**Sexual contact between physician and former patient - Ethical Issues**

*Prof Azhar Md Zain*
*Member, Malaysian Medical Council*

Sexual relationships between doctors and patients have been the subject of discussion, writings and perhaps legislation but there has been scarce research on this area. And with the sprouting of Family Physicians and General Practitioners, more attention ought to be paid to such issues among these colleagues of ours. In USA, it is estimated that 11% of Family Physicians have had sexual contact with at least one of their patients. The American Medical Association as well as our Malaysian Medical Council and Malaysian Medical Association has ethical guidelines addressing this issue. However there are grey areas. Are there conditions under which a doctor may become involved with a former patient? Sexual involvement with patients appears to exist on an ethical continuum; it however results in reduced patient autonomy. In USA, sexual contacts between patients and Mental Health Professionals are now explicitly illegal, but there are no clear guidelines for non-psychiatric doctors. There is some research evidence that when sexual contact occurs between a doctor and patient, it is the patient who suffers long-term psychological consequences.

In this paper, I am trying to present some views from the perspective of a psychiatrist why even non-psychiatrist should be disallowed to have sexual relationships with their former patients. My views are stronger after reading an article by a General Practitioner in New Zealand in the Journal Family Practice(1). According to her, 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.

Some doctors are at risk of violating boundaries. These are doctors who cannot identify transference and counter transference in the doctor-patient relationship of every encounter. Transference is defined as the unconscious assignment to others of feelings and attitudes that were originally associated with important figures by the patient onto the doctor. Counter-transference is the doctor's reaction to this process and this can include erotic feelings. Doctors make mistake that the feelings of love that arise in a therapeutic relationship as being the same as love that arises elsewhere; it is not. This love is not based on reality and is based on unequal power structure. Even skilled and experienced doctors are not immune to rationalizing their behaviour and convincing themselves that a patient is very special. The risk increases when the doctor is responding to particular triggers such as marital discord, loss of important relationships and a professional crisis in their own lives. The risk seems to increase with age by a ratio of 1.44 with every increasing decade (2). To avoid such mishaps, doctors must ensure ethical-doctor patient relationships at all times. That relationship depends upon the doctor creating an environment of mutual respect and trust in which the patient can have confidence and safety. Trust is a crucial aspect of that relationship together with providing confidence that one is having a good conscience and is therefore bound to act in good faith. To build that relationship, the unequal power

distribution between doctor and patient has to be acknowledged and contained in an ethically correct manner. The onus lies in the person with the most power, i.e. the doctor.

What is the relevance of this analysis to relationships with former, non-current patients? First, any privileged knowledge gained under the conditions of the original power imbalance of doctor-patient cannot be “unlearnt” or forgotten and this can continue as an unfair advantage for the doctor. Information gained in such power imbalance can be artificially intimate; for example one will not normally discuss details of sexual function within a few minutes of meeting a stranger but this happens in a general practice consultation. Secondly, based on the above example, it is hard to see how a relationship of equals could develop from such unequal beginnings.

How can a claim be judged that a former patient gave his or her consent before entering into the relationship? There is no disagreement that a current patient cannot validly consent, but a former patient? This is more debatable. Evidence is beginning to show that transferences can persist indefinitely and with it the perpetuation of potential or real incompetence of the patient to recognize these feelings for their true nature (for Psychiatrist at least, the view is generally held “once a patient, always a patient”). This is held so strongly that the American Psychiatric Association has stated categorically that “sexual activity with a current or former patient is unethical” with no qualifications (3).

In California, legally there is a two year gap period with no patient contact that will make it possible to have a relationship. But there is no empirical research to show that transference disappears for the patient or even decreases with cessation of the doctor-patient relationship. The concept of a supposed “waiting period” after termination before sexual intimacies is naive because it does not take into account the timeless nature of the subconscious. There has been no published reports demonstrating or suggesting that therapist-patient sexual involvement becomes safe at a point 6 months or 6 years after termination. Even the Council of Ethical and Judicial Affairs of the American Medical Association has stated “sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship” (4).

The other issue is one of consent. It can be argued that for any relationship, there must be autonomous choice, i.e. the choice where all relevant information has been provided, with the person having the necessary capacities to comprehend that information whilst not acting under any form of coercion. Coercion can arise from imposed restraints on any or all of three types of autonomy; autonomy of thought or the ability to think for oneself, autonomy of will or the freedom to make a choice based on one’s deliberations, and autonomy of action or the freedom to enact one’s choice physically. The persistence of transference can exert a coercive effect on one’s autonomy of thought and will.

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

It would be wise, I think, to consider relationships with former patients to be considered as ethically not permissible.

**References**


1. Hall KH. Sexualisation of the doctor-patient relationship: Is it ever ethically permissible? Family Practice 2001;18:511-515
2. Dehlendorf CE, Wolfe SM. Physicians disciplined for sex-related offences. J Am Med Assoc 1998; 279: 1883-1888
3. American Psychiatric Association. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington (DC): APA 1993
4. Council on Ethical and Judiciary Affairs. American Medical Association. Sexual Misconduct in the practice of Medicine. J Am Med Assoc 1991;266: 2741-2745