sexual relationships with former patients[7] appear to be necessary, but not sufficient. They have correctly identified several situations where the likelihood of significant and persistent transference–counter-transference, and the perpetuation of a significant power imbalance in the relationship, is very high. However, other situations may well occur which fall beyond these criteria but nevertheless have a similar degree of transference–counter-transference and residual power imbalance so that a sexualized relationship is equally as abusive as the listed criteria. It is these underlying factors, rather than any more superficial descriptors, by which the ethical acceptability should be judged. This being the case, relationships with former patients should not be regarded as ethically permissible except under such rare circumstances.

Acknowledgements

The author wishes to thank Dr Chrys Jaye for reviewing an earlier draft of this paper and for her very helpful comments and suggestions.

References

[1] New Zealand Medical Council. *Statement on Sexual Abuse in the Doctor–Patient Relationship*. 1994. New Zealand Medical Council website: http://www.mcnz.org.nz/about/forms/statement%20on%20sexual%20abuse.pdf.

[2] Cullen RM. Medical discipline and sexual activity between doctors and patients. *NZ Med J* 1995; **108:** 481–483.

[3] Briant RH, St George IM. Sexual activity between doctors and patients [letter]. *NZ Med J* 1996; **109:** 127–128.

[4] White G. Sexual activity between doctors and patients [letter]. *NZ Med J* 1996; **109:** 128.

[5] Cullen R. Medical discipline and sexual activity between doctors and patients [letter]. *NZ Med J* 1996; **109:** 150.

[6] Northwood B. Medical discipline and sexual activity between doctors and patients [letter]. *NZ Med J* 1996; **109:** 150.

[7] New Zealand Medical Council. *Policy Statement on Sexual Relationships with Former Patients*. 1996. New Zealand Medical Council website: http://www.mcnz.org.nz/about/forms/policy%20sexual%20relationships%20former.pdf.

[8] Gutheil TG, Gabbard GO. The concept of boundaries in clinical practice: theoretical and risk-management dimensions. *Am J Psychiatry* 1993; **150:** 188–196.

[9] Simon RI. Therapist–patient sex. From boundary violations to sexual misconduct. *Psychiatr Clin N Am* 1999; **22:** 31–47.

[10] Searight HR, Campbell DC. Physician–patient sexual contact: ethical and legal issues and clinical guidelines. *J Fam Pract* 1993; **36:** 647–653.

[11] Stone EM: *American Psychiatric Glossary*. 7th edn. Washington (DC): American Psychiatric Press, 1994: 135.

[12] Simon RI. Transference in therapist–patient sex: the illusion of patient improvement and consent. Part II. *Psychiatr Ann* 1994; **24:** 561–565.

[13] Fahy T, Fisher N. Sexual contact between doctors and patients almost always harmful. *Br Med J* 1992; **304:** 1519–1520.

[14] Dreiblatt IS. Health care providers and sexual misconduct. *Fed Bull* 1992; **79:** 8–14.

[15] Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offenses. *J Am Med Assoc* 1998; **279:** 1883–1888.

[16] Enbom JA, Thomas CD. Evaluation of sexual misconduct complaints: the Oregon board of medical examiners, 1991 to 1995. *Am J Obstet Gynecol* 1997; **176:** 1340–1348.

[17] Kardener SH, Fuller M, Mensh IN. A survey of physicians' attitudes and practices regarding erotic and non-erotic contact with patients. *Am J Psychiatry* 1973; **130:** 1077–1081.

[18] Zelas K. Sex and the doctor–patient relationship. *NZ Med J* 1997; **110:** 60–62.

[19] Feldman-Summers S. Sexual contact in fiduciary relationships. In Gabbard GO. *Sexual Exploitation in Professional Relationships*. Washington (DC): American Psychiatric Press, 1989: 193–209.

[20] Brody H. *The Healer's Power*. New Haven (CT): Yale University Press, 1992.

[21] McMillan J, Anderson L. Knowledge and power in the clinical setting. *Bioethics* 1997; **11:** 265–270.

[22] Gabbard GO, Pope KS. Sexual intimacies after termination: clinical, ethical and legal aspects. In Gabbard GO (ed.). *Sexual Exploitation in Professional Relationships*. Washington (DC): American Psychiatric Press, 1989: 115–127.

[23] Epstein RS. *Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process*. Washington (DC): American Psychiatric Press, 1994: 15–34.

[24] American Psychiatric Association. *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*. Washington (DC): American Psychiatric Association, 1993.

[25] Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. *J Am Med Assoc* 1991; **266:** 2741–2745.

[26] Gillon R. Autonomy and the principle of respect for autonomy. *Br Med J* 1985; **290:** 1806–1808.

[27] Nedelsky J. Reconceiving autonomy: sources, thoughts and possibilities. *Yale J Law Feminism* 1989; **1:** 7–36.

[28] Brody H. *Stories of Sickness*. New Haven (CT): Yale University Press, 1987: 171–181.