

# Sexual Relationships between Patients and Health Professionals: A Literature Review

Health Professions Regulatory Advisory  
Council (HPRAC)



**Ontario**

Health Professions Regulatory  
Advisory Council

Conseil consultatif de  
réglementation des professions  
de la santé

# A Literature Review on Sexual Relationships between Patients and Health Professionals

Prepared by the Planning Unit  
Health System Planning, Research &  
Analysis Branch  
Health System Strategy & Policy Division  
Ministry of Health and Long-Term Care  
September 2011

## Health System Planning and Research Branch Contacts

Director (A) – [Alison Paprica, PhD](#)  
416-327-0951

Manager (A) – [Catia Creatura-Amelio](#)  
416-327-7948

Project Lead:  
[Cindy Perry, PhD](#) 416- 212-0938  
[Nathan Harron](#) 416-212-4372

Contributors:  
[Andrea Hatvani](#) 416-314-4668  
[Tracy Verhoeve](#) 416-327-8539

*Please take the time to complete an anonymous two-minute [Literature Review Survey](#) to inform us how this review met, or did not meet, your needs.*

Please note that this Rapid Literature Review is a summary of information from other sources, not a representation of the policy position or goals of the Ministry of Health and Long-Term Care. If material in the review is to be referenced, please cite the original, primary source, rather than the review itself.

## OBJECTIVES

The requestor's stated objective was to understand the risks and merits of allowing sexual relations between health care providers and their patients. The initial focus of the search was on treatment by providers of their spouses or current sexual partners, but few studies addressed treatment of patients who were sexual partners before treatment occurred. Therefore, the scope was expanded to include sexual relationships between patients and providers generally. Specifically, the requestor was interested in (1) ethical concerns around sexual relationships between health care providers and spouses or sexual partners, (2) prevalence of sexual boundary violations, (3) risk factors leading to such boundary violations, (4) impact of sexual relationship with their health care provider on patients, and (5) recidivism and effectiveness of disciplinary mechanisms in other jurisdictions. Five professions were of particular interest: physicians, dentists, psychologists, chiropractors, and massage therapists.

The scope excluded definitions of sexual misconduct, descriptions of penalties for sexual abuse/misconduct, and exemptions from penalties in other jurisdictions. Literature prior to 1991 was excluded as these studies would have likely been captured in the 1991 report of the Task Force on Sexual Abuse of Patients produced by the College of Physicians & Surgeons of Ontario.

## SEARCH METHODS FOR IDENTIFICATION OF STUDIES

Individual peer-reviewed articles and review articles were identified through the Ontario Ministry of Health and Long-Term Care's computerized library database, PubMed, and Google Scholar. Grey literature was identified through Google and relevant government websites. The search was limited to English sources and therefore may not capture the full extent of initiatives in non-English speaking countries.

The Medical Subject Heading (MeSH) terms "Societies, Medical/standards", "Professional Misconduct", "Ethics, Professional", "Physician-Patient Relations", "Sexual Behavior", "Nurse-Patient Relations", "Professional-Patient Relations", "Dentist-Patient Relations", and "Sex offenses" were used in combination with the following keywords to identify relevant articles and documents for this review: "Physician-patient relations", "Patient-Doctor Sexual Relationship", "Professionalism", "Professional boundaries", "Ethical Guidelines", "Patient-Therapist Sexual Involvement", "Power \*Balance", and "Influenc\* Patient Decision\*".

A total of 29 references were identified and cited in this review: six review articles, 20 original research papers from peer-reviewed journals, and three documents from the grey literature. Table 1 in the Appendix consists of a summary table with details for each of the sources cited in the review. In total, the searching for relevant material and the writing of this review was completed by two people in approximately 15 working days.

## SUMMARY OF MAIN FINDINGS

- Limitations of literature: Very few relevant studies on sexual relationships between patients and providers were located in this search, and most referred to sexual relationships that occurred between a patient and a provider following the establishment of a professional relationship, rather than the treatment of spouses in particular. The time period for the search was expanded to include over two decades of studies. Findings should therefore be interpreted with caution.

- Boundary Violations and Ethical Concerns:
  - There is much disagreement regarding how to define boundaries for acceptable sexual contact between patients and providers, ranging from zero tolerance to case-by-case evaluation. Some argue that zero tolerance for up to an infinite period of time following termination of the professional relationship is an appropriate standard while others advise more flexibility in defining what is an appropriate relationship following treatment. Flexibility is given based on factors such as the nature of the professional relationship (e.g., therapeutic or not), the length of time since treatment ended, and whether or not the patient has a condition that could affect their ability to make decisions.
  - Several authors noted that treatment of spouses could reasonably be excluded from definitions of sexual boundary violations.
- Prevalence: The most common range reported for the percentage of providers who report having had sexual contact with a current or former patient is between 4% and 10%.
- Risk Factors: Providers who violate sexual contact boundaries are most commonly male and middle aged. The practitioner categories which receive the most disciplinary sanctions for sexual abuse are psychiatrists (including child psychiatrists), general practitioners, and gynaecologists/obstetricians.
- Impact on Patients:
  - Studies of psychotherapist-patient sexual relationships have reported harms to patients that include severe ill effects, including depression, emotional disturbance, impaired social adjustment, suicidal feelings and behaviour, and increased use of drugs and alcohol.
  - One author argues that there is no evidence to suggest that harm following a failed relationship with a health professional is any different to that following the break-up of a relationship with a non-health professional, particularly in the case of non-therapeutic professions.
- Recidivism and Effectiveness of Disciplinary Mechanisms:
  - Only one article was found that referred to rates of recidivism. This article refers to a 1977 publication which states that "a large percentage, estimated as high as eighty percent, of those therapists who sexually exploit patients do so more than once."
  - No empirical studies evaluating effectiveness of disciplinary mechanisms were identified.
- Treatment of Family Members: One article explicitly examined physician treatment of family members (including spouses) and found that this is not uncommon. General risks related to treating family members include loss of physician objectivity (i.e., not performing procedures needed to investigate serious illness or pursuing care that the physicians responding to the survey considered futile); physician interference with appropriate diagnostic or therapeutic measures; performance of medically contraindicated procedures; and inadequate examination or follow-up of family members.

## DESCRIPTION OF THE FINDINGS

### Limitations of the Literature

Very few articles include information about sexual relationships between health care providers and their existing spouses; the majority of the literature addresses issues relating to health care providers that developed a sexual relationship after their professional relationship began with a patient (or former patient).

Due to a lack of recent research evidence addressing the questions posed by the requestor, the search was extended to include research produced since 1991. Recently published review articles also refer to older studies, which may indicate that these studies are the best available information on this topic.

### 1. Ethical concerns around sexual relationships between health care providers and spouses or sexual partners

The academic and grey literature is mixed on what is considered to be inappropriate or unethical sexual contact between health care providers and patients.

Several sources (e.g., Dehlendorf and Wolfe, 1998; Disch and Avery, 2001; Galletly, 2004) note that there is a power imbalance between health care providers and patients. For example, Hall (2001) argues that by the sheer nature of the patient role, there is always an unequal power differential between the physician and patient. She further notes that because any privileged knowledge gained under the original power imbalance cannot be forgotten, this power imbalance will continue even after a patient is no longer being treated by a provider. She concludes that, while having sexual relationships with current patients is clearly unethical, sexual relationships with former patients is almost always unethical due to persistence of transference\* and the unequal power distribution in the original doctor-patient relationship.

In a 1991 report, the American Medical Association (AMA) Council on Ethical and Judicial Affairs also notes that there may be a power imbalance between patients and physicians. The report concluded that:

- (1) Sexual contact or a romantic relationship concurrent with the physician-patient relationship is unethical;
- (2) Sexual contact or a romantic relationship with a former patient is also unethical if the physician exploits trust, knowledge, emotions, or influence derived from the previous professional relationship (Council on Ethical and Judicial Affairs [AMA], 1991).

The Task Force on Sexual Abuse of Patients (commissioned by the College of Physicians and Surgeons of Ontario) went further in its 1991 report, recommending a zero tolerance standard toward sexual contact<sup>†</sup> between patients and providers. Under this standard, sexual contact is prohibited between patients and providers for up to two years following the date of the last professional contact with the patient. In addition,

---

\* Transference is "the unconscious assignment to others of feelings and attitudes that were originally associated with important figures" by the patient onto the doctor. (as cited in Hall, 2001)

† Sexual violation is defined in this report to include "patient-physician sex, whether initiated by the patient or not, and engaging in any conduct with a patient that is sexual, or may reasonably be interpreted as sexual, including, but not limited to, sexual intercourse, genital to genital contact, oral to genital contact, oral to anal contact, oral to oral contact, except Cardiopulmonary Resuscitation, touching breasts or genitals except for the purpose of appropriate physical examination or treatment or where the patient has refused or withdrawn consent, and encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present." (McPhedran et al., 1991)

when the patient-physician relationship has been primarily for the purpose of psychotherapy, sexual contact should be prohibited at any time following treatment “due to the lasting nature of transference and the power imbalance” (McPhedran et al., 1991). This recommendation was upheld in the subsequent report by the same task force (McPhedran et al., 2000).

Jousset et al. (2008) suggest that each situation must be dealt with on an individual basis. They note that in order to find out if the sexual or sentimental relationship between a practitioner and a former patient is ‘suitable’ or not, it is necessary to take into consideration certain factors, such as i) the patient’s maturity, ii) whether or not the patient has a condition which could affect their ability to make decisions, iii) the length of time since the end of treatment, and iv) the nature, intensity and duration of the treatment itself. The authors state that the most important factor is the probability that the practitioner is exploiting the trust, knowledge and dependency which developed during the professional relationship.

In a similar vein, Gorman (2009) argues that different standards should apply to different disciplines. He asserts that “exploitation, in the sense that a patient might lack some capacity to appreciate the risks of a sexual relationship, is extremely unlikely in nonpsychotherapeutic professions... There’s good reason to believe that patients of most nonpsychotherapeutic professions (1) will have no greater rate of the relevant preexisting conditions than the public in general, (2) will not trust the therapists as blindly, and (3) will not experience transference. First, unlike mental therapy, people who seek out physical therapy—chiropractic, massage, acupuncture—do so to resolve conditions that would normally not diminish their ability to recognize the risks of a sexual relationship with the professional and make autonomous decisions regarding those risks. Second, a patient would be quite silly to place special trust in or reliance on her physical therapist’s judgment about sexual relationships, and for that reason we should not assume that she has a diminished ability to make her own autonomous decisions about a sexual relationship with her therapist... Likewise with transference: In some psychotherapeutic relationships, transference is more frequent or more intense than in relationships between peers because it is encouraged as central to healing. Transference is not encouraged in any nonpsychotherapeutic professions. Chiropractors, massage therapists and even occupational therapists do not rely on an analysis of a patient’s transference emotions for treatment” (Gorman, 2009).

“Likewise, there appear to be fewer and less significant threats to the effectiveness of therapy and to the reputation of the profession... The three ways in which sexual intimacies between a psychotherapist and patient reduce the effectiveness of therapy do not give much more reason for concern than the concept of exploitation. First, since nonpsychotherapeutic professionals generally do not offer advice on these matters as part of treatment, it’s unlikely that their judgment about the patient’s treatment would be affected... Second, the patient who feels taken advantage of by a nonpsychotherapeutic professional would be unlikely to discount the value of the therapy where the therapy only treated her physical health... Finally, for many nonpsychotherapeutic professions we should not be as concerned that a sexual relationship between the patient and the professional would harm the effectiveness of the therapy by making the patient less inclined to share necessary information” (Gorman, 2009).

In addition, two empirical studies suggest that practitioner opinions differ about when patient-provider sexual contact is ethically acceptable.

A survey of 1500 (with 777 responses for a response rate of 53.7%) obstetrician-gynecologists, ophthalmologists, internists, and general practitioners in the United States fielded in 1991 found that “outside of consultation but concurrent with treatment, sexual contact was perceived to be appropriate by

about 3% of internists, 3% of obstetrician-gynecologists, 9% of general practitioners, and 12% of ophthalmologists... Sexual contact after termination of treatment was seen as appropriate by nearly 60% of internists, obstetrician-gynecologists, and ophthalmologists, and by nearly 50% of general practitioners" (Coverdale et al., 1994).

Another study (White et al., 1994) based on focus groups of general practitioners in New Zealand found that the behaviours defined by the Ontario Task Force as sexual abuse were not necessarily viewed by the participants as sexual abuse, unless positional power was used for self-gratification. Recognizing one's own intentions, and the interpretation of those intentions by others, was deemed crucial. The participants in these focus groups felt it was not clear at what point the manifestation of sexual attraction between a general practitioner and patient shifted from being acceptable to unacceptable or abusive behaviour, but the authors did note that "doctor-sexual partner roles were not seen as compatible with doctor-patient roles, unless the sexual partner was the doctor's spouse" (White et al., 1994).

## 2. Prevalence of sexual boundary violations

A 1994 article notes that physician surveys conducted in the late 1980s and early 1990s have shown consistent results: between 4% and 10% of respondents acknowledged having had sexual contact with current or former patients, with little variation across specialties (Appelbaum et al., 1994). The most recently available data as cited in a 2008 review was a decade-old review of studies spanning thirty years, which found similar rates (Swiggan & Stack et al., 2002, as quoted in Spickard et al., 2008). Other articles, which cite studies from the seventies, eighties, or early nineties as sources, report similar ranges for self-reported lifetime prevalence rate for patient-physician "sexual or erotic contact" (e.g., White et al., 1994; Coverdale et al., 1995; Sarkar, 2004).

In 1986 Gartrell et al. (as quoted in Galletly, 1993) found that 7.1% of male psychiatrists and 3.1 % of female psychiatrists responding to their survey reported sexual contact with patients. In most cases this occurred after therapy ended, but usually within six months of termination. The survey had a low (26%) response rate, and may have underestimated the true incidence. Borys and Pope (1989) surveyed psychiatrists, psychologists and social workers, and found no significant difference between the professions in the incidence of sexual intimacies with clients during therapy (0.5% of professionals) or after termination of therapy (3.9% of professionals) (Galletly, 1993).

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.† (Dehlendorf and Wolfe, 1998)

While most articles identified focused on physician-patient sexual contact that occurs concurrent with, or following, the establishment of a professional relationship, one article (LaPuma et al., 1991) explicitly examined physician treatment of family members (including spouses) and found that this is not uncommon. A 1991 study of physician treatment of family members found that of 465 survey respondents, 386 (83%) had prescribed medication, 372 (80%) had diagnosed medical illnesses requiring treatment, 334 (72%) had performed physical examinations, 68 (15%) had attended a family member as primary physician in the hospital, 32 (7%) had consulted in the hospital, 44 (9%) had performed elective surgery on family members, and 17 (4%) had performed emergency surgery.

---

† The offenses for which the physicians were disciplined were: (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.

### 3. Risk factors leading to sexual boundary violations

A recent review (Spickard et al., 2008) reports that "currently the evidence is unclear about why physicians sexually offend". Hall (2001) notes that physicians may be more at risk of crossing sexual boundaries with patients if they are reacting to particular triggers in their own lives such as marital discord, loss of important relationships, and professional crises. The author cites studies that show "socially isolated, middle-aged men experiencing a mid-life crisis and who are eminent in their field" as particularly vulnerable and reports that the risk of sexual misconduct also increases with age (Hall 2001).

A 2003 review of boundary problems and sexual misconduct in psychotherapy relationships notes that the risk factors for therapist boundary violations (defined broadly to include both sexual and non-sexual violations) include the therapist's own life crises, a tendency to idealize a "special" patient or an inability to set limits, and denial about the possibility of boundary problems (Norris et al., 2003). A summary of the characteristics of practitioner sex abusers by Jousset et al. (2008) note that male practitioners are more frequently involved (over 85% of cases) and the most highly represented age group is 45 to 64 year olds.

Dehlendorf and Wolfe (1998) examined records for 761 physicians disciplined for sex-related offenses from 1989 through 1996 in the United States and found that 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 than in other specialties. They were also older than the national physician population, but were no different in terms of board certification status. A more recent article (Jousset et al., 2008) confirmed that the practitioner categories which receive the most disciplinary sanctions for sexual abuse (in France and the United States) are psychiatrists (including child psychiatrists), general practitioners, and gynaecologists/obstetricians; the 2008 article cites studies published between 1992 and 2000 for this finding.

### 4. Impact on patients of sexual relationship with their health care provider

The reported impact on patients of a sexual relationship with their health care providers ranges widely, from no effect or positive effect (White et al., 1994; Coverdale et al., 1995) to depression and other emotional disturbances (Bouhoustos et al., 1983 as cited in Galletly, 1993) depending on the circumstances of the patient-provider professional relationship and the nature of the sexual contact.

A 1994 article noted that emotional factors that accompany sexual involvement may affect a physician's judgment. The authors noted that sexually involved physicians might discourage patients from seeking consultation with other physicians because they fear their relationship will be revealed (Appelbaum et al., 1994). Additionally, patients who hear about a sexual relationship between a patient and physician may lose trust in the medical profession generally (Appelbaum et al., 1994).

In a survey of 217 general practitioners (GP) in New Zealand (with 187 respondents for an 86% response rate) regarding sexual contact between the GPs and their patients, respondents who knew of colleagues' sexual contact with patients reported their opinion of the effect of the last known contact on the patients involved. Thirteen percent (six respondents) thought it was positive, 28.3% thought it negative, 6.5% thought there was a mixed effect, and 45.7% did not know (the other three respondents reported it had no effect). The effect of the last known relationship on the doctor involved was described as positive by 8.7% of respondents, negative by 34.8%, mixed by 10.9%, and was unknown by 37.0% (8.7% reported it had no effect). Comments about positive effects included that 'life took a new direction for the good', that a 'stable

and ongoing relationship was developed', and comments on negative effects included 'marital strife', 'peer disapproval', 'disciplinary action', 'subjection to blackmail by the patient' and 'depression'. For all questions, GPs were asked to exclude from consideration patients with whom there had been a prior relationship such as a spouse (Coverdale et al., 1995).

Patients who have sexual contact with their psychotherapists have reported many symptoms. Pope and Bouhoutsos (1986) describe a particular syndrome that includes, among other things, "ambivalence, guilt, feelings of emptiness," "inability to trust," "sexual confusion," and "increased suicidal risk." Other effects have included "depression and other emotional disturbances, impaired social adjustment, and substance abuse" (as cited in Gorman, 2009). Galletly (1993) cites a study published in 1983 which surveyed psychologists about patients who had been sexually involved with a previous therapist. The authors note that in this study, 90% of patients had suffered "severe ill effects, including depression, emotional disturbance, impaired social adjustment, suicidal feelings and behaviour, and increased use of drugs and alcohol". The study also found that 11% were hospitalized and 1% committed suicide (Bouhoustos et al., 1983 as cited in Galletly, 1993). Perlman (2009) cites a 1991 study, which had a similar research design and nearly identical findings (Pope & Vetter, 1991 as cited in Perlman, 2009).

In a discussion of their findings, White et al. (1994) note that there is "[no] evidence to suggest that harm following a failed relationship with a health professional is any different to that following the break-up of a relationship with a non-health professional. There are parallel power differentials in all types of human relationships. Sexual relationships, in particular, involve power, traditionally a male-female imbalance. Thus theoretically, when the power of a predominantly male medical profession is combined with the vulnerability of a predominantly female patient population there is potential for abuse."

The one article (LaPuma et al., 1991) identified that examined physician treatment of family members (rather than patients who became sexual partners concurrent to or following the establishment of a professional relationship) found that of the 152 respondents (physicians at a large suburban community teaching hospital) who had observed a physician whom they considered "inappropriately involved" in the care of a family member, 117 reported the circumstances, which fell into four broad categories: (1) 44% of respondents described individual physicians who had lost their objectivity (not performing procedures needed to investigate serious illness or pursuing care that the respondents considered futile); (2) 29% described physicians who had interfered directly or indirectly with appropriate diagnostic or therapeutic measures; (3) 15% described physicians who had performed medically contraindicated procedures; and (4) 11% described physicians who had examined or followed family members inadequately (LaPuma et al., 1991).

Gorman (2009) argues that in many instances, categorical bans against sexual relationships between patients and providers "reach conduct that gives no cause for concern: fewer harms are risked by sex between an optician and a former client, for instance, than are risked by sex between a psychologist and a former patient."

## **5. Recidivism and Effectiveness of disciplinary mechanisms in other jurisdictions.**

Only one article was found that referred to rates of recidivism. This article refers to a 1977 publication which states that "a large percentage, estimated as high as eighty percent, of those therapists who sexually exploit patients do so more than once" (Holroyd & Brodsky, 1977, quoted in Strasburger et al., 1992). The same article asserts that "although professional societies have issued ethical proscriptions against sexual contact, these are widely regarded as not sufficiently effective," and that "it is widely assumed, though not

yet empirically demonstrated, that the existence of criminal sanctions would lower the incidence of sexual contact with patients, serving a preventative function for the injuries resulting from such contact" (Strasburger et al., 1992).

No articles were obtained that evaluated the effectiveness of disciplinary mechanisms in a rigorous way.

## APPENDIX

**Table 1 – Articles about sexual relationships between patients and providers<sup>§</sup>**

No.	Description	Reference
<b>Reviews</b>		
1	Studies put forward figures for male practitioner sex abuse of around ten percent. This practice, which is contrary to medical ethics, is highly reprehensible in ethical terms. The assaults range from uninvited meddling in patients' sexual lives to proven rape and inappropriate touching. The majority of this type of abuse is perpetrated by psychiatrists, but in more recent times a growing number of cases have been uncovered involving general practitioners or obstetric gynaecologists. For the most part, the abusers are men, aged between 45 and 64, who are insufficiently trained in terms of the 'practitioner-patient' relationship, or who are suffering from a mental pathology or who are in a situation of personal or professional crisis. Raising awareness of this issue is the driving force behind the implementation of prevention strategies, based on initial and ongoing training for practitioners in France, whistle-blowing on fellow practitioners in the United States and professional help in Canada. Disciplinary sanctions are more severe than those given within the framework of non-sexual misconduct in the United States. In France, the Order of Practitioners does not appear to be taking its role of defending patients seriously, since it seldom issues anything more substantial than minor penalties.	Jousset, N., Gaudin, A., Penneau, M., Rouge-Maillart, C. (2008). Practitioner sex abuse: occurrence, prevention and disciplinary sanction. <i>Med. Sci. Law</i> , 48(3), 203-210.
2	In psychiatric and psychotherapeutic practice, 'boundaries' delineate the personal and the professional roles and the differences that should characterise the interpersonal encounters between the patient/client and the professional. Boundaries are essential to keep both parties safe. The author outlines the various types of boundary violation that can arise in clinical practice, their consequences (both clinical and legal), how professionals can avoid them and how health care institutions might respond, should they occur. The author concentrates on sexual boundary violations, because these have been the subject of most empirical study.	Sarkar, S.P. (2004). Boundary violation and sexual exploitation in psychiatry and psychotherapy: a review. <i>Advances in Psychiatric Treatment</i> , 10, 312-320.
3	Drawing on their own consultative experience illustrated by case vignettes and with support from the professional literature, the authors discuss the perennial problematic issue of boundary violations and sexual misconduct, aiming at an audience of both experienced and novice clinicians. The authors review the difference between boundary crossings and boundary violations and stress the therapist's responsibility to maintain boundaries. Therapist risk factors for violations include the therapist's own life crises, a tendency to idealize a "special" patient or an inability to set limits, and denial about the possibility of boundary problems. Factors exacerbating patient vulnerability, such as overdependence on the therapist, seeking therapy to find an intense relationship or even "true love," and the acceptance by childhood abuse victims of an abusive therapy relationship, are discussed. Consultation and education—for students and for clinicians at all levels of experience—and effective supervision are reviewed as approaches to boundary problems.	Norris, D.M., Gutheil, T.G., Strasburger, L.H. (2003). This couldn't happen to me: boundary problems and sexual misconduct in the psychotherapy relationship. <i>Psychiatric Services</i> , 54(4), 517-522.

<sup>§</sup> Please note the studies, programs, and findings presented in this table may originate from jurisdictions with health systems that are significantly different from Ontario's. If there is intent to draw heavily from one or more sources presented in this table, we recommend that you contact the lead author of this review for assistance with evaluating the local applicability.

No.	Description	Reference
4	Boundaries in the doctor-patient relationship is an important concept to help health professionals navigate the complex and sometimes difficult experience between patient and doctor where intimacy and power must be balanced in the direction of benefiting patients. This paper reviews the concept of boundary violations and boundary crossings in the doctor-patient relationship, cautions about certain kinds of boundary dilemmas involving dual relationships, gift giving practices, physical contact with patients, and self-disclosure. The paper closes with some recommendations for preventing boundary violations.	Nadelson, C. & Notman, M.T. (2002). Boundaries in the Doctor-Patient Relationship. <i>Theoretical Medicine</i> , 23, 191-201.
5	The author argues that having sexual relationships with current patients is clearly unethical, but the ethics of such a relationship between a doctor and former patient is more debatable. The author reviews current evidence, based on major articles listed in Medline and Bioethicsline in the period from 1994 through 2001 and makes the argument 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.	Hall, K.H. (2001) Sexualization of the doctor-patient relationship: is it ever ethically permissible? <i>Family Practice</i> , 18, 511-515.
6	Sexual relationships between psychiatrists and their patients raise a number of important ethical issues. The power inequality, transference and dependence which often occur in a therapeutic relationship render patients vulnerable to exploitation. Psychiatrists informed by a patient of sexual contact with a previous psychiatrist face a complex ethical dilemma. Attempts at regulation by professional organisations, or by the legal system, may create conflicts between the rights of the persons involved. The role of the psychiatric profession in confronting the problem of sexual exploitation of patients is discussed.	Galletly, C.A. (1993). Psychiatrist-Patient sexual relationships: The ethical dilemmas. <i>Australian and New Zealand Journal of Psychiatry</i> , 27, 133-39.
<b>Articles in Peer-Reviewed Journals</b>		
7	This article attempts to facilitate an open, compassionate discussion in an effort to understand the human experience of each participant in the psychoanalytic relationship with its joys, but also its dangers, one of which is falling into sexuality. The paper is focused on one-time transgressors and their patients.	Perlman, S.D. (2009). Falling into Sexuality: Sexual Boundary Violations in Psychotherapy. <i>Psychoanalytic Review</i> , 96(6), 917-941.
8	In many states, sexual misconduct regulations categorically prohibit various healthcare professionals from having sexual contact with current patients and with former patients for years after the end of therapy. In many instances, these categorical bans reach conduct that gives no cause for concern: fewer harms are risked by sex between an optician and a former client, for instance, than are risked by sex between a psychologist and a former patient. This Comment identifies precisely what are the harms we should worry about in these types of healthcare professions, and explains why these harms don't apply equally in all professions or cases. It then proposes a model code standard that addresses the identified harms while permitting harmless relationships. The existence of a standard alternative to a categorical ban is important because the United States and many state constitutions recognize rights of sexual autonomy that are significantly burdened by categorical bans. This Comment argues that many current regulations are unconstitutional largely because the alternative would do just as well at preventing the harms risked by sexual relationships. This is extremely important for healthcare professionals who wish to engage in harmless relationships, however few and far between. States must provide more substantial justification for categorical bans that appear to negatively affect only a few unlucky citizens if those citizens are supported by constitutional rights.	Gorman, S.W. (2009). Sex outside of the therapy hour: Practical and constitutional limits on therapist sexual misconduct regulations. <i>UCLA Law Review</i> , 56, 983-1038.

No.	Description	Reference
9	<p><b>Introduction:</b> Physician sexual boundary violations are a public health problem. Few resources exist to address physicians who behave inappropriately with patients. In response, the Center for Professional Health at Vanderbilt University developed a three-day continuing medical education (CME) course about proper professional sexual boundaries in 2000. The mission of this CME course is to offer an educational intervention for those physicians whose professional sexual misconduct has required such education as part of a larger accountability sanction. Previous studies suggest that when such education is offered through non-traditional medical education, it is effective in promoting behavioral change. This paper describes the three-day intensive educational experience offered by a CME course with a particular focus on lessons learned from more than seven years of experience working with these physicians.</p> <p><b>Methods:</b> Over 381 physicians from 40 states and Canada have attended. Data about course participants was collected by self-report and aggregated into three categories: demographics, results of assessment tools administered, and quality of the experience. Assessment tools used include the Family Adaptability and Cohesion Evaluation Scale II (FACES II), the Trauma Symptom Inventory (TSI™) and the Sexual Addiction Screening Test (SAST). <b>Results:</b> Most physicians were referred to the course from physician health programs and boards of medical examiners. The majority of physician participants were male and in group or solo practice. A full range of medical specialties was represented with most physicians being internists, psychiatrists, obstetricians and surgeons. Results of assessment tools administered indicate that physicians referred for sexual boundary violations often come from dysfunctional families and demonstrate symptoms indicative of trauma related problems and possible sexual addiction. Physician attendees report being highly satisfied with the new knowledge attained in this course. <b>Discussion:</b> Curriculum aimed at addressing sexual boundary violations should address family of origin issues, trauma coping skills and sexual acting out. Satisfaction data continues to support a small group, experiential, and confidential format as an effective means for intervention. <b>Conclusion:</b> A CME course offers a model for future training experiences for faculty, residents, medical students and community physicians to teach skills that may help prevent and remediate professional boundary crossings.</p>	<p>Spickard, W.A., Swiggart, W.H., Manley, G.T., Samenow, C.P., &amp; Dodd, D.T. (2008) A continuing medical education approach to improve sexual boundaries of physicians, <i>Bulletin of the Menninger Clinic</i>, 72(1), 38-53.</p>
10	<p><b>Objective.</b> In a study performed with The NorVold Abuse Questionnaire (NorAQ) among Nordic gynecological patients, the prevalence of lifetime abuse in health care (AHC) was 13–28%. In the present study the authors chose a qualitative approach. The aim was to develop a more in-depth understanding of AHC; as experienced by female Swedish patients. <b>Study design:</b> Qualitative interviews with 10 Swedish gynecological patients who had experienced AHC. The interviews were analyzed through Grounded Theory. <b>Results:</b> Saturation was reached after six interviews. In the analyses four categories emerged which explain what AHC meant to the participating women: felt powerless, felt ignored, experienced carelessness, and experienced non-empathy. To be nullified is the core category that theoretically binds the four categories together. The women's narratives described intensive current suffering even though the abusive event had taken place several years ago. <b>Conclusions:</b> The fact that AHC exists is a critical dilemma for an institution that has the society's commission to cure and/or to alleviate pain and suffering. In their narratives, women described the experience of 'being nullified', a core category that embodies AHC.</p>	<p>Swahnberg, K., Thapar-Bjorkert, S., Bertero, C. (2007). Nullified: Women's perceptions of being abused in health care. <i>Journal of Psychosomatic Obstetrics &amp; Gynecology</i>, 28(3), 161-167.</p>

No.	Description	Reference
11	<p><b>Objective:</b> This study examined the frequency and associated distress of potentially traumatic or harmful experiences occurring within psychiatric settings among persons with severe mental illness who were served by a public-sector mental health system.</p> <p><b>Methods:</b> Participants were 142 randomly selected adult psychiatric patients who were recruited through a day hospital program. Participants completed a battery of self report measures to assess traumatic and harmful events that occurred during the course of their mental health care, lifetime trauma exposure, and symptoms of posttraumatic stress disorder. <b>Results:</b> Data revealed high rates of reported lifetime trauma that occurred within psychiatric settings, including physical assault (31%), sexual assault (8%), and witnessing traumatic events (63%). The reported rates of potentially harmful experiences, such as being around frightening or violent patients (54%), were also high. Finally, reported rates of institutional measures of last resort, such as seclusion (59%), restraint (34%), takedowns (29%), and handcuffed transport (65%), were also high. Having medications used as a threat or punishment, unwanted sexual advances in a psychiatric setting, inadequate privacy, and sexual assault by a staff member were associated with a history of exposure to sexual assault as an adult. <b>Conclusions:</b> Findings suggest that traumatic and harmful experiences within psychiatric settings warrant increased attention.</p>	<p>Frueh, B.C., Knapp, R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., et al. (2005). Patients' Reports of Traumatic or Harmful Experiences within the Psychiatric Setting. <i>Psychiatric Services, 56</i>(9), 1123-1133.</p>
12	<p>This article reviews and comments on the five categories of arguments used to defend zero tolerance with regard to sexual contacts resulting from the physician-patient relationship as summarised by Cullen. In addition it puts forward a hypothesis—"fear of loss by third party"—as a psychological explanation for the collective insistence on a zero tolerance policy.</p>	<p>Spiegel, W., Colella, T., Lupton, P. (2005). Private or intimate relations between doctor and patient: is zero tolerance warranted? <i>Journal of Medical Ethics, 31</i>, 27-28.</p>
13	<p>While some cases of sexual exploitation involve predatory doctors, many other cases represent the culmination of a series of boundary crossings (non-exploitative departures from usual practice). The deliberate move to reduce formality in medicine has increased the likelihood of boundary crossings and violations. There are also individual doctor risk factors; boundary violations appear more likely when doctors are under stress, with insufficient emotional support. Preventive strategies include continuing education about ethics and the management of professional boundaries, along with appropriate psychological support structures for doctors. Doctors are often involved in other professional relationships as teachers, supervisors and team leaders; inappropriate sexual behaviour in these relationships is harassment. Public pressure for more punitive responses is likely if the profession is not seen to be doing all it can to deal with these issues effectively, and to be cooperating with other responsible agencies.</p>	<p>Galletly, C.A. (2004). Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation. <i>Medical Journal of Australia, 181</i>, 380-383.</p>
14	<p>The impact on 149 survivors of sexual abuse by medical and mental health professionals and clergy was compared. Loss, emotional turmoil, mistrust, depression, relationship difficulties, and difficult complaint procedures were reported by all three groups, with survivors of abuse by medical health professionals reporting the most pronounced negative effects. Implications for subsequent mental health treatment of survivors from all three abuse groups are explored.</p>	<p>Disch, E. &amp; Avery, A. (2001). Sex in the Consulting Room, the Examining Room, and the Sacristy: Survivors of Sexual Abuse by Professionals. <i>American Journal of Orthopsychiatry, 71</i>(2), 204-217.</p>

No.	Description	Reference
15	<p><b>Context:</b> 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. <b>Objectives:</b> To determine the frequency and severity of discipline against physicians who commit sex-related offenses and to describe the characteristics of these physicians. <b>Design and Setting:</b> Analysis of sex-related orders from a national database of disciplinary orders taken by state medical boards and federal agencies. <b>Subjects:</b> A total of 761 physicians disciplined for sex-related offenses from 1981 through 1996. <b>Main Outcome Measures:</b> Rate and severity of discipline over time for sex-related offenses and specialty, age, and board certification status of disciplined physicians. <b>Results:</b> 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 &lt; 0.001 for trend). Discipline for sex-related offenses was significantly more severe (P &lt; 0.001) 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 &lt; 0.001) than in other specialties and were older than the national physician population, but were no different in terms of board certification status. <b>Conclusions:</b> 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.</p>	<p>Dehlendorf, C.E., Wolfe, S.M. (1998). Physicians Disciplined for Sex-Related Offenses. <i>JAMA</i>, 279(23), 1883-1888.</p>

No.	Description	Reference
16	<p><b>Context:</b> State medical boards discipline several thousand physicians each year. Although certain subgroups, such as those disciplined for malpractice, substance use, or sexual abuse, have been studied, little is known about disciplined physicians as a group. <b>Objective:</b> To assess the offenses, contributing factors, and type of discipline of a consecutive series of disciplined physicians. <b>Design:</b> Case-control study on publicly available data matching 375 disciplined physicians with two groups of control physicians, one matched solely by locale, and a second matched for sex, type of practice, and locale. <b>Subjects:</b> All disciplined physicians publicly reported by the Medical Board of California from October 1995 through April 1997. <b>Main Outcome Measures:</b> Characteristics of disciplined physicians, offenses leading to discipline, and type of discipline. <b>Results:</b> A total of 375 physicians licensed by the Medical Board of California (approximately 0.24% per year) were disciplined for 465 offenses. The most frequent causes for discipline were negligence or incompetence (34%), abuse of alcohol or other drugs (14%), inappropriate prescribing practices (11%), inappropriate contact with patients (10%), and fraud (9%). Discipline imposed was revocation of medical license (21%), actual suspension of license (13%), stayed suspension of license (45%), and reprimand (21%). Type of offense was significantly associated with severity of discipline (<math>P = 0.03</math>). In logistic regression models comparing disciplined physicians with controls matched by locale, board discipline was significantly associated with physicians' sex (odds ratio [OR] for women, 0.44; 95% confidence interval [CI], 0.28-0.70) and involvement in direct patient care (OR, 2.56; 95% CI, 1.75-3.75). In the regression model with additional matching criteria, disciplinary action was negatively associated with specialty board certification (OR, 0.42; 95% CI, 0.29-0.60) and positively associated with being in practice more than 20 years (OR, 2.02; 95% CI, 1.39-2.92). <b>Conclusions:</b> A small but substantial proportion of physicians is disciplined each year for a variety of offenses. Further study of disciplined physicians is necessary to identify physicians at high risk for offenses leading to disciplinary action and to develop effective interventions to prevent these offenses.</p>	<p>Morrison, J. &amp; Wickersham, P. (1998). Physicians disciplined by a state medical board. <i>JAMA</i>, 279(23), 1889-1893.</p>
17	<p><b>Objective:</b> This article proposes ethically justified guidelines that should govern the ethical obligations of obstetrician-gynecologists when they experience sexual feelings toward patients. <b>Study Design:</b> The authors reviewed literature on physician-patient sexual contact and related that literature to ethical principles. <b>Results:</b> Existing guidelines that prohibit sexual contact between physicians and patients are based on an ethical argument that such relationships violate the ethical principles of respect for both autonomy and beneficence. This argument is incomplete because patients can provide valid consent for sexual relationships with their own obstetrician-gynecologists. <b>Conclusion:</b> The authors propose a virtues-based ethical argument that is independent of informed consent for governing sexual relationships between obstetrician-gynecologists and their patients. In the context of the physician-patient relationship the professional virtues of self-effacement and self-sacrifice obligate the obstetrician-gynecologist to set aside and never act on feelings of sexual attractiveness toward patients.</p>	<p>McCullough, L.B., Chervenak, F.A., Coverdale, J.H. (1996). Ethically justified guidelines for defining sexual boundaries between obstetrician-gynecologists and their patients. <i>Am. J. Obstet. Gynecol.</i>, 175(2), 496-500.</p>

No.	Description	Reference
18	<p><b>Background:</b> Doctor-patient social and sexual contact is increasingly acknowledged as an issue of importance for the medical profession. However, there is little research concerning general practitioners on this topic. <b>Aim:</b> A study was undertaken to obtain data on social and sexual contact between general practitioners and their patients. <b>Method:</b> An anonymous questionnaire was mailed to a nationwide randomized sample of 217 general practitioners in New Zealand. <b>Results:</b> A response rate of 86% was obtained. Dating and sexual contact with patients was considered to be sometimes or usually acceptable to 35% and 10% of general practitioners, respectively. Of respondents, 6% reported having dated a patient, 4% reported having had sexual contact with a patient at some point during their career and 2% reported having engaged in sexual contact with a former patient. General practitioners who had personally known of a colleague who had engaged in sexual contact with a patient were more likely to believe this behaviour had negative consequences than general practitioners who themselves reported having engaged in sexual contact with a patient. <b>Conclusion:</b> The study results have implications for developing behavioural guidelines and educational interventions for general practitioners.</p>	<p>Coverdale, J.H., Thomson, A.N., White, G.E. (1995). Social and sexual contact between general practitioners and patients in New Zealand: attitudes and prevalence. <i>British Journal of General Practice</i>, 45, 245-247.</p>
19	<p>In this article, the authors provide a conceptual framework for discussion of professional boundaries in the physician-patient relationship and offer their view of measures the profession can take to prevent serious violations of these boundaries. The authors use instances from their own clinical experiences or those of their trainees to illustrate the relevant issues.</p>	<p>Gabbard, G.O., &amp; Nadelson, C. (1995) Professional Boundaries in the Physician-Patient Relationship, <i>JAMA</i>, 273, 1445-1449.</p>
20	<p>In the face of evidence suggesting that there is a substantial incidence of sexual contact between physicians of all specialties and their patients, the medical profession and the courts have not yet reached a consensus regarding appropriate responses. Some commentators, including the American Medical Association, have urged bans on sexual contact during treatment and extensive restriction of posttreatment sexual relationships. Others favor looser restrictions, particularly after termination of the physician-patient relationship. These differences in approach stem from the varying importance given the two conflicting values involved: (1) protecting patients from being harmed by unfair manipulation by physicians and (2) insulating choices about intimate relationships from intrusion by society. The authors propose a model for balancing these interests that would bar sexual contact during the physician-patient relationship and for a fixed period after termination; thereafter, in most cases, sexual relationships would not be proscribed. A waiting-period approach of this sort is likely to diminish most of the harms that might result from physician-patient sexual contact and may constitute a template for the resolution of similar issues elsewhere in society.</p>	<p>Appelbaum, P.S., Jorgenson, L.M., &amp; Sutherland, P.K. (1994). Sexual Relationships Between Physicians and Patients. <i>Archives of Internal Medicine</i>, 154, 2561-2565.</p>
21	<p>To determine the attitudes of physicians toward social and sexual contact with patients, the authors mailed a self-report survey to a nationwide randomized sample including general practitioners, internists, obstetrician-gynecologists, and ophthalmologists. The 777 physicians who responded specified whether or not behavior such as hugging, dating, and sexual contact with their own patients may be appropriate. Less than 1% of all respondents thought that sexual contact with patients was appropriate during patient consultations. Three percent of internists and obstetrician-gynecologists considered sexual contact with patients appropriate when concurrent with treatment but outside of patient consultation, as compared with 9% of general practitioners and 12% of ophthalmologists (<math>\chi^2 = 17.8</math>, <math>df = 5</math>, <math>P &lt; 0.001</math>). Nearly 50% of general practitioners and more than 50% of all other physicians thought that sexual contact might be appropriate after termination of treatment of a patient. These findings may facilitate professional discussion on standards for social and sexual contact with patients.</p>	<p>Coverdale, J., Bayer, T., Chiang, E., Thornby, J. Bangs, M. (1994). National survey on physicians' attitudes toward social and sexual contact with patients. <i>Southern Medical Journal</i>, 87(11).</p>

No.	Description	Reference
22	<p>This paper presents a qualitative exploration of social and sexual contact between general practitioners and their patients. Social contacts have been implicated in the development of sexual relationships between members of the mental health professions and their patients. However, there has been little examination of the implications for general practitioners. Six focus groups were conducted by teleconference with New Zealand general practitioners. Participant anonymity was maintained. Questions focused on issues of social and sexual contact in general practice. Major themes were extracted from the data. A range of definitions of 'patient', 'sexual contact' and 'social contact' were offered by the participants which demonstrated that 'grey areas' existed for them in relation to social and sexual relationships with patients. Mandatory reporting of colleagues for alleged sexual misconduct was not supported, informal mechanisms being preferred. General practitioners need to be aware of potential boundary violations in their practice. These issues are also important to address in the teaching of medical students, continuing medical education, and in the development of appropriate guidelines for general practice.</p>	<p>White, G.E., Coverdale, J.A., Thomson, A.N. (1994). Can one be a good doctor and have a sexual relationship with one's patient? <i>Family Practice</i>, 11(4), 389-393.</p>
23	<p>To document the current prevalence of physician-patient sexual contact and to estimate its effect on involved patients, 10,000 family practitioners, internists, obstetrician-gynecologists, and surgeons were surveyed. Of the 1,891 respondents, 9% acknowledged sexual contact with one or more patients. Even in the unlikely case that none of the non respondents had sexual contact with patients, its prevalence among all 10,000 physicians surveyed would still be 2%. Of respondents, 23% had at least one patient who reported sexual contact with another physician; 63% thought this contact was "always harmful" to the patients. Almost all (94%) responding physicians opposed sexual contact with current patients; 37% also opposed sexual contact with former patients. More than half of respondents (56%) indicated that physician-patient sexual contact had never been addressed in their training; only 3% had participated in a continuing education course focusing on this issue. Clear and enforceable medical ethics codes concerning physician-patient sexual contact are needed, as well as preventive educational programs for medical schools and residency programs.</p>	<p>Gartrell, N.K., Milliken, N., Goodson, W.H., Thiemann, S., Lo, B. (1992). Physician-Patient Sexual Contact Prevalence and Problems. <i>The Western Journal of Medicine</i>, 157(2), 139-143.</p>
24	<p>Sexual contact between psychotherapists and patients is unethical, exploitative, and harmful. It commonly begins through breaches of appropriate therapeutic boundaries. A preventive approach involves training clinicians, educating the public, and establishing an institutional policy. Treatment of victims raises issues that require special attention in order to forestall further injury.</p>	<p>Strasburger, L.H., Jorgenson, L., Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. <i>American Journal of Psychotherapy</i>, 46(4), 544-555.</p>

No.	Description	Reference
25	<p><b>Background:</b> Little is known about the circumstances under which physicians care for family members. The authors sought to examine current practice and, in particular, to learn how often family members request medical care or treatment, whether physicians accede to such requests, and what concerns, if any, physicians have about caring for their family members. <b>Methods:</b> In late 1990 the authors distributed a pretested, structured questionnaire to all members of the active medical staff (physicians with M.D. or D.O. degrees) of a large suburban community teaching hospital. Of 691 eligible members of the medical staff, 465 physicians responded. <b>Results:</b> Of the 465 respondents, 461 (99%) reported requests from family members for medical advice, diagnosis, or treatment. A total of 386 (83 %of the respondents) had prescribed medication for a family member, 372 (80%) had diagnosed medical illnesses, 334 (72%) had performed physical examinations, 68 (15 %) had acted as a family member's primary attending physician in the hospital, and 44 (9%) had operated on a family member. In addition, 152 (33%) reported that they had observed another physician "inappropriately involved" in a family member's care, and 103 (22%) had acceded to a specific request about which they felt uncomfortable. <b>Conclusions:</b> Practicing physicians often attend and treat their family members and diagnose their illnesses. They may often experience some disquiet in doing so. For physicians, complete medical data, proper training, and sound judgment are essential when family members request treatment.</p>	<p>La Puma, J.L., Stocking, C.B., La Voie, D., Darling, C.A. (1991). When physicians treat members of their own families: practices in a community hospital. <i>New England Journal of Medicine</i>, 325(18), 1290-1294.</p>
26	<p>The American Medical Association's Council on Ethical and Judicial Affairs recently reviewed the ethical implications of sexual or romantic relationships between physicians and patients. The Council has concluded that (1) sexual contact or a romantic relationship concurrent with the physician-patient relationship is unethical; (2) sexual contact or a romantic relationship with a former patient may be unethical under certain circumstances; (3) education on the ethical issues involved in sexual misconduct should be included throughout all levels of medical training; and (4) in the case of sexual misconduct, reporting offending colleagues is especially important.</p>	<p>Council on Ethical and Judicial Affairs, American Medical Association. (1991). Sexual Misconduct in the Practice of Medicine, <i>JAMA</i>, 266, 2741-2745.</p>
<b>Grey Literature</b>		
27	<p>The mandate of the task force was to conduct an independent inquiry into the experiences of patients and members of the public on the subject of sexual abuse by regulated health professionals in Ontario in order to provide Advice and Recommendations to the Health Professions Regulatory Advisory Council and the Minister of Health and Long-Term Care as part of the five year review of the Regulated Health Professions Act. In this report, Task Force concluded that the philosophy of Zero Tolerance of sexual abuse of patients must remain the guiding principle for the development, implementation, and evaluation of all policies and practices designed to stop sexual abuse by health professionals.</p>	<p>McPhedran, M., Armstrong, H., Long, B., Marshall, P., Roach, R., Bessner, R. (2000). "What about accountability to the patient?" Final Report of the Special Task Force on Sexual Abuse of Patients.</p> <p>Available at:  <a href="https://ospace.scholarsportal.info/handle/1873/8637">https://ospace.scholarsportal.info/handle/1873/8637</a>. Last accessed August 25, 2011.</p>

No.	Description	Reference
28	Sexual misconduct by physicians and other health care practitioners is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. The purpose of this report is to provide state medical boards with a framework within which to handle sexual misconduct cases. The guidelines described are intended to apply to all health care professions regulated by the state medical board.	Federation of State Medical Boards of the United States, Addressing Sexual Boundaries: Guidelines for State Medical Boards. 2006. Available at: <a href="http://www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf">www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf</a> . Last accessed August 25, 2011.
29	This task force had the mandate to seek information from the public, the College, and individual doctors through public and private hearings in various cities in Ontario. The Task Force was charged with recommending improvements to College policies and procedures related to sexual abuse complaints, changes to relevant legislation and legal practices, guidelines for doctors with patients and former patients, and educational initiatives for doctors and the public.	McPhedran, M., Armstrong, H., Edney, R., Marshall, P., Roach, R., Long, B. et al. (1991). The Final Report of the Task Force on Sexual Abuse of Patients, Commissioned by the College of Physicians and Surgeons on Ontario, November 25, 1991.

**Health Professions Regulatory Advisory Council**

55 St. Clair Avenue West  
Suite 806 Box 18  
Toronto, Ontario, Canada M4V 2Y7

Telephone: 416-326-1550  
Toll-Free: 1-888-377-7746  
Fax: 416-326-1549

Website: [www.hprac.org](http://www.hprac.org)  
Twitter: [www.twitter.com/hpraontario](http://www.twitter.com/hpraontario)  
Email: [hpracwebmaster@ontario.ca](mailto:hpracwebmaster@ontario.ca)



**Ontario**

**Health Professions Regulatory  
Advisory Council**

**Conseil consultatif de  
réglementation des professions  
de la santé**