

Physicians Disciplined for Sex-Related Offenses

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Context.—Physicians who abuse their patients sexually cause immense harm, and, therefore, the discipline of physicians who commit any sex-related offenses is an important public health issue that should be examined.

Objectives.—To determine the frequency and severity of discipline against physicians who commit sex-related offenses and to describe the characteristics of these physicians.

Design and Setting.—Analysis of sex-related orders from a national database of disciplinary orders taken by state medical boards and federal agencies.

Subjects.—A total of 761 physicians disciplined for sex-related offenses from 1981 through 1996.

Main Outcome Measures.—Rate and severity of discipline over time for sex-related offenses and specialty, age, and board certification status of disciplined physicians.

Results.—The number of physicians disciplined per year for sex-related offenses increased from 42 in 1989 to 147 in 1996, and the proportion of all disciplinary orders that were sex related increased from 2.1% in 1989 to 4.4% in 1996 ($P < .001$ for trend). Discipline for sex-related offenses was significantly more severe ($P < .001$) than for non-sex-related offenses, with 71.9% of sex-related orders involving revocation, surrender, or suspension of medical license. Of 761 physicians disciplined, the offenses committed by 567 (75%) involved patients, including sexual intercourse, rape, sexual molestation, and sexual favors for drugs. As of March 1997, 216 physicians (39.9%) disciplined for sex-related offenses between 1981 and 1994 were licensed to practice. Compared with all physicians, physicians disciplined for sex-related offenses were more likely to practice in the specialties of psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice (all $P < .001$) than in other specialties and were older than the national physician population, but were no different in terms of board certification status.

Conclusions.—Discipline against physicians for sex-related offenses is increasing over time and is relatively severe, although few physicians are disciplined for sexual offenses each year. In addition, a substantial proportion of physicians disciplined for these offenses are allowed to either continue to practice or return to practice.

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SEXUAL RELATIONSHIPS between physicians and their patients can have devastating consequences for the patients¹⁻⁶ and can harm physicians' ability

to make objective medical judgments.⁷ Ethical prohibitions against sexual relationships between physicians and their patients date back at least to the Hippocratic oath, which was probably written in the late fourth century BC.⁸ However, only in the last 30 years has sexual contact with patients been clearly condemned by the medical profession.

In 1973, the first code of ethics of the American Psychiatric Association (APA) explicitly condemned sexual contact with patients.⁹ The ethics code published in 1989 added that even with a former patient sex "almost always is unethical."¹⁰ In 1993, the APA's ethics code stated, presumably based on the growing recognition that the power imbalance of the physician-patient relationship endured even after treatment had been terminated, that "sexual activity with a current or former patient is unethical."¹¹

See also pp 1889 and 1915.

In 1986, the Council of Ethical and Judicial Affairs of the American Medical Association (AMA) first issued an opinion⁷ on physician sexual misconduct that stated, "Sexual misconduct in the practice of medicine violates the trust the patient reposes in the physician and is unethical."¹² In 1992, the Council updated this opinion to explicitly define sexual misconduct, stating that all sexual contact with current patients constitutes sexual misconduct, and "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."⁷

State legislatures have increasingly paid attention to this issue by passing laws that criminalize sexual contact between patients and psychotherapists. In 1996, Idaho passed the first law, as far as we are aware, to criminalize all sexual contact between a patient (except for spouses and domestic partners) and any medical care provider.¹³ However, whether the increased attention to this problem is resulting in increased disciplinary activity against physicians who have sexual rela-

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tions with patients is unknown. In this study, we analyzed the frequency and severity of disciplinary actions taken against physicians for sex-related offenses and determined the characteristics of the disciplined physicians.

METHODS

Construction of Database on Disciplinary Activity

In 1989, the Public Citizen's Health Research Group began requesting information on all disciplinary orders that state medical boards and federal agencies (the Department of Health and Human Services, the Drug Enforcement Agency, and the Food and Drug Administration) had taken against physicians, including both doctors of medicine (MDs) and doctors of osteopathic medicine (DOs). By October 1996, 20 914 disciplinary orders taken prior to January 1, 1995, had been reported and entered into our database of disciplinary orders. However, not all jurisdictions have provided complete data for all the years. Ten states or agencies reported no data or partial data in 1989; 6 agencies reported no data or partial data in 1990; 4 in 1991; 5 in 1992; and 3 in 1993 and 1994. Some agencies provided data for years prior to 1989, dating back as far as the mid-1970s.

The information provided by each agency varied, as disciplinary actions are prepared for public release in different ways by the agencies. Once this information was received, it was entered into our database in a standardized format using a detailed data-entry protocol. A record was created for each order and included the following data items: the agency that sanctioned the physician, physician name, license number, address, birth date, date of the disciplinary action, the 2 most serious disciplinary actions, the offense, and a note field that included any additional relevant information contained in the information provided by the agency. The agencies varied in the amount of detail provided, thereby affecting whether the offense or the actions taken in the disciplinary order could be identified and entered into the database. For example, the proportion of orders from a given agency that had an identifiable offense ranged from 11% to 100%, whereas the number of orders with an identifiable action ranged from 61% to 100%. Overall, 68% of orders had an identifiable offense, and 95% had an identifiable action.

Actions taken against physicians by state medical boards and federal agencies were entered as 1 of 24 types. These actions, in order of decreasing severity, were revocation of license, surrender of license, disallowance of the right to re-

new a license, revocation of controlled substance license, surrender of controlled substance license, disallowance of the right to renew a controlled substance license, denial of a license, denial of license reinstatement (from a revocation or surrender), reinstatement (from a revocation or surrender), suspension, suspension of controlled substance license, emergency suspension, license probation, probation of controlled substance license, fine, license restriction, restriction of controlled substance license, reprimand, education, enrollment into an impaired physician's program or alcohol or other drug treatment program, cease and desist order, monitoring of a physician's practice, participation in community service, and exclusion from Medicare (only the Department of Health and Human Services can take this action). In about one third of the orders in the database, state medical boards imposed more than 1 action in a single disciplinary order.

To create a database of disciplinary orders for sex-related offenses, the database was searched for sex-related orders that had been taken prior to January 1, 1995. *Sex-related orders* were defined as any orders in which the state board or federal agency mentioned a sex offense, ranging from rape to indecent exposure, as one of the causes for action. Some sex-related orders may have been missed in this search, as the state board or federal agency may not have indicated that a sex offense was a cause of action. Therefore, our database most likely underestimated both the number of physicians disciplined for sex-related offenses and the number of orders taken against physicians identified as having been disciplined.

After identifying all relevant orders, the state and federal agencies that had sanctioned each physician were contacted to determine the current licensure status of that physician and to inquire about any modifications (such as court overturns of disciplinary actions) to the selected orders.

In addition to that process, we also updated the database of disciplinary orders and searched for sex-related orders taken in 1995 and 1996. These orders were only used in the analyses of the number of orders taken, physicians disciplined by year, and the type of sexual offense and are not included in the analysis of severity of discipline or physician characteristics.

Physician Characteristics in the Database on Disciplinary Activity

The date of the earliest action for a sex-related offense taken against each physician included in the database of sex-related orders was identified, and

the year of this action was used to select an edition of the *Directory of Physicians in the United States* (titled the *American Medical Directory* prior to 1992) (for MDs), published by the AMA, or the *Yearbook and Directory of Osteopathic Physicians* (for DOs), published by the American Osteopathic Association (AOA). If the relevant sourcebook had been published in the year of the disciplinary order, the physician-specific information provided in these publications, which included information about the physicians' self-reported primary specialty, board certification status, major professional activity, and ZIP code of the preferred professional address was obtained. If the relevant publication was not available from that year, the publication from the closest preceding year was used.

The birth date of the disciplined physicians was found either on the original disciplinary information, if the disciplinary agency had provided it, or from subsequent calls to these agencies. We did not obtain birth dates for all physicians, as 9 of the 42 state agencies we contacted did not provide this information.

Whether the preferred professional address of the MDs in the database of sex-related orders was in a metropolitan area or not was determined by entering the ZIP codes obtained from the relevant *Directory of Physicians in the United States* into the MABLE/GEOCORR Geographic Correspondence Engine, found on the World Wide Web at <http://www.oseda.missouri.edu/plue/geocorr/>.

Frequency and Severity of Discipline and Offenses

The frequency and severity of disciplinary orders for sex-related offenses was tabulated for the years 1989 to 1994, the period with the most complete data, and was compared with the overall frequency and severity of disciplinary orders for all offenses. Additional data on the frequency of sex-related offenses were included for 1995 to 1996. The number of physicians disciplined in each year was also determined using a computer protocol supplemented by additional information in the material from the agencies to identify records belonging to the same physician.

The severity of orders taken by state medical boards over time from 1989 to 1994 was tabulated, with surrender and revocation of licensure being the most severe, followed by suspension or emergency suspension, probation or restriction, and less serious actions. The most serious action taken against each physician was determined using these same hierarchies. Physicians who had any orders for which the disciplinary agency had not

Table 1.—Number of Disciplinary Orders for Sex-Related Offenses and Physicians Against Whom They Were Taken, 1989-1994*

Year	No. of Orders	No. of Physicians†	No. of Total Orders in Database (Sex and Not Sex Related)	Sex-Related Orders as a % of Total Orders	No. of Agencies With Complete Data Reported
1989	47	42	2266	2.1	43
1990	68	63	2659	2.6	47
1991	81	78	2427	3.3	49
1992	112	104	2354	4.8	48
1993	126	112	2684	4.7	50
1994	162	144	3087	5.2	50
1995	167	155	3564	4.7	51
1996	154	147	3492	4.4	51
Total	917	...	22533	4.1	...

*The physicians include doctors of medicine and doctors of osteopathic medicine. Ellipses indicate data not applicable.

†This column is not cumulative, as physicians may be disciplined in more than 1 year.

reported which action(s) they took were not included in this analysis. Only physicians who had an order taken after 1988 were included for these analyses.

The offenses for which all physicians, including those disciplined in 1995 and 1996, were disciplined were categorized according to the nature of the sexual offense. The first 3 categories involve patients and the last involves persons who are either nonpatients or whose identities were not specified. The first 3 categories, in descending order of known severity, are (1) sexual intercourse or sexual relationship or rape involving a patient; (2) sexual touching or contact; and (3) sexual offenses involving patients, details not specified. If a physician committed offenses in more than 1 category, he or she was counted once, and the classification was based on the most severe identifiable offense.

The percentage of disciplined physicians who were licensed to practice as of March 1997 was calculated. A physician with all licenses suspended, revoked, or not renewed was classified as inactive, and a physician who had 1 or more licenses restricted, on probation, or free of restrictions was classified as active.

The rate of discipline by individual state medical boards was determined using only the 42 medical boards that had identifiable offenses in at least 50% of all orders reported to us for MDs between 1989 and 1994. For determining the state with the highest rate of discipline, only the 21 medical boards that met this criteria and had reported 10 or more sex-related orders to us between 1989 and 1994 were considered. Only MDs were used in this state-by-state analysis because we do not have information on disciplinary actions taken against DOs in states with separate osteopathic boards.

Physician Characteristics

The characteristics of disciplined physicians were compared with the characteristics of the national physician popu-

lation, as reported for MDs¹⁴ and the DOs.¹⁵ Most of the analysis of characteristics was performed only for MDs, due to difficulty in standardizing information given by the 2 organizations. However, information on DOs was included when possible (in the analysis of age and major professional activity) to present the most complete data possible.

To allow for comparison of our data with the MD data¹⁴ in the analysis of the specialties of physicians disciplined for sex-related offenses, the more than 100 specialties, which a physician can identify in the *Directory of Physicians in the United States*, were grouped into the 38 specialties used by the AMA for statistical purposes. No data on specialties were collected for physicians whose major professional activity was listed as unknown or inactive in the relevant *Directory of Physicians in the United States*. This was necessary to allow for comparison with the national data¹⁴ on physician distribution among specialties. In the analysis of the specialties of disciplined physicians over time, only the year of the first action taken against the physician was used.

The age of the physicians at the time of the first disciplinary action was calculated using the date of the first action and the birth date. In analyses of the major professional activity of physicians, data on MDs and DOs were combined. In the analyses of board certification status and practice location, only specialties that were overrepresented among disciplined physicians and had large enough cell sizes (greater than 10) were analyzed individually.

Statistical Analysis

Stata statistical software (Stata Corp, College Station, Tex) was used in the analysis. All tests of proportions were 2-tailed z tests using a significance level of .05. The χ^2 tests for trend that were analyzed with EPI5 software (EPI Information, Inc, Stone Mountain, Ga)

Table 2.—Disciplinary Actions Taken Against Individual Physicians for Sex-Related Offenses*

Disciplinary Action	No. (%) (N = 448)
Revocation	156 (34.8)
Surrender	43 (9.6)
Suspension	101 (22.5)
Emergency suspension	17 (3.8)
Probation and restriction	88 (19.6)
No serious actions	43 (9.6)

*Only physicians who had orders taken after 1988 and through 1994 are included in this table. Physicians who had any orders in which the regulatory agency did not report what actions were taken are not included in this analysis. The disciplinary actions included in this table are the most serious actions taken against an individual physician. The physicians include doctors of medicine and doctors of osteopathic medicine.

were used in the analysis of time-trend data, with a significance level of .05.

RESULTS

Frequency and Severity of Discipline and Offenses

The database contained 728 sex-related orders taken against 542 physicians between 1981 and 1994 and 321 additional orders taken in 1995 and 1996. From 1989 to 1996, the number of physicians disciplined in each year increased from 42 in 1989 to 147 in 1996, while the number of orders in each year increased from 47 to 154 (Table 1). The percentage of all orders reported to us by the state and federal agencies that were sex related also increased during this time, from 2.1% of all orders in 1989 to 4.4% of all orders in 1996 (Table 1) ($P < .001$ for trend). The year with the highest rate of discipline for sex-related offenses was 1994, in which 5.2% of all orders were sex related, and 0.02% of all physicians in the country were disciplined for sex-related offenses (based on 621 129 practicing physicians).¹⁶ In 1996, the rate of discipline for sex-related offenses had declined to 4.4% of all orders.

Of physicians disciplined for sex-related offenses from 1989 to 1994, 44.4% had one or more of their licenses revoked or surrendered them. For 26.3%, suspension or emergency suspension was the most serious action; the remaining 29.2% had less serious actions taken against them (Table 2).

Disciplinary orders for sex-related offenses from 1989 to 1994 were more severe than orders for non-sex-related offenses, with 71.9% of sex-related orders involving loss or suspension of license, compared with 42.8% of the 11 561 non-sex-related disciplinary orders ($P < .001$). During this period, 38.2% of orders for sex-related offenses involved loss of license; 33.7% involved suspension of license; 22.3% involved restriction of license; and 5.8% had no serious actions.

Table 3.—Sex-Related Offenses for Which Physicians Were Disciplined

Offense	No.
Involving patients (n = 567)	
Sexual intercourse*	170
Sexual contact†	112
Unclear as to which of the above‡	285
Not involving patients or unclear about patient involvement	194
Total of All Offenses	761

*Includes sexual relations, sex with patients, sexual act(s) with a patient, engagement in sex with patient, and sexually involved.

†Includes sexual contact, intimate nonmedical physical contact, sexually harassed and improperly handled, and physical contact of a sexual nature.

‡Includes sexually mauled, sexual abuse, sexually exploited, sexual encounter, sexual intimacies, sexually molested, sexual favors for drugs, convicted of sexual assault, sexual transgressions, gross sexual imposition, sexual assault, history of sexual activity, and willful physical and sexual abuse.

There was no trend toward increased or decreased severity of discipline over time.

Of the 761 physicians disciplined for sexually related offenses, the offenses of 567 (75%) involved patients. As shown in Table 3, 170 physicians (22% of those disciplined) had sexual intercourse with their patients, 112 (15%) had sexual contact or touching, and 285 physicians (37%) committed sexual offenses in which it was not clear which of the previous 2 categories were involved (including sex abuse, sexual assault, sexual encounter, and sexual favors for drugs) (Table 3). Offenses of the other 194 physicians (25%) either involved nonpatients or, in some instances, unspecified individuals.

As of March 1997, 216 of physicians (39.9%) reported as having been disciplined for sex-related offenses prior to 1995 were licensed to practice in 1 or more of the jurisdictions that originally sanctioned them. An additional 50 disciplined physicians (9.2%) had no active licenses but had 1 or more suspended licenses.

The rate of discipline by state boards for sex-related offenses between 1989 and 1994 varied widely, from 3.3 MDs disciplined per 1000 MDs to 0 MDs disciplined per 1000 MDs. The severity of orders for sex-related offenses varied from state to state, with the percentage of sex-related orders involving severe penalties (license revocation, surrender, suspension, emergency suspension, probation, or restriction), ranging from 68.4% to 100%.

Characteristics of Disciplined Physicians

The specialties of psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice were all significantly overrepresented among physicians disciplined for sex-related offenses prior to 1995 as compared with

Table 4.—Selected Specialties of MDs Disciplined for Sex-Related Offenses*

Specialty	No. of MDs in Specialty		MDs in Specialty, %		
	Disciplined	Nationally	Disciplined MDs	All MDs	P Value
Psychiatry	133	36 405	27.9	6.3	<.001
Child psychiatry	12	4618	2.5	0.8	<.001
Obstetrics and gynecology	60	35 273	12.6	6.1	<.001
Family and general practice	97	71 688	20.3	12.4	<.001
Emergency medicine	12	15 470	2.5	2.7	.83
Orthopedic surgery	11	20 640	2.3	3.6	.14
General surgery	17	39 211	3.6	6.8	<.005
Internal medicine	43	109 017	9.0	18.9	<.001
Anesthesiology	9	28 148	1.9	4.9	<.002
Pediatrics	14	44 881	2.9	7.8	<.001
Total†	477	578 108

*This table only includes MDs (doctors of medicine) for whom a specialty was located in the relevant *Directory of Physicians in the United States*, and for whom a known and active major professional activity was listed. Only the 10 most frequent specialties in our database are included. Other specialties represented in our database are allergy and immunology, cardiovascular diseases, colon and rectal surgery, dermatology, diagnostic radiology, gastroenterology, general preventive medicine, neurological surgery, neurology, occupational medicine, ophthalmology, otolaryngology, pathology, physical medicine and rehabilitation, plastic surgery, public health, pulmonary diseases, radiation oncology, other specialty, and unspecified specialty. Ellipses indicate data not applicable.

†Totals include physicians in all specialties.

the proportion of all MDs in the country in that specialty (Table 4). Psychiatry was the specialty with the highest number (133) of disciplined physicians and was also the most overrepresented among disciplined physicians. Of all physicians in the country, 6.3% identify psychiatry as their primary specialty, whereas 27.9% of disciplined physicians were psychiatrists, a 4.4-fold overrepresentation. General surgery, internal medicine, anesthesiology, and pediatrics were all underrepresented among disciplined physicians. The percentage of disciplined physicians who were psychiatrists decreased over time, from 39.4% in 1989 to 21.6% in 1994 ($P = .02$). In contrast, the percentage of disciplined physicians who specialized in family and general practice increased from 9.1% in 1989 to 24.5% in 1994 ($P = .02$). There were no significant differences over time for rates of discipline for physicians who practice obstetrics and gynecology or all other specialties.

Physicians disciplined for sex-related offenses were older than the national physician population. Among all physicians only 34.5% were between the ages of 45 and 64 years, whereas 58.1% of disciplined physicians were in this age group ($P < .001$) (Table 5). However, among physicians older than 64 years, there was no significant difference between physicians disciplined for sex-related offenses and the national physician population.

Disciplined physicians were significantly overrepresented ($P < .001$) among physicians whose major professional activity was direct patient care, and significantly underrepresented among those involved in postgraduate education or non-patient care activities ($P < .001$ and $P = .02$, respectively) (Table 6). There

was no significant difference between disciplined MDs and all MDs in the percentage who were board certified overall (58.7% vs 60.2%) and for each of the specialties studied. Disciplined physicians as a whole, as well as in each specialty studied, were not more or less likely to list a preferred professional address in metropolitan areas than all physicians in the country (86.0% vs 88.4%).

COMMENT

Our study found that the number and rate of disciplinary orders for sex-related offenses increased over time, from 42 orders (2.1% of all orders) in 1989 to 147 orders (4.4% of all orders) in 1996, and that disciplinary actions were more severe for sex-related offenses than for non-sex-related offenses. However, discipline had not become more severe over time and almost 40% of disciplined physicians were licensed to practice as of March 1997. Of 761 physicians disciplined, 567 (75%) were disciplined for sexual offenses involving their own patients (including sexual intercourse, rape, sexual molestation, and sexual favors for drugs), all of which are gross violations of the boundaries that must exist between physician and patient.

Disciplined physicians were more likely to practice in psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice than nondisciplined physicians and were older than the national physician population, but were no more or less likely to be board certified than all physicians in the country. The increased frequency of discipline for sex-related offenses over time found in our study is in agreement with a report by the Federation of State Medical Boards,¹⁷ which found that the percentage of actions that involved sexual

Table 5.—Age of Physicians Disciplined for Sex-Related Offenses at the Time of the First Disciplinary Action Taken Against Them*

Age, y	All Physicians in 1992,		P Value
	No. (%)	No. (%)	
<35	26 (6.0)	141 711 (22.6)	<.001
35-44	112 (25.7)	205 638 (32.7)	<.002
45-54	142 (32.6)	130 772 (20.8)	<.001
55-64	111 (25.5)	86 224 (13.7)	<.001
>64	44 (10.1)	63 699 (10.1)	.98
Total	435 (100)	628 044† (100)	

*No birth date was located for 107 physicians. The physicians include doctors of medicine (MDs) and doctors of osteopathic medicine (DOs).

†This total includes all active and not classified MDs, all MDs listed by the American Medical Association as "address unknown," and all active, inactive, and not classified DOs.

misconduct had increased from 2.6% in 1990 to 3.9% in 1992.

While this finding suggests that the public is being better protected from physicians who commit sex-related offenses, our analysis of the severity of discipline indicates that regulatory agencies may not be adequately sanctioning those physicians whom they do discipline for these offenses. While the severity of actions taken for sex-related offenses was greater than that for non-sex-related offenses according to our analysis, more than 25% of disciplinary orders were no more severe than probation or restriction of license. The Federation of State Medical Board's data support our findings, as 28.6% and 31.0% of orders in their database for 1990 and 1992, respectively, did not involve revocation, suspension, or surrender of license.¹⁷

Physicians disciplined for sex-related offenses apparently are being allowed to continue to practice with, at most, safeguards, such as having a chaperone present during examinations and having another physician monitor patient records. This finding is problematic considering that there are difficulties in properly assessing the potential for successful and sustained rehabilitation of these professionals.^{18,19} Furthermore, safeguards such as monitoring are often inadequately overseen by medical boards.¹⁹

Not only is the severity of discipline for sex-related offenses seemingly inadequate, but the frequency of discipline, although improving, also seems to be deficient, as the highest annual rate of discipline in our study was only 0.02%. Even if all physicians were to practice for 40 years, not even 1% of all physicians in the country would be disciplined for sex-related offenses. Previous studies indicate that this rate is low in comparison with the actual occurrence of sex-related offenses. In a 1992 survey of male and female family practitioners, internists, obstetricians-gynecologists, and surgeons, Gartrell et al²⁰ found that 9% of

Table 6.—Major Professional Activity of Physicians Disciplined for Sex-Related Offenses*

MPA	Disciplined Physicians in MPA, No. (%) (n = 498)	All Federal and Nonfederal Physicians in MPA, No. (%) (n = 602 109)	P Value
Direct patient care	459 (92.2)	460 134 (76.4)	<.001
Nonpatient care activity	22 (4.4)	43 539 (7.2)	.02
Postgraduate education	17 (3.4)	98 436 (16.3)	<.001

*This table excludes all inactive or not classified major professional activities (MPAs). The physicians include doctors of medicine and doctors of osteopathic medicine.

physicians reported having engaged in sexual contact with 1 or more current or former patients. In 1992, the College of Physicians and Surgeons of British Columbia found that 3.5% of physicians acknowledged sexual contact with a current patient.²¹ Comparing these results with our findings suggest that only a fraction of offending physicians are disciplined.

Certain limitations to our data must be noted when considering the frequency and severity of discipline against physicians who commit sex-related offenses. It is probable, due to the difficulty in obtaining detailed information from disciplinary agencies, that we did not identify all physicians against whom discipline for sex-related offenses has been taken. This limitation is at least partly offset by the conservative nature of the estimates in the self-reporting survey studies. Also, for physicians identified as having been disciplined, we may not have located all orders taken against them, as some orders for the same or similar offenses may not have identified the offense as sex related.

Our findings on the characteristics of physicians disciplined for sex-related offenses are in agreement with previous studies. In a study of the disciplinary activity of the Oregon Board of Medical Examiners, Enbom and Thomas²² found that the specialties most likely to have reportable disciplinary actions taken against them were psychiatry and obstetrics and gynecology. Gartrell et al²⁰ reported that obstetrics and gynecology and family practice were the 2 specialties in which physicians were most likely to engage in sexual contact with patients or former patients, whereas physicians in the specialties of internal medicine and surgery were less likely to participate in this behavior.

In an earlier survey, Gartrell et al²³ had found that psychiatrists reported less sexual contact with patients than did physicians in any of the specialties reported in the subsequent study, except internal medicine.²⁰ The discrepancy between this study and our results may reflect the increased attention to sex-related offenses in psychiatry and the lack of attention to this problem in other specialties.

As in our study, Enbom and Thomas²² also found a difference in age between disciplined physicians and their colleagues, with the odds of sexual misconduct allegation increasing by a factor of 1.44 for each increasing decade of age. This age difference may be due to a lag time between offenses and discipline or because the rate of sex-related offenses is higher among older practitioners.

To protect the public, the first line of defense must be the medical disciplinary system. We recommend that agencies responsible for regulating physicians be given the authority to protect the identities of survivors of sex-related offenses by physicians during the investigation and hearing process. In addition, state medical boards should require all investigators and board members to receive training in sensitivity to the issues surrounding sex-related offenses. Although these measures should improve the likelihood that a survivor of sex-related offenses by a physician will file a complaint, Enbom and Thomas²² data suggest that a low frequency of complaints is not the only problem. In their study, only 20 (25%) of 80 physicians who had sexual misconduct complaints filed against them between 1991 and 1995 had actions taken by the board that were reportable to the National Practitioner Data Bank. Given that false allegations of sexual offenses by physicians probably are rare,^{2,18} this finding implies that medical boards should take complaints seriously once they are filed. Moreover, the use of treatment programs and safeguards, such as monitoring for physicians guilty of sex-related offenses, should be considered with the knowledge that there are questions regarding their efficacy.

The medical profession, medical education system, and the legal system also have roles to play in addressing this problem. All state medical boards should consider enacting laws, such as that passed in Idaho, that criminalize all sexual contact between any physician and a patient. The medical profession can participate by altering the pattern of behavior found in past reports that have suggested that physicians who are aware of sexual misconduct by their colleagues are unlikely to take any action.^{5,24}

The willingness of physicians to take corrective action against offending physicians also will be heightened by the existence of medical education that addresses the issues of boundaries and professional ethics. Gartrell and colleagues²⁰ found that, in 1992, 56% of physicians reported they had no education during their training regarding physician-patient sexual contact, and only 3% had taken a continuing medical education

course on this subject. The failure of the educational system to address this issue may allow new physicians to treat patients with little understanding of the responsibilities intrinsic to their new position. Finally, patients should be encouraged to protect themselves by knowing their rights in therapeutic relationships and by filing complaints with their state medical boards should inappropriate behavior by a physician occur.

Data for years prior to 1995 were released in June of 1997 in a report entitled *Physicians Disciplined for Sex-Related Offenses* by Public Citizen's Health Research Group.²⁵ Copies of this report can be obtained by sending \$15 to Public Citizen Publications Department at 1600 20th St NW, Washington, DC 20009-1001.

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