BY ADAM DORIN, MD

"*Whatever the reasons, research indicates that health systems are a breeding ground for sexual harassment.*"
— Indra Lahiri and Austin Sedicum (1)

Sex in Medicine

The inappropriate introduction of 'sex' into the practice of medicine in 21st century America appears to be as prevalent a problem today as it ever has been. According to the *2002 Sexual Misconduct Claims Review Panel* and The Doctors Company Board of Governors chairman, Dr. Richard Anderson of UCSD, "the high number of (sexual misconduct) claims underscores the seriousness of the problem" (2).

I became introduced to the problem of sexual harassment in medicine a few years back as the medical director of a busy, primarily cosmetic surgery-oriented, ambulatory surgery center outside of Washington, D.C. Over the course of my three-year tenure there, I fielded dozens of complaints by patients, nurses, and nurses who were patients, of inappropriate sexual behavior by male surgeons toward female patients. There was one solitary complaint by a male patient toward his male plastic surgeon. The high incidence of this type of complaint, and the serious implications for both patient and physician, are what prompted me to work on an Internet-based survey on this very subject that will be sent to approximately 2,000 readers of *Outpatient Surgery* magazine in February 2004. So, what is factually known about this problem?

Starting with a broad overview of sexual harassment in healthcare, a 1998 national survey found that 47.7% of all women physicians reported having experienced gender-based harassment [defined as harassment having to do with being "female" in a traditionally male environment, "without a sexual or physical component" (3)], and "36.9% reported sexual

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harassment defined as harassment with a sexual or physical component." Focusing in on the practice of medicine itself, in California, there has been an increase in the interest of the California legislature and hospital staffs in preventing and punishing sexual misconduct by physicians (4).

Henry Fenton, Esq., writes "under the California Business and Professions Code Section 726, any 'act of sexual abuse, misconduct, or relations with a patient' constitutes unprofessional conduct and grounds for disciplinary action by the Medical Board of California" (5). Although the actual application of this statute to the prosecution of a physician can be complex (as illustrated by a 1992 case, *Gromis vs. Medical Board*, which ran through the court of appeals), and does not necessarily subject a physician to disciplinary action, "physicians would be well advised not to take any chances and follow a strict policy of avoiding relations with patients or employees" (6).

Physicians can be the target of sexual harassment suits, subject to California Civil Code Section 51.9, and liable for damages if several conditions are satisfied. There must exist a physician-patient relationship; the defendant must have made 'persistent or severe' sexual advances after a request to stop such behavior; there must exist an inability of the plaintiff to terminate the relationship without some degree of hardship; the plaintiff must have suffered some degree of economic loss or personal injury. Interestingly, the law extends beyond the actual practice of medicine, as indicated by Business and Professions Code Section 729. Here it states that a physician or psychotherapist is at risk if he has a doctor-patient relationship with a 'former' patient and engages in a sexual affair with that former patient in the setting where the medical treatment was terminated specifically to continue with the sexual relationship. A violation of Section 729 carries with it the possibility of criminal prosecution and disciplinary action by the Medical Board of California.

In 2002, the Doctors Company published *Sexual Misconduct Claims Review Panel*. The panel of physicians reviewed 17 current cases. Here is an overview of the 17 cases as described by that panel (7):

- Nine specialties were involved: internal medicine, family practice, gastroenterology, orthopedics, plastic surgery, pediatrics, urology, psychiatry, and anesthesiology;
- The adjunct fields of chiropractic medicine, physical therapy, and psychology were also involved;
- All 17 defendants were male. Sixteen of the plaintiffs were women; only one was a man;
- In three cases, a clear sexual relationship existed between the physician and a current patient;
- Six cases showed what appeared to be harassment and sexual abuse for the purpose of financial gain;
- Three physicians had previous histories of sexual charges;
- In two alleged incidents, physicians claimed impairment by drugs or alcohol;
- One plaintiff was only thirteen years old, but most were older than 21. The underage plaintiff case resulted in criminal charges against the physician;
- In at least three cases, claims were considered preventable if the physician had exhibited a reasonable degree of basic politeness and/or professional demeanor.

The AMA Council on Ethical and Judicial Affairs states that "sexual contact or a romantic relationship with a patient concurrent with the physician-patient relationship is unethical" (8). Despite this, a national survey of ten thousand family practitioners, internists, obstetricians/gynecologists, and surgeons revealed 9% of respondents who admitted anonymously to sexual contact with one or more patients (9). Despite laws that vary from state to state and varying recommendations on dealing with grace periods before becoming involved romantically with previous patients, suggested guidelines for all specialties tend to include a two-year interval after the last episode of patient care prior to the commencement of an intimate relationship. In the case of psychiatrists, some have suggested that the doctor-patient relationship is permanent and that a romantic relationship is not acceptable at any time under any circumstances.

Commentators, legislators, and panelists have disagreed on the importance of having a nurse chaperon in the room when patient examinations are being performed. Clearly, due to the lack of good research in this area and the fact that the use of nurse companions is sporadic in many practices, it is hard to speculate on how many cases of sexual harassment could have been prevented by this practice. Good judgment, however, suggests that a nurse chaperon could only improve the perception of the professional practice of medicine during the examination of patients.

Sadly, the problem of sexual misconduct in medicine does not seem to be abating. Anyone working in the healthcare setting can attest to the fact that stories of affairs — and even blatantly obvious indications of sexual impropriety — are commonplace. Perhaps it is due to the highly stressful and intimate nature of the medical profession. Regardless of the reasons, it is obvious that the real dangers of devastation to both patient and physician in terms of professional, legal, and emotional tolls warrant a high degree of respect for a healthy personal distance between doctors and patients beyond the performance of one's medical duties. ♥

REFERENCES

1. Workforce Development Group, 2000; "Sexual Harassment in Health Care"; Indra Lahiri and Austin Sedicum.
2. Sexual Misconduct Review Panel, 2002; The Doctors Company; Richard Anderson, MD, FACP, UCSD.
3. "Prevalence and Correlates of Harassment Among U.S. Women Physicians"; *Internal Medicine*; vol. 158, pp. 352–358; February 23, 1998; Frand, Grogan, and Schiffman.
4. "Physicians and Sexual Misconduct"; *LACMA Physician*; February 5, 1996; Henry Fenton, Esq.
5. Ibid.
6. Ibid.
7. Sexual Misconduct Review Panel, 2002; The Doctors Company; Richard Anderson, MD, FACP, UCSD.
8. Council on Ethical and Judicial Affairs, AMA; "Sexual Misconduct in the Practice of Medicine"; *JAMA*; 1991; 226: 2741–2745.
9. N. Gartrell, N. Milliken, et al; "Physician/Patient Sexual Contact: Prevalence and Problems"; *Western Journal of Medicine*; August 1992; 157: 139–143.