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When the doctor–patient relationship turns sexual

Simon asked her out to lunch because he needed a shoulder to cry on. His girlfriend, who was diagnosed with a brain tumor some time ago, had recently died. During lunch, she told Simon that she had just ended a relationship and joined a dating service. Quit the dating agency, Simon told her, and go out with me instead. She was taken aback — gobsmacked, really. Here she was, expecting to console someone in grief, and was instead faced with an ill-timed romantic proposal.

Still, she was interested. Just two days earlier, she had been crying into her cappuccino with her girlfriends, worried that she would never again find a loving relationship. So, despite her reservations, she accepted Simon's offer. Their relationship blossomed, and the couple wed two years later.

But in 2013, after 13 years of marriage, they decided it was time to end the relationship, which they felt had deteriorated beyond repair. By then, in fact, Simon had already begun seeing someone else, a businesswoman named Ellen. A mere six months after the divorce, in February of 2014, Simon married Ellen, and they remain together today.

There are, however, a few complicating factors about this story, beyond the regular emotional turmoil that so often accompanies failed romantic endeavors. Simon's full name is Simon Holmes, and he is a 59-year-old family doctor in the United Kingdom. He got to know his first wife, identified in court hearings as Patient A, while treating her for depression. And he got to know his second wife, identified in court hearings as Patient B, while counselling her over relationship troubles with her former husband. After these details eventually came to light, a medical disciplinary panel suspended Holmes from practising for three months for failing to maintain professional boundaries.

This case, of course, is a rather exceptional one. British newspapers had a field day with it, more than one going all caps in their headlines to note Holmes had married not one but TWO of his patients. Though instances of doctors and patients entering romantic relationships are indeed rare, it does sometimes happen. Physicians sometimes have sexual relationships with patients, or with former patients. Sometimes the initiator is the physician, and sometimes it is the patient. Often times these are clear-cut cases of unethical behaviour on the part of doctors — perhaps even criminal behaviour. But sometimes, in certain contexts, considering certain factors, these affairs of the heart are a little more complicated.

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There is no such thing as a consensual sexual relationship between a doctor and a patient, but sometimes, in certain contexts, considering certain factors, things aren't so black and white.

Black and white rules

In Canada, if a doctor engages in sexual activity with a current patient, and doesn't terminate the professional relationship, it is considered sexual misconduct by provincial medical regulatory colleges. And it doesn't matter if the relationship is consensual.

"There is no such thing as a consensual sexual relationship between a doctor and a patient," says Dr. Carol Leet, former president of the College of Physicians and Surgeons of Ontario. "There is a power imbalance that makes it impossible for a patient to actually be consenting to having that relationship."

According to the college's policy on maintaining appropriate boundaries with patients, "any form of sexual relations between physicians and patients is considered sexual abuse" under the Ontario Regulated Health Professions Act. This includes not only sexual contact, but also behaviour or remarks of a sexual nature. There are typically two types of doctors who commit sexual abuse of

patients, says Leet. Some are sexual predators — "There are criminals in all walks of life," she notes — and some are going through personal problems that have compromised their judgement.

"One of the things about sexual abuse by physicians is that it isn't necessarily a very common thing but it's certainly a very serious thing," says Leet. "That's why the college devotes a fair bit of energy and resources to try to not only prevent it but to deal with it when it happens and to support the victims."

In any given year, the proportion of licensed physicians disciplined by provincial regulatory colleges ranges from 0.06% to 0.11%, so relatively speaking sexual abuse isn't common. But according to a 2011 paper in *Open Medicine*, among those physicians disciplined by professional colleges in Canada, sexual misconduct is the most common offence. Between 2000 and 2009, just over 600 Canadian physicians were disciplined for committing a total of 852 different violations. The most common categories were sexual misconduct (20%), standard of care issues (19%) and unprofessional conduct (16%).

"It is concerning that a large proportion of violations by Canadian physicians involved sexual misconduct, which is an egregious breach of public trust," states the paper, also noting that "despite a lack of consensus regarding how to educate medical trainees and physicians with regard to sexual boundaries, this finding may identify a need for greater attention to this critical topic within the medical education curricula."

"The good news is that it's not common," says Dr. Chaim Bell, a coauthor of the paper and an associate professor of medicine, health policy, management and evaluation at the University of Toronto. "The bad news is that when it's not common and you don't have that much information, it's hard to develop targeted interventions, and so instead you are using fairly diffuse interventions that may not be pertinent or relevant."

Sexual misconduct does appear to be a bigger issue, however, in some medical disciplines than in others. A 1998 study of physicians disciplined for sex-related offenses in the United States, published in the *Journal of the American Medical Association*, found that they were more likely to belong to the specialties of psychiatry, family medicine and obstetrics and gynecology. One theory is that the nature and length of doctor–patient relationships in these disciplines increases the chances of boundary violations.

"Psychiatry is a special kind of practice because, by and large, the nature of our contact with patients is more intimate," says Dr. Mona Gupta, an assistant professor of psychiatry at the Université de Montréal and a member of the bioethics committee of the Royal College of Physicians and Surgeons. "The very things you are addressing in these encounters makes patients extra vulnerable, because you are talking about their most private fears or sources of distress."

There are, however, characteristics about the practice of medicine in general that may make a physician susceptible to violating a boundary with a patient. Historically, notes Gupta, doctors have been expected to deal with all and any stress that occurs in the context of their work, to metabolize it, and to not show they need help. That can increase vulnerability, compromise judgement and lead doctors to engage in behaviour that, in retrospect, when they are doing better, they recognize as inappropriate.

From the patient's perspective, the empathy of a caring physician can sometimes be confusing. A patient who has suffered abuse or lost a spouse or is vulnerable for any number of reasons may mistake a doctor's kind words or gestures for romantic interest. This could lead to a patient seeking more from a doctor than health care.

"Psychiatrists are trained to understand that as something that reflects the state the person is in and not to take it at face value or to ignore it or trivialize it, but rather to understand it as a reflection of what the patient may be going through, and possibly even to address it, depending on the circumstances," says Gupta. "The fact that something is initiated by a patient doesn't in any way change your responsibilities in terms of keeping boundaries or in terms of helping that person."

Real-life grey zone

When a patient becomes a former patient, things become less clear. You can't violate the doctor–patient relationship, after all, if it no longer exists. Well, that may be true, but these situations can still be tricky. The discussion moves, however, from the realm of sexual abuse into the world of ethics.

The College of Physicians and Surgeons of Ontario, for example, doesn't consider sexual contact with former patients to be abuse, but does warn in its boundaries policy that "the physician may still be found to have committed professional misconduct." The American Psychiatric Association, in its Principles of Medical Ethics, states that "sexual activity with a current or former patient is unethical."

In the United Kingdom, the General Medical Council once discouraged physicians from having romantic relationships with any former patient. That changed in 2013, however, though the council did update its guidelines to include factors a doctor should consider before doing down that path. These include the nature of the professional relationship, how long ago it ended and whether the physician is caring for other members of the former patient's family.

The problem with rules by regulatory bodies, however, is that they tend to be broad and leave little room for nuance. Their purpose is to establish clear and easy-to-communicate norms that apply to large groups. In the real world, when dealing with human relationships, each one unique and complex, such rules, however well intentioned, may not apply in every case.

"I totally support the norms that one should avoid at all costs entering into a romantic or sexual relationship with a patient because there is a high probability that it could undermine the doctor-patient relationship with potential risk to the patient," says Dr. Eugene Bereza, director of the Centre for Applied Ethics at the McGill University Health Centre. "Having said that, in real life, there may be the rare — and I stress the word rare — justifiable exception where vulnerability is virtually zero, the risk to the patient is zero, there is a way to manage it by transferring care

and you invoke a third party if necessary to adjudicate."

One scenario often mentioned in discussions of possible exceptions is the dilemma of the rural doctor. What if, for instance, you are the only doctor in a remote community? Should you really be expected to forgo romantic relationships and marriage and a family? It is generally less frowned upon when a rural doctor falls in love with a patient, though ethicists still suggest that the professional relationship be terminated and, barring an emergency, that care be transferred to a doctor in a different community, even if that proves burdensome.

The general rule of thumb, however, is generally agreed upon in the medical profession. Romantic relationships between doctors and patients are fraught with hazards and best avoided. The doctor–patient relationship is fiduciary, and the physician's responsibility is to put the patient's health needs first, not their own wants or desires. But doctors are people, too. And people sometimes find love even if they aren't looking for it.

"I do know of rare, rare cases where a physician has unintentionally and unwittingly, over time, fallen in love with somebody," says Bereza. "It was mutual, consensual and they went on to get married and have a family and be a pillar of the community." — Roger Collier, *CMAJ*

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