

## Sexual Misconduct and Abuse

*“ . . . I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons . . . .”<sup>1</sup>*

### Introduction

#### Background

Sexual misconduct between practitioners and patients or key third parties detracts from the goals of the practitioner-patient relationship, exploits the vulnerability of the patient, obscures the practitioner’s objective judgment concerning the patient’s health care, and is detrimental to the patient’s well-being. Abusive behavior by a practitioner can harm a patient. The Medical Quality Assurance Commission (Commission) does not tolerate sexual misconduct or abuse in any form.

The Commission first adopted a policy on sexual misconduct in 1992. The Commission revised the policy in 1996 and again in 2002. In 2006, the Commission established separate rules prohibiting sexual misconduct and prohibiting abuse. The Commission issues these guidelines to increase practitioner awareness of the rules and to help practitioners maintain appropriate practitioner-patient boundaries.

#### Definitions

A “patient” is a person who is receiving health care or treatment, or has received health care or treatment without a termination of the physician-patient relationship. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services is not the sole determining factor.<sup>2</sup> A Practitioner, as used in these guidelines, is a physician licensed under [Chapter 18.71 RCW](#) or a physician assistant as licensed under [Chapter 18.71A RCW](#).

A “key third party” is a person in a close personal relationship with the patient and includes, but is not limited to spouses, partners, parents, siblings, children, guardians and proxies.<sup>3</sup>

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<sup>1</sup> Excerpt from Hippocratic Oath, Fourth Century B.C.

<sup>2</sup> [WAC 246-919-630\(1\)\(a\)](#) and [WAC 246-918-410\(1\)\(a\)](#).

<sup>3</sup> [WAC 246-919-630\(1\)\(c\)](#) and [WAC 246-918-410\(1\)\(c\)](#).

## Guideline

The Commission will not tolerate a practitioner engaging in sexual misconduct with a patient or key third party.

As stated in the rules, a practitioner engages in sexual misconduct when he or she engages in the following behaviors with a patient or key third party, whether or not it occurred outside the professional setting:

- (a) Sexual intercourse or genital to genital contact;
- (b) Oral to genital contact;
- (c) Genital to anal contact or oral to anal contact;
- (d) Kissing in a romantic or sexual manner;
- (e) Touching breasts, genitals or any sexualized body part for any purpose other than appropriate examination or treatment;
- (f) Examination or touching of genitals without using gloves;
- (g) Not allowing a patient the privacy to dress or undress;
- (h) Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present;
- (i) Offering to provide practice-related services, such as medications, in exchange for sexual favors;
- (j) Soliciting a date;
- (k) Engaging in a conversation regarding the sexual history, preferences or fantasies of the physician.<sup>4</sup>

## Consent

A patient's or key third party's consent to, initiation of, or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct. The practitioner has full and sole responsibility to maintain proper boundaries. It is not a defense or a mitigating factor that the patient or key third party consented to, proposed, or initiated the sexual contact or the sexual or romantic relationship.

It is improper for a practitioner who engages in sexual misconduct with a patient or key third party to make efforts to avoid full and sole responsibility by pointing to the patient's or key third party's consent or initiation, or by making any other attempt to shift responsibility to the patient, for example, by asserting that the patient or key third party was seductive or manipulative.

## Termination of Practitioner-Patient Relationship

Once the practitioner-patient relationship has been established, the practitioner has the burden of showing that the relationship no longer exists. The mere passage of time is not determinative of the issue. Because of the varying nature of types of practitioner-patient relationships, variety of settings, differing practice types, and imbalance in power between practitioner and patient, individual analysis is

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<sup>4</sup> [WAC 246-919-630](#) (physicians), [WAC 246-918-410](#) (physician assistants).

essential. As stated in the rules, the Commission will analyze each case individually and will consider a number of factors including, but are not limited to, the following:

- (a) Documentation of formal termination;
- (b) Transfer of the patient's care to another health care provider;
- (c) The length of time that has passed;
- (d) The length of time of the professional relationship;
- (e) The extent to which the patient has confided personal or private information to the physician;
- (f) The nature of the patient's health problem;
- (g) The degree of emotional dependence and vulnerability.

Some practitioner-patient relationships may never terminate because of the nature and extent of the relationship. These relationships may always raise concerns of sexual misconduct whenever there is sexual contact.

### **Former Patients or Key Third Parties**

As provided in the rules, a practitioner cannot engage in any of the above behaviors with a former patient or former key third party if the practitioner

- (a) Uses or exploits the trust, knowledge, influence, or emotions derived from the professional relationship; or
- (b) Uses or exploits privileged information or access to privileged information to meet the physician's personal or sexual needs.

### **Diagnosis and Treatment**

Sexual misconduct does not include conduct that is required for medically recognized diagnostic or treatment purposes if the conduct meets the standard of care appropriate to the diagnostic or treatment [situation](#).

### **Abuse**

The Commission will not tolerate a practitioner abusing a patient. As stated in the rules, a practitioner abuses a patient when he or she:

- (a) Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;
- (b) Removes a patient's clothing or gown without consent;
- (c) Fails to treat an unconscious or deceased patient's body or property respectfully; or
- (d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.<sup>5</sup>

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<sup>5</sup> [WAC 246-919-640](#) (physicians), [WAC 246-918-420](#) (physician assistants).

## Discipline

Upon a finding that a practitioner has engaged in sexual misconduct or abuse, the Commission will impose one or more sanctions set forth in [RCW 18.130.160](#). In some cases, revocation may be the appropriate sanction. In others, the Commission may restrict and monitor the practice of a practitioner who is actively engaging in a treatment program. When imposing sanctions, the Commission must first consider what sanctions are necessary to protect the public. Only after this is done may the Commission consider and include sanctions designed to rehabilitate the practitioner.

### Recommendations to Practitioners

To help prevent sexual misconduct and abuse, and to help practitioners maintain good practitioner-patient boundaries, the Commission strongly recommends that a practitioner:

1. Consider having a chaperone present during examination of any sensitive parts of the body.
2. Be aware of any feelings of sexual attraction to a patient or key third party. The practitioner should discuss such feelings with a supervisor or trusted colleague. Under no circumstances should a practitioner act on these feelings or reveal or discuss them with the patient or key third party.
3. Transfer care of a patient to whom the practitioner is sexually attracted to another health care provider. Recognizing that such feelings in themselves are neither wrong nor abnormal, a practitioner should seek help in understanding and resolving them.
4. Be alert to signs that a patient or key third party may be interested in a sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the patient.
5. Respect a patient's dignity and privacy at all times.
6. Provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a patient might have regarding the practitioner's intentions and the care being given.
7. Communicate with a patient in a clear, appropriate and professional manner. A practitioner should never engage in communication with a patient or key third party that could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.
8. Refrain from discussing the practitioner's personal problems, or any aspect of the practitioner's intimate life with a patient.

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Number:	GUI2017-03
Date of Adoption:	June 30, 2017
Reaffirmed / Updated:	N/A
Supersedes:	MD2002-05