Physicians Disciplined for Sex-Related Offenses

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

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

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

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

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

Results.—The number of physicians disciplined per year for sex-related offenses increased from 42 in 1989 to 147 in 1996, and the proportion of all disciplinary orders that were sex related increased from 2.1% in 1989 to 4.4% in 1996 (P<.001 for trend). Discipline for sex-related offenses was significantly more severe (P<.001) than for non–sex-related offenses, with 71.9% of sex-related orders involving revocation, surrender, or suspension of medical license. Of 761 physicians disciplined, the offenses committed by 567 (75%) involved patients, including sexual intercourse, rape, sexual molestation, and sexual favors for drugs. As of March 1997, 216 physicians (39.9%) disciplined for sex-related offenses between 1981 and 1994 were licensed to practice. Compared with all physicians, physicians disciplined for sex-related offenses were more likely to practice in the specialties of psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice (all P<.001) than in other specialties and were older than the national physician population, but were not different in terms of board certification status.

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

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

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

See also pp 1889 and 1915.

In 1986, the Council of Ethical and Judicial Affairs of the American Medical Association (AMA) first issued an opinionon physician sexual misconduct that stated, “Sexual misconduct in the practice of medicine violates the trust the patient reposes in the physician and is unethical.” In 1992, the Council updated this opinion to explicitly define sexual misconduct, stating that all sexual contact with current patients constitutes sexual misconduct, and “sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.”

State legislatures have increasingly paid attention to this issue by passing laws that criminalize sexual contact between patients and psychotherapists. In 1996, Idaho passed the first law, as far as we are aware, to criminalize all sexual contact between a patient (except for spouses and domestic partners) and any medical care provider. However, whether the increased attention to this problem is resulting in increased disciplinary activity against physicians who have sexual rela-
tions with patients is unknown. In this study, we analyzed the frequency and severity of disciplinary actions taken against physicians for sex-related offenses and determined the characteristics of the disciplined physicians.

METHODS
Construction of Database on Disciplinary Activity

In 1989, the Public Citizen’s Health Research Group began requesting information on all disciplinary orders that state medical boards and federal agencies (the Department of Health and Human Services, the Drug Enforcement Agency, and the Food and Drug Administration) had taken against physicians, including both doctors of medicine (MDs) and doctors of osteopathic medicine (DOs). By October 1996, 20,914 disciplinary orders taken prior to January 1, 1995, had been reported and entered into our database of disciplinary orders. However, not all jurisdictions have provided complete data for all the years. Ten states or agencies reported no data or partial data in 1989; 6 agencies reported no data or partial data in 1990; 4 in 1991; 5 in 1992; and 3 in 1993 and 1994. Some agencies provided data for years prior to 1989, dating back as far as the mid-1970s. The information provided by each agency varied, as disciplinary actions are prepared for public release in different ways by the agencies. Once this information was received, it was entered into our database in a standardized format using a detailed data-entry protocol. A record was created for each order and included the following data items: the agency that sanctioned the physician, physician name, license number, address, birth date, date of the disciplinary action, the 2 most serious disciplinary actions, the offense, and a note field that included any additional relevant information contained in the information provided by the agency. The agencies varied in the amount of detail provided, thereby affecting whether the offense or the actions taken in the disciplinary order could be identified and entered into the database. For example, the proportion of orders from a given agency that had an identifiable offense ranged from 11% to 100%, whereas the number of orders with an identifiable action ranged from 61% to 100%. Overall, 68% of orders had an identifiable offense, and 85% had an identifiable action.

Actions taken against physicians by state boards and federal agencies were entered as 1 of 24 types. These actions, in order of decreasing severity, were revocation of license, surrender of license, disallowance of the right to renew a controlled substance license, denial of a license, denial of license reinstatement (from a revocation or surrender), reinstatement (from a revocation or surrender), suspension, suspension of controlled substance license, emergency suspension, license probation, probation of controlled substance license, fine, license restriction, restriction of controlled substance license, reprimand, education, enrollment into an impaired physician’s program or alcohol or other drug treatment program, cease and desist order, monitoring of a physician’s practice, participation in community service, and exclusion from Medicare (only the Department of Health and Human Services can take this action). In about one third of the orders in the database, state medical boards imposed more than 1 action in a single disciplinary order.

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

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

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

Physician Characteristics in the Database on Disciplinary Activity

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

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

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

Frequency and Severity of Discipline and Offenses

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

The severity of orders taken by state medical boards over time from 1989 to 1994 was tabulated, with surrender and revocation of licensure being the most severe, followed by suspension or emergency suspension, probation or restriction, and lesser serious actions. The most serious action taken against each physician was determined using these same hierarchies. Physicians who had any orders for which the disciplinary agency had not
Table 1.—Number of Disciplinary Orders for Sex-Related Offenses and Physicians Against Whom They Were Taken, 1989-1994*

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Orders</th>
<th>No. of Physicians†</th>
<th>No. of Total Orders in Database (Sex and Not Sex Related)</th>
<th>Sex-Related Orders as a % of Total Orders</th>
<th>No. of Agencies With Complete Data Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>47</td>
<td>42</td>
<td>2266</td>
<td>2.1</td>
<td>43</td>
</tr>
<tr>
<td>1990</td>
<td>68</td>
<td>63</td>
<td>2659</td>
<td>2.6</td>
<td>47</td>
</tr>
<tr>
<td>1991</td>
<td>81</td>
<td>78</td>
<td>2427</td>
<td>3.3</td>
<td>49</td>
</tr>
<tr>
<td>1992</td>
<td>112</td>
<td>104</td>
<td>2354</td>
<td>4.8</td>
<td>48</td>
</tr>
<tr>
<td>1993</td>
<td>126</td>
<td>112</td>
<td>2684</td>
<td>4.7</td>
<td>50</td>
</tr>
<tr>
<td>1994</td>
<td>162</td>
<td>144</td>
<td>3087</td>
<td>5.2</td>
<td>50</td>
</tr>
<tr>
<td>1995</td>
<td>167</td>
<td>155</td>
<td>3564</td>
<td>4.7</td>
<td>51</td>
</tr>
<tr>
<td>1996</td>
<td>154</td>
<td>147</td>
<td>3492</td>
<td>4.4</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>917</td>
<td></td>
<td>22,533</td>
<td>4.1</td>
<td>...</td>
</tr>
</tbody>
</table>

*This column is not cumulative, as physicians may be disciplined in more than 1 year.
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Table 2.—Disciplinary Actions Taken Against Individual Physicians for Sex-Related Offenses*

<table>
<thead>
<tr>
<th>Disciplinary Action</th>
<th>No. (%)</th>
<th>(N = 448)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revocation</td>
<td>156 (34.8)</td>
<td></td>
</tr>
<tr>
<td>Surrender</td>
<td>43 (9.6)</td>
<td></td>
</tr>
<tr>
<td>Suspension</td>
<td>101 (22.5)</td>
<td></td>
</tr>
<tr>
<td>Emergency suspension</td>
<td>17 (3.8)</td>
<td></td>
</tr>
<tr>
<td>Probation and restriction</td>
<td>88 (19.6)</td>
<td></td>
</tr>
<tr>
<td>No serious actions</td>
<td>43 (9.6)</td>
<td></td>
</tr>
</tbody>
</table>

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

Physician Characteristics

The characteristics of disciplined physicians were compared with the characteristics of the national physician population, as reported for MDs and DOs. Most of the analysis of characteristics was performed only for MDs, due to difficulty in standardizing information given by the 2 organizations. However, information on DOs was included when possible (in the analysis of age and major professional activity) to present the most complete data possible.

To allow for comparison of our data with the MD data in the analysis of the specialties of physicians disciplined for sex-related offenses, the more than 100 specialties, which a physician can identify in the Directory of Physicians in the United States, were grouped into the 8 specialties used by the AMA for statistical purposes. No data on specialties were collected for physicians whose major professional activity was listed as unknown or inactive in the relevant Directory of Physicians in the United States. This was necessary to allow for comparison with the national data on physician distribution among specialties. In the analysis of the specialties of disciplined physicians over time, only the year of the first action taken against the physician was used.

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

Statistical Analysis

Stata statistical software (Stata Corp, College Station, Tex) was used in the analysis. All tests of proportions were 2-tailed z tests using a significance level of .05. The χ² tests for trend that were analyzed with EP15 software (EPI Information, Inc, Stone Mountain, Ga) were used in the analysis of time-trend data, with a significance level of .05.

RESULTS

Frequency and Severity of Discipline and Offenses

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

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

Disciplinary orders for sex-related offenses from 1989 to 1994 were more severe than orders for non–sex-related offenses, with 71.3% of sex-related orders involving loss or suspension of license, compared with 42.8% of the 11,561 non–sex-related disciplinary orders (P<.001). During this period, 33.7% of orders for sex-related offenses involved loss of license; 33.7% involved suspension of license; 22.3% involved restriction of license; and 5.8% had no serious actions.
There was no trend toward increased or decreased severity of discipline over time.

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

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

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

Characteristics of Disciplined Physicians

The specialties of psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice were all significantly overrepresented among physicians disciplined for sex-related offenses prior to 1995 as compared with the proportion of all MDs in the country in that specialty (Table 4). Psychiatry was the specialty with the highest number (133) of disciplined physicians and was also the most overrepresented among disciplined physicians. Of all physicians in the country, 6.3% identify psychiatry as their primary specialty, whereas 27.9% of disciplined physicians were psychiatrists, a 4.4-fold overrepresentation. General surgery, internal medicine, anesthesiology, and pediatrics were all underrepresented among disciplined physicians. The percentage of disciplined physicians who were psychiatrists decreased over time, from 39.4% in 1989 to 21.6% in 1994 (P = .02). In contrast, the percentage of disciplined physicians who specialized in family and general practice increased from 9.1% in 1989 to 24.5% in 1994 (P = .02). There were no significant differences over time for rates of discipline for physicians who practice obstetrics and gynecology or all other specialties.

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

Disciplined physicians were significantly overrepresented (P < .001) among physicians whose major professional activity was direct patient care, and significantly underrepresented among those involved in postgraduate education or non–patient care activities (P < .001 and P = .02, respectively) (Table 6). There was no significant difference between disciplined MDs and all MDs in the percentage who were board certified overall (58.7% vs 60.2%) and for each of the specialties studied. Disciplined physicians as a whole, as well as in each specialty studied, were not more or less likely to list a preferred professional address in metropolitan areas than all physicians in the country (86.0% vs 88.4%).

COMMENT

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

Disciplined physicians were more likely to practice in psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice than nondisciplined physicians and were older than the national physician population, but were no more or less likely to be board certified than all physicians in the country. The increased frequency of discipline for sex-related offenses over time found in our study is in agreement with a report by the Federation of State Medical Boards,17 which found that the percentage of actions that involved sexual...
Physicians include doctors of medicine (MDs) and doctors of osteopathic medicine (DOs). MDs listed by the American Medical Association as adequately overseen by medical boards. 

 Obstetricians-gynecologists, and surgeons, who commit sex-related offenses, are less likely to participate in this behavior. 

 In an earlier survey, Gartrell et al reported that obstetrics and gynecology and family practice were the 2 specialties in which physicians were most likely to engage in sexual contact with patients or former patients, whereas physicians in the specialties of internal medicine and surgery were less likely to participate in this behavior. 

 In a study of the disciplinary activity of the Oregon Board of Medical Examiners, Enbom and Thomas found that 3.5% of physicians acknowledged sexual contact with a current patient. Comparing these results with our findings suggests that only a fraction of offending physicians are disciplined. 

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

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

 In an earlier survey, Gartrell et al had found that psychiatrists reported less sexual contact with patients than did physicians in any of the specialties reported in the subsequent study, except internal medicine. The discrepancy between this study and our results may reflect the increased attention to sex-related offenses in psychiatry and the lack of attention to this problem in other specialties.
The willingness of physicians to take corrective action against offending physicians also will be heightened by the existence of medical education that addresses the issues of boundaries and professional ethics. Gartrell and colleagues found that, in 1992, 56% of physicians reported they had no education during their training regarding physician-patient sexual contact, and only 3% had taken a continuing medical education course on this subject. The failure of the educational system to address this issue may allow new physicians to treat patients with little understanding of the responsibilities intrinsic to their new position. Finally, patients should be encouraged to protect themselves by knowing their rights in therapeutic relationships and by filing complaints with their state medical boards should inappropriate behavior by a physician occur.

References