PERSPECTIVE

Time to End Physician Sexual Abuse of Patients: Calling the U.S. Medical Community to Action

Azza AbuDagga, M.H.A., Ph.D, Michael Carome, M.D., and Sidney M. Wolfe, M.D.

Health Research Group, Public Citizen, Washington, DC, USA.

Despite the strict prohibition against all forms of sexual relations between physicians and their patients, some physicians cross this bright line and abuse their patients sexually. The true extent of sexual abuse of patients by physicians in the U.S. health care system is unknown. An analysis of National Practitioner Data Bank reports of adverse disciplinary actions taken by state medical boards, peer-review sanctions by institutions, and malpractice payments shows that a very small number of physicians have faced "reportable" consequences for this unethical behavior. However, physician self-reported data suggest that the problem occurs at a higher rate. We discuss the factors that can explain why such sexual abuse of patients is a persistent problem in the U.S. health care system. We implore the medical community to begin a candid discussion of this problem and call for an explicit zero-tolerance standard against sexual abuse of patients by physicians. This standard must be coupled with regulatory, institutional, and cultural changes to realize its promise. We propose initial recommendations toward that end.

KEY WORDS: medical board; sexual abuse; sexual misconduct; National Practitioner Data Bank; zero tolerance.

J Gen Intern Med 34(7):1330–3
DOI: 10.1007/s11606-019-05014-6

The prohibition against physician sexual relations with their patients, which can cause lasting damage to patients, is one of the most universally agreed upon ethical principles in medicine. For example, in 1991, the American Medical Association (AMA) declared unequivocally that these relations are unethical, noting that this prohibition was incorporated into the Hippocratic oath.[1] Other professional medical organizations and state medical boards have echoed this stance.

Yet numerous reports of physicians who have violated this prohibition (such as the disgraced gymnastics physician, Lawrence Nassar) indicate that more definitive action is needed to prevent physician sexual abuse of patients in the U.S.A.

In this Perspective, we discuss the available evidence on the extent of physician sexual abuse of patients in the U.S.A. and factors that contribute to this problem, and we propose recommendations to safeguard against it.

Sexual contact between a physician and a patient or any behavior or remarks of a sexual nature by physicians toward patients have been legally considered sexual abuse since 1994 in Ontario, Canada, under the province's Regulated Health Professions Act, which defines sexual abuse as[2]: "(a) sexual intercourse or other forms of physical sexual relations between the [physician] and the patient, (b) touching, of a sexual nature, of the patient by the [physician], or (c) behavior or remarks of a sexual nature by the [physician] towards the patient." One explicit purpose of the Ontario law is "to eradicate the sexual abuse of patients by [physicians]." The term sexual abuse does not exist in U.S. state regulations of physicians. In lieu of "sexual abuse," the U.S. medical community, including the Federation of State Medical Boards (FSMB), uses the term "sexual misconduct" to characterize this unethical behavior. Although U.S. definitions of sexual misconduct tend to overlap with Ontario's definition of sexual abuse, the former term encompasses misconduct that does not involve patients and fails to connote the profound unethical nature of sexual relations between physicians and their patients.

DATA ON PHYSICIAN SEXUAL ABUSE AND SEXUAL MISCONDUCT

A 2017 exploratory analysis of 101 cases of physician sexual abuse of patients found that the primary forms of abuse in these cases were inappropriate touching (33%), sodomy (31%), rape (16%), child molestation (14%), and purportedly consensual sex (7%).[3] It also revealed that certain patient characteristics (such as female gender and young age) and certain physician characteristics (including male gender, age greater than 39, and consistently examining patients alone in nonacademic settings) were associated with physician sexual abuse.[3] However, the authors concluded that "there were no necessary conditions for [sexual abuse] cases to occur except for the sexual urges of the physicians."

A 1998 study identified 567 U.S. physicians who were disciplined by state medical boards from 1981 through 1996 for sex-related offenses (including sexual intercourse, rape,

Prior presentation: *This perspective has not been presented or published elsewhere.*

Received May 1, 2018
Revised October 22, 2018
Accepted March 21, 2019
Published online May 1, 2019

sexual molestation, and sexual favors for drugs), 75% of which involved patients. These violations would have been considered physician sexual abuse of patients as defined by the aforementioned Ontario law.[4]

Our 2016 analysis of data from the U.S. National Practitioner Data Bank (NPDB) showed that from January 2003 through September 2013, 862 physicians had state licensing disciplinary actions because of sexual misconduct, totaling 974 such actions.[5] These numbers represent fewer than 0.1% of all licensed U.S. physicians.[5] The U.S. rate of such disciplinary actions was approximately 9.5 per 10,000 physicians per 10 years. Importantly, the NPDB Public Use Data do not report any details about the nature of the sexual misconduct.

In comparison, data from a 2011 study of disciplinary actions by medical licensing authorities in Canada from 2000 to 2009[6] showed an approximate rate of disciplinary actions for sexual misconduct of 25.1 per 10,000 physicians per 10 years. Thus, the Canadian rate of discipline for sexual misconduct was 2.6 times higher than the U.S. rate. Like the U.S. study, the Canadian study did not characterize the nature of the sexual misconduct. Also, neither study reported the proportions of sexual misconduct that involved patients.

Despite the limitations of both studies, the difference in the rates of disciplinary actions for sexual misconduct by U.S. and Canadian medical licensing authorities likely reflects more frequent detection and disciplining of physicians who commit sexual misconduct in Canada rather than more frequent sexual misconduct by Canadian physicians; there is no evidence that Canadian physicians are more prone to sexual misconduct than U.S. physicians.

Studies analyzing reports of disciplinary actions for physician sexual misconduct likely underestimate the scope of the problem. For example, a 1996 anonymous random national survey of U.S. physician members of the AMA (response rate = 52%) showed that 3.4% of the respondents reported a history of personal sexual contact (genital–genital, oral–genital, or anal–genital) with one or more patients.[7]

FACTORS THAT ALLOW THIS PROBLEM TO PERSIST

Several factors may explain why physician sexual abuse of patients continues to be a persistent problem in the U.S.A. First, many cases of physician sexual abuse of patients go unreported. This is because patients may be shocked and consumed by feelings of disbelief, guilt, or shame; may be fearful that they will not be believed due to the significant power imbalance between physicians and their patients; or may be unwilling to publicly disclose the abuse. Additionally, victims may not know how to navigate the regulatory system to seek redress for the harms of physician sexual abuse, such as filing a complaint with the state medical boards that licensed the physicians. Even when they file complaints, victims can be further traumatized by the investigation and legal procedures, which may lead them to withdraw their complaints. Importantly, physicians often are unwilling to report their impaired or incompetent colleagues to relevant authorities,[8] likely due to the absence of enforceable legal mandates for such reporting.

Second, according to the FSMB, many hospitals and health care organizations regularly ignore or circumvent reporting requirements for medical boards regarding impaired physicians.[9]

Third, medical boards may not always act on complaints of physician sexual abuse of patients, especially when there is no material evidence or witnesses.[10, 11] A 2006 report found that two-thirds of all complaints received by medical boards were closed either due to inadequate evidence to support the charges or because these cases were resolved informally, through a notice of concern or a similar communication with the involved physician.[12] The report noted that only 1.5% of the overall complaints to medical boards reached the formal hearing stage.

There is evidence that even when medical boards discipline physicians for sexual abuse, those physicians often are permitted to resume medical practice. For example, a 2016 nationwide investigation of thousands of medical board orders for physicians who were disciplined for sexually abusing patients or other sex-related offenses since 1999 found that more than one-half of these physicians were still licensed to practice.[13] Little information exists on the effectiveness of possible safeguards, such as counseling of sexually abusive physicians, to prevent recidivism and possible harm to future patients. Additionally, the aforementioned 2016 NPDB analysis showed that medical boards did not discipline 70% of the physicians who had peer-review sanctions or malpractice payments made on their behalf due to sexual misconduct.[5]

PROPOSED RECOMMENDATIONS TO ADDRESS PHYSICIAN SEXUAL ABUSE OF PATIENTS

Physician sexual abuse of patients must be classified as "never events": No patient should ever experience any form of sexual abuse, or fear of being subjected to such behavior, by a physician. We offer the following recommendations as initial steps to reach this goal:

(1) Replace the term "sexual misconduct" currently used in the U.S. medical community with the term "sexual abuse" when referring to any physician conduct that meets the Ontario Regulated Health Professions Act's definition of the latter term. Furthermore, the U.S. medical community and all state medical practice acts, as the Government of Ontario and the Medical Council of New Zealand[14] did, should adopt an explicit "zero-tolerance" standard against all forms of physician sexual abuse of patients. This standard should be incorporated into all applicable policies and regulations governing U.S. physicians.

(2) Educate physicians at every stage of their training and careers about the enormity of sexual abuse of patients, how to avoid it, and how to seek help if they are struggling with challenges to their professional boundaries with patients.
(3) Educate the public about how to prevent, recognize, and report physician sexual abuse. This should be a shared responsibility between state medical boards and health care institutions.
(4) Encourage and facilitate patient and patient surrogate reporting of all forms of physician sexual abuse. This recommendation can be accomplished by having health care institutions and medical boards establish standardized processes, which should be made known to patients and their surrogates, for filing complaints regarding any physician sexual abuse they may have experienced or witnessed and hiring patient-advocate professionals with whom patients and their surrogates can be encouraged to discuss such allegations.
(5) The medical community should mandate reporting by physicians and other health care professionals of any witnessed or suspected physician sexual abuse of a patient and should institute necessary measures to prevent reprisal against individuals who make such reports. Penalties for failing to report physician sexual abuse of patients should be set and enforced. Educational bystander intervention training should be encouraged to equip physicians and other health care professionals with the skills necessary to take appropriate action if they witness or suspect physician sexual abuse of patients.
(6) Medical boards and health care institutions should investigate each complaint of alleged physician sexual abuse of patients and conduct hearings if there are grounds for proceeding (while providing due process for the accused physician and for patient witnesses). The 2006 FSMB guidelines for state medical boards for dealing with physician sexual misconduct are a good resource.[15] However, these guidelines need to be vetted further by other stakeholders to determine the best practices for handling these cases. Similar guidelines are needed for health care institutions. We acknowledge that innocent physicians may be falsely accused of sexual abuse. Therefore, all complaints of alleged physician sexual abuse of patients should be pursued fairly and through due process.
(7) Health care institutions and medical boards should discipline physicians who are found to have engaged in any form of sexual abuse of patients. Health care institutions should be required to report physicians found to have engaged in such behavior to the appropriate medical board. Clear penalties (including suspension and revocation of medical license and clinical privileges) should be established and enforced by the medical community. The severity and length of these penalties should be based on the severity of the type of sexual abuse. In no case should public safety be compromised for any financial consideration, such as the revenue generated by the offending physician.
(8) Health care institutions and medical boards also should report physicians who were found to have engaged in sexual intercourse or other forms of physical sexual relations or touching of a sexual nature of a patient to law enforcement authorities in all cases, not just when the victim is a child.
(9) Medical boards should disclose on their websites complete information concerning all disciplinary actions against physicians who have been found to have sexually abused their patients.
(10) Health care institutions and medical boards should establish and fund programs to provide subsidized psychological counseling for all patients who were found to have been abused by their physicians. These institutions can seek reimbursement for such costs from the sexually abusive physicians.
(11) Health care institutions should provide trained chaperones to act as "practice monitors" during breast, full-body skin, genital, and rectal exams, having previously discussed this issue when patients first seek care.[16] The offer should be made regardless of the physician's gender.[17]

CONCLUSION

It is time for the U.S. medical community to begin a candid discussion of what needs to be done to end physician sexual abuse of patients. Each medical board, professional organization, and health care institution should evaluate its current systems and procedures regarding this problem and should take comprehensive and stronger actions, including seeking legislation, to protect patients from all physicians who evade medical ethics, betray the trust of their patients, and exploit the patient–physician relationship for their own sexual gratification.

Corresponding Author: *Azza AbuDagga, M.H.A., Ph.D; Health Research Group, Public Citizen, Washington, DC, USA (e-mail: aabudagga@citizen.org).*

Author Contributions *All authors take responsibility for the integrity of this perspective: All authors conceived it; AbuDagga prepared the first draft; and AbuDagga, Carome, and Wolfe critically revised it. The authors thank Fiona Lynn, MPS, managing editor of Public Citizen's Health Research Group, for her work on editing this article, and thank Dr. Robert E. Oshel (Retired Associate Director for Research and Disputes, Division of Practitioner Data Banks, Health Resources and Services Administration, U.S. Department of Health and Human Services) for his in-kind contribution to their work on physician sexual abuse and for reviewing early drafts of this perspective.*

Funding *Funding was provided by Public Citizen Foundation.*

Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. JAMA. 1991;266(19):2741–2745.
2. Government of Ontario. Regulated Health Professions Act, 1991, S.O. 1991, c. 18. (Currency date: November 1, 2018). https://www.ontario.ca/laws/statute/91r18/v6. Accessed 15 March 2019.
3. **Dubois JM, Walsh HA, Chibnall JT, et al.** Sexual violation of patients by physicians: A mixed-methods, exploratory analysis of 101 cases [published online June 19, 2017]. Sex Abuse. https://doi.org/10.1177/1079063217712217. Accessed 15 March 2019.
4. **Dehlendorf CE, Wolfe SM**. Physicians disciplined for sex-related offenses. JAMA. 1998;279(23):1883–1888.
5. **AbuDagga A, Wolfe SM, Carome M, Oshel RE**. Cross-sectional analysis of the 1039 U.S. physicians reported to the National Practitioner Data Bank for sexual misconduct, 2003–2013. PLoS One. 2016;11(2):e0147800.
6. **Alam A, Klemensberg J, Griesman J, Bell CM**. The characteristics of physicians disciplined by professional colleges in Canada. Open Med. 2011;5(4):e166-e172.
7. **Bayer T, Coverdale J, Chiang E**. A national survey of physicians' behaviors regarding sexual contact with patients. South Med J. 1996;89(10):977–982.
8. **Campbell EG, Regan S, Gruen R**, et al. Professionalism in medicine: results of a national survey of physicians. Ann Intern Med. 2007;147(11):795–802.
9. Federation of State Medical Boards. Position statement on duty to report. https://www.fsmb.org/globalassets/advocacy/policies/position-statement-on-duty-to-report.pdf. Published 2016. Accessed 15 March 2019.
10. **Moktadier A.** Sexual abuse in hospitals is more common than you think. https://www.vix.com/en/health/525583/sexual-abuse-in-hospitals-is-more-common-than-you-think. Published 2018. Accessed 15 March 2019.
11. **Sakal M.** Misconduct claims against doctors raise concerns. *East Valley Tribune*. http://www.eastvalleytribune.com/local/mesa/misconduct-claims-against-doctors-raise-concerns/article_6e720470-8ba7-11df-9419-001cc4c002e0.html. Published July 11, 2010. Accessed 15 March 2019.
12. **Bovbjerg RR**, **Josephine G**. State Discipline of Physicians: Assessing State Medical Boards Through Case Studies. Washington, D.C: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; 2006.
13 **Hart A.** AJC doctors & sex abuse investigation sparks improved patient protection. AJC. http://doctors.ajc.com/impact/. Accessed 15 March 2019.
14. Medical Council of New Zealand. Sexual boundaries in the doctor-patient relationship. https://www.mcnz.org.nz/assets/News-and-Publications/2018-Review/2018-ReviewConsultation-Appendix-IDraft-statementSexual-boundaries.pdf. Published 2018. Accessed 15 March 2019.
15. Federation of State Medical Boards. Addressing sexual boundaries: Guidelines for state medical boards. https://www.fsmb.org/siteassets/advocacy/policies/grpol_sexual-boundaries.pdf. Published 2006. Accessed 15 March 2019.
16. **Pimienta AL, Giblon RE**. The case for medical chaperones. Fam Pract Manag. 2018;25(5):6–8.
17. Committee on Ethics, American College of Obstetricians and Gynecologists. ACOG Committee opinion no. 373: Sexual misconduct. Obs Gynecol. 2007;110(2 Pt 1):441–444.