CEJA Report 11 – A-98
Sexual or Romantic Relations Between Physicians and Key Third Parties

INTRODUCTION

There is a long-standing consensus that sexual contact or sexual relations between physicians and patients is unethical. Little has been said on whether this conclusion extends to sexual contact or relations with individuals who are not patients but are considered “key third parties” in the patient-physician relationship. Discussion in the literature regarding sexual misconduct has traditionally focused on the boundary between the patient and the physician, almost as though they are an isolated dyad. In reality, physicians often find themselves interacting with family members and others who are affiliated with patients. Clinical encounters can and often do include such key third parties, because patients are often accompanied by those with whom they are intimately allied. Physicians naturally find themselves maintaining their professional role when interacting with these individuals, some of whom turn to them for comfort and guidance. The questions that arise, and that have until now remained relatively unexplored, are: what should the boundaries of these third-party relationships be and what obligations do physicians have in honoring these boundaries?

In this report, the Council on Ethical and Judicial Affairs reviews the ethical implications of sexual or romantic relationships between physicians and key third parties.

IMPORTANCE OF CHARACTERIZING THE THIRD PARTY

A careful definition of the key third party must be considered before the need for restraint in this area can be established. A wide-reaching restriction on sexual contact with any third party associated with the patient threatens to encroach on the liberty our society gives individuals, particularly in regard to such personal choices as the decision to enter into an intimate relationship. It is for this reason that the Council emphasizes a case-by-case appraisal of such relationships and offers some guidance when doing so.

KEY THIRD PARTIES—HOW THEY RELATE TO THE PATIENT AND THE PHYSICIAN

Key third parties possess one or more of the following features:

1) The physician interacts and communicates with them about the patient’s condition on a regular basis, and is in a position to offer information, advice, and emotional support. For this reason, the physician assumes a professional role in any interactions with these individuals.

2) They are responsible for the patient’s welfare and hold decision-making power on behalf of the patient. Through any of a variety of circumstances, they have been charged with the authority to speak for the patient.

3) They are emotionally close to the patient. Their participation in the clinical encounter, more often than not, matters a great deal to the patient—as demonstrated explicitly in some cases by a durable power of attorney.

Examples of key third parties include but are not limited to: spouses or partners, parents, guardians, surrogates, and proxies designated by durable power of attorney.

© 1998 American Medical Association. All Rights Reserved.

The first feature is necessary in order to be considered a key third party. Family members, friends, and associates of patients whom the physician may meet as part of the social circle that surrounds the patient but with whom the physician does not form a professional relationship would not be considered key third parties. The formation of this professional relationship, however, is not sufficient.

The more deeply involved the individual is in the medical decision-making and the clinical encounter, the more troubling sexual contact with a physician would appear to be. This is particularly true for individuals who hold decision-making power on behalf of an incompetent patient. Because of the impact their decisions may have on the health and welfare of the patient, such individuals play an important role in the fiduciary relationship between doctor and patient, and should therefore be accorded a similar respect that is given to patients.

Consider the pediatrician-parent relationship as an illustration of this dynamic. Our laws delegate the ability to decide the best interests of minors to their parents on the presumption that these individuals are the best situated physically, morally, and emotionally to make such decisions. If this ability is to be acknowledged, pediatricians must hold some of the same fiduciary obligations to parents as they would toward patients.

The role of a parent or surrogate, however, is distinctly different from that of a patient. Parents or surrogates are not vulnerable in the same way patients are vulnerable—they may suffer from the emotional stresses that come with their roles as caregivers or decision-makers, but they are neither ill nor exposed to the discomfort and invasions that patients have to endure. These individuals are not the direct recipients of the physician’s knowledge or skills. Nevertheless they are the immediate source of goals and decisions—a fact that must be respected.

An inherent imbalance of knowledge, expertise, and status characterizes a professional relationship. Key third parties are just as susceptible as patients to the influence a physician can hold in this relationship. For this reason, as well as for the sake of the patient, boundaries must be set and respected in the relationship between a physician and a key third party.

RISK OF EXPLOITATION

There are other elements to consider before determining physician sexual contact with third parties to be unethical. In the same way sexual contact between physicians and former patients may be unethical if it “occurred as a result of the use or exploitation of trust, knowledge, influence, or emotions derived from the former professional relationship,” [1] sexual contact between physicians and key third parties may likewise be unethical because of the risk of exploitation.

Some elements to weigh when considering this risk are as follows:

1) The intensity and emotional nature of treatment (e.g. chemotherapy as compared to splinting a fracture).
2) The nature of the patient’s medical problem (e.g. in the setting of a life-threatening illness or a psychiatric disorder).
3) The length of the professional relationship.
4) The degree of emotional dependence the third party has on the physician.
5) The importance to the surrogate and the patient of the clinical encounter.

All of these factors contribute to the vulnerability of the key third party and the patient. The last item cannot be underestimated. One mother who became sexually involved with an Ohio pediatrician explained her consent as follows: "I thought this extra care he gave to the family would be dependent on [my involvement with him]."[2] Because of their feelings of gratitude and their position of dependency, key third parties may find it difficult to decline sexual initiatives from physicians taking care of their loved ones.

KEEPING THE PATIENT'S BEST INTERESTS FOREMOST

In addition to the risk of exploitation, a sexual or romantic relationship between a physician and a key third party can detract from the goal of furthering the patient's best interests. It has the potential of becoming a preoccupation that affects the clarity of both the physician and the third party's decision-making powers. The independent medical judgment of the physician can be compromised in any setting where the physician's self-gratification comes into play.

RECOMMENDATIONS

The Council recommends approval of the following recommendations and that the remainder of this report be filed:

1) Patients are often accompanied by third parties who play an integral role in what has usually been seen as a dyadic patient-physician relationship. The physician interacts and communicates with these individuals about the patient's condition and is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the medical decision-making and the clinical encounter, the more troubling is any sexual or romantic contact with the physician. This is especially true for individuals whose decisions directly impact on the health and welfare of the patients. Such key individuals may include, but are not limited to: spouses or partners, parents, guardians, surrogates, and proxies designated by durable power of attorney.

2) The risk of exploitation can vary with the intensity and emotional nature of treatment. Several things contribute to the vulnerability of the patient and key third party: the nature of the patient's medical problem; the length of the professional relationship; the degree of emotional dependence the third party has on the physician; and the importance of the clinical encounter to the surrogate and the patient.

3) Physicians should refrain from sexual or romantic interactions with these key third parties. Sexual contact with these individuals that occurs concurrent with the patient-physician relationship is unethical and constitutes sexual misconduct.

REFERENCES

1. Council on Ethical and Judicial Affairs, American Medical Association. "Sexual misconduct in the practice of medicine." *JAMA*. 1991; 266: 2741-2745.

2. Somerson M. "Doctor says affairs did not breach ethics." *The Columbus Dispatch*. May 20, 1997.