



# Sexual boundaries in the doctor-patient relationship

- **Doctors are responsible for maintaining sexual boundaries in the doctor-patient relationship.**
- **There is an inherent power imbalance in the doctor-patient relationship which can result in breaches of trust.**
- **Sexual misconduct is an abuse of the doctor-patient relationship and can cause significant and lasting harm to patients.**
- **It is never appropriate for a doctor to engage in a sexual relationship with a patient.**
- **A doctor must only conduct a physical examination of a patient when it is clinically indicated and with the patient's informed consent.**
- **Open and clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship.**

## Trust

1. Trust is the essence of the doctor-patient relationship. Trust in a doctor-patient relationship lets a patient share and discuss private, confidential and personal information with you. By creating an environment of mutual respect and trust in which your patients feel confident and safe, a patient will allow you to perform physical examinations critical to providing optimal care.
2. A breach of sexual boundaries is a breach of trust and a failure in your duty of care to your patient. Boundaries are vital to maintaining appropriate behaviour between doctors and their patients.

## The importance of open and clear communication

3. Open, clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship. Your actions and how you communicate them to a patient influence the patient's perceptions about what you do and the treatment the patient receives. Open and clear communication includes:
  - (a) Listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences.
  - (b) Explaining why you are asking questions or why an investigation or physical examination is necessary and what is involved in them.
  - (c) Giving patients adequate opportunity to ask questions, or to defer or refuse an intervention or treatment.
  - (d) Responding to patients' questions and keeping them informed about their clinical situation and the outcome of any investigations or examinations you propose or initiate.
  - (e) Checking that your patient understands what you have said.

## Power imbalance

4. A key difficulty arises from a power imbalance inherent in the doctor-patient relationship. The doctor-patient relationship is not equal, whether seeking assistance, guidance or treatment. In some situations, the patient may become dependent on the doctor emotionally and be vulnerable to an inappropriate relationship with their doctor.
5. The major reasons for a power imbalance in the doctor-patient relationship are:
  - (a) The patient shares personal information with you that they rarely share with others.
  - (b) You do not reciprocate with personal information; creating a one-sided relationship.
  - (c) The close physical contact that occurs in a consultation is based solely on your position as a doctor.
  - (d) As the doctor, you determine the level of physical contact required to provide care.
6. At your request, and solely on the basis that you are a doctor, a patient will undress, allow physical touch normally limited to partners and family, and share private and personal information. As the doctor, it is your responsibility to ensure professional and ethical behaviour is maintained within a professional relationship.

## Breaches of sexual boundaries are unacceptable

7. It is never appropriate for a doctor to engage in a sexual relationship with a current patient. The Council has a zero-tolerance position on doctors who breach sexual boundaries with a current patient. This is because:
  - (a) A breach of sexual boundaries in the doctor-patient relationship has proven to be harmful to patients and may cause psychological, emotional or physical harm to both the patient and the doctor.
  - (b) The doctor-patient relationship is not equal. Doctors can influence and potentially manipulate patients, so even if a patient has consented to a sexual relationship that is not a sufficient excuse. It is still considered a breach of sexual boundaries.
  - (c) Sexual involvement with a patient can impair your judgement about diagnosis or treatment because your emotions are involved. That may influence your decisions about seeking and providing good care to the patient.

## What is considered a breach of sexual boundaries?

8. A breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse, or gratify sexual desires. It is not limited to physical behaviour. It incorporates any words, actions or behaviour that could reasonably be interpreted as sexually inappropriate.
  9. The Council has defined three levels of sexually inappropriate behaviour in the doctor-patient relationship. These are sexual impropriety, sexual transgression and sexual violation.
  10. **Sexual impropriety** means any behaviour, including gestures or expressions, that are sexually demeaning to a patient, or that demonstrate a lack of respect for the patient. Such behaviour includes, but are not limited to:
    - (a) Examining the patient intimately without their consent.
    - (b) Conducting an intimate examination of a patient in the presence of students or other parties without the patient consenting to the presence of the students or other parties.
    - (c) Making inappropriate comments about, or to, the patient, for example, in relation to a patient's body or underclothing.
    - (d) Making sexualised or sexually-demeaning comments to a patient.
    - (e) Making comments about sexual performance during an examination or consultation (except where pertinent to clinical issues of sexual function or dysfunction).
    - (f) Making irrelevant comments about or ridiculing a patient's sexual orientation.
    - (g) Requesting details of sexual history or sexual preferences not relevant to the consultation.
    - (h) Any conversation regarding the sex life of the doctor, or the sexual preferences or fantasies of the doctor.
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11. **Sexual transgression** means any inappropriate touching of a patient of a sexual nature, short of sexual violation, including but not limited to:
  - (a) Manual internal or manual external genital or anal examination without gloves.
  - (b) Touching breasts or genitals, except for the purpose of appropriate physical examination or treatment.
  - (c) Touching breasts or genitals when the patient has refused or withdrawn consent for the examination or treatment.
  - (d) Propositioning a patient.
12. **Sexual violation** is the act of a person raping another person, or who has unlawful sexual connection with another person<sup>1</sup>.

## Required practice during consultation

### Physical examination

13. You should only conduct a physical examination if it is clinically warranted. You must obtain the patient's consent before conducting a physical examination.<sup>2</sup>
14. You must also obtain the patient's consent if an observer or chaperone attends the consultation.
15. Make sure the patient is aware that they should voice any feelings of discomfort or pain and that they can ask you to stop the examination at any time.

### Disrobing facilities

16. If the consultation involves a physical examination that requires the patient to remove their clothes, you should provide an appropriate place to undress. This is an area where the patient can undress in private, out of view of anyone, including you.
17. You should not require a patient to undress unnecessarily or to stay undressed longer than necessary or to an extent more than required for the examination. The patient only needs to uncover the part of the body that is being examined, and should be allowed to cover it again as soon as you have finished.

### When another person is present during a consultation

18. You or your patient may want another person present during a consultation. Appendix 1, at the end of this statement, gives more information about this.

## Recognising that boundaries are threatened

19. An attraction may develop between you and your patient. It is important that you recognise this and take appropriate steps to manage any attraction and ensure that professional boundaries are maintained.

### Warning signs

20. You need to watch for warning signs that could indicate a blurring of professional boundaries and/or that professional boundaries are being crossed. Early recognition and action can help avoid discomfort and harm to your patient or to you. Warning signs include:
  - (a) Seeing a patient at an unusual hour or location without clinical justification, especially when other staff are not there.
  - (b) Preferring a certain patient to have the last appointment of the day without any clinical justification.
  - (c) Accessing the patient's records without any clinical justification.
  - (d) Providing the patient with your personal contact information when there is no clinical basis for doing so.
  - (e) Social invitations: Before accepting a social invitation from or extending a social invitation to a patient, it would be wise to consider the nature of the invitation.

<sup>1</sup> As defined under Section 128 of the Crimes Act 1961.

<sup>2</sup> See also Council's statement on *Information, choice of treatment and informed consent* for guidance on instances when a patient is not competent to give informed consent.

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- (f) Revealing intimate details about your life to a patient during a professional consultation, especially personal crises or sexual desires or practices.

#### **Patients acting inappropriately towards doctors**

- 21. If a patient is attracted to you and their behaviour threatens, or poses a risk of threatening, the sexual boundaries of the doctor-patient relationship, you need to take measures to manage the situation to avoid any breach of sexual boundaries. Document the actions you have taken.
- 22. If possible, try to discuss the patient's feelings and attraction in a constructive and helpful manner that explains the inappropriateness of a relationship. If that is not possible, it is best to transfer the care of the patient to another doctor.
- 23. If the situation persists, advice from your peers could be helpful.

#### **Your obligation to notify**

- 24. If you receive or become aware of information that another doctor may have breached sexual boundaries with a patient, you have an ethical obligation to act including informing the Council of your concerns.

#### ***When a patient discloses a concern to you***

- 25. If a patient discloses an alleged breach of sexual boundaries by another doctor, you should try to help the patient by explaining their options. This could include telling the police, contacting a patient advocate, or making a complaint to the Health and Disability Commissioner.<sup>3</sup>
- 26. As the patient's doctor, you are obliged to try to answer any questions the patient raises about sexual behaviour in a professional relationship, or to help them to find another source of assistance.
- 27. If the patient does not want their name revealed, but still wants to disclose an alleged breach of sexual boundaries, you have a professional and ethical obligation to notify the Council about the alleged behaviour. This obligation exists, even if the information is limited, or you have not witnessed, or have no evidence of the alleged breach of sexual boundaries. This may be done by phone, e-mail or in writing, and should include your name and contact details, the name of the doctor involved, and the details of the allegation(s).
- 28. If the patient says they do not want to make a complaint, but you believe there is a serious and imminent threat to the patient's safety or the safety of another person, you should tell the police immediately. Under the Health Information Privacy Code 1994, you are not liable for any interference with privacy that arises from a notification if the threat is 'serious and imminent'.<sup>4</sup>
- 29. In each of the above scenarios, you have an ethical obligation to discuss the issue and offer to help the patient to make a complaint, or find more help for the patient.

#### ***When a peer discloses something or seeks advice***

- 30. If you are approached for advice from a peer who feels attracted to a patient but who assures you that they have not acted inappropriately, you do not have an ethical duty to inform anyone. You may counsel and advise the doctor without being concerned that you must notify the Council.
- 31. However, if you feel that the doctor or a patient may be at risk of breaching professional boundaries or if you feel that you need help in advising your peer, the Council strongly recommends that you ask for help.
- 32. If you are approached by a doctor who has breached sexual boundaries with a patient, your first priority must be the patient's safety. You may ask a senior staff member of the Medical Council for advice.

<sup>3</sup> The Council has an information pamphlet for patients on breaches of sexual boundaries in the doctor-patient relationship and the nationwide Health and Disability Advocacy service may be able to help (0800 555 050).

<sup>4</sup> Please refer to the Council's statement *What to do when you have concerns about a colleague* for more details, or contact the Council if you are unsure about the level of seriousness.

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### **What happens when you notify the Medical Council?**

33. When you contact the Medical Council to notify it that a peer may have breached sexual boundaries, the matter may be referred to the Council. Council staff will discuss with you what further action you may wish to take.

### **Disciplinary action – the role of the Health Practitioners Disciplinary Tribunal**

34. The Council is not a disciplinary body. Its role is to protect the public by putting appropriate safeguards in place. Complaints will be assessed by the Council and/or the Health and Disability Commissioner's office. This might, after further investigation of a complaint, result in a charge being laid with the Health Practitioners Disciplinary Tribunal (the Tribunal). The Tribunal is responsible for disciplinary decisions regarding doctors and other health practitioners. Detailed information about the Tribunal process is available from the Tribunal website ([www.hpdt.org.nz](http://www.hpdt.org.nz)).
35. If the Tribunal finds a doctor guilty of professional misconduct as a result of breaching sexual boundaries, the Tribunal may make a number of orders including:
- (a) Imposing a fine;
  - (b) Contribution towards some of the costs of the Tribunal hearing;
  - (c) Suspension for up to three years;
  - (d) Placing conditions on the doctor's practice;
  - (e) Cancelling the doctor's registration.
36. The Tribunal does not have the ability to remove a doctor from the medical register permanently, but can specify one or more conditions that the doctor must satisfy before they may apply for registration again.

### **Sexual relationships with former patients**

37. A former patient may be harmed by having a relationship with their former doctor even if they have been transferred to another doctor. The degree of harm is linked to the intensity of the doctor-patient relationship. For example, the length of the professional relationship, the frequency of contact, and the type of care provided.
38. Because each doctor-patient relationship is unique, and because everyone reacts differently to different circumstances, it is difficult to have clear rules on when it is or is not acceptable for a doctor to have a relationship with a former patient.
39. Council's zero-tolerance position on sexual relationships in the doctor-patient relationship does not extend to doctors and former patients. The Council recognises that, where a former doctor-patient relationship was very minor or temporary, a total ban on any subsequent relationship is unfair and unrealistic.
40. However, there are some situations where it would never be acceptable for a doctor to have a sexual relationship with a former patient.

### **When a sexual relationship is never acceptable**

41. A sexual relationship between a doctor and a former patient is never acceptable if:
- (a) The doctor-patient relationship involved psychotherapy, and/or the doctor provided long-term emotional support or counselling to the patient.
  - (b) The patient has had, or has, a condition or impairment likely to confuse their judgement or thinking about what they may want to do.
  - (c) The patient has been sexually abused in the past.
  - (d) The doctor-patient relationship is ended in order to initiate a sexual relationship.
42. A sexual relationship between a doctor and a former patient will always be unethical where that relationship is strongly influenced by the previous doctor-patient relationship.
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### **Intimate relationships with family members of patients**

43. You should think carefully before developing a relationship with a family member of a patient. An intimate relationship between you and a family member of a patient<sup>5</sup> (irrespective of whether there is any sexual contact) will always be regarded as unethical if:
- (a) there is any likelihood that such a relationship could impact negatively on the patient's care; and/or
  - (b) you have used any power imbalance, knowledge or influence obtained as the patient's doctor to initiate or maintain that relationship.

### **Seeking clarification or further advice**

44. If you are unsure about any aspect of this statement, please contact the Medical Council. You might also seek advice from a trusted colleague, the New Zealand Medical Association (NZMA), your medical indemnity insurer, Medical Sexual Assault Clinicians Aotearoa (MEDSAC) or your professional college or association.

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<sup>5</sup> Council regards a 'family member of a patient' as an individual with whom the patient has a familial connection or is a member of the patient's household.

# Appendix 1

## When another person is present during a consultation

For some or all consultations, a doctor or patient may want another person present. When a third person attends a consultation, the doctor and the patient should understand their rights to grant or withhold consent and when the attendance of a third person is mandatory. The role and function of the third person should be clearly understood by all parties.

1. The use of a third person is not restricted to consultations between male doctors and female patients or when conducting physical or intimate examinations. Male and female patients may wish to have a third person present for any number of reasons and doctors, whether they are male or female, may also have this preference.

### Definition and role of the third person

2. The individual circumstances of the consultation, the doctor and the patient, will determine the role of the third person in a consultation. A third person may be present to participate in one of the following five roles as defined in this statement:
  - a support person for the patient
  - an interpreter for the patient
  - an observer for the doctor
  - a student or trainee
  - the doctor's chaperone.

### Support person for the patient

3. Right 8 of the Code of Health and Disability Services Consumers' Rights states that "every consumer has the right to have one or more support persons of their choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed".
4. The support person(s) may be present in all or part of the consultation to provide support for the patient. Any aspect of a consultation, not just a physical examination, may cause discomfort or confusion and the patient has a right to request one or more support people in attendance. The function and role of the support person(s) focuses on the needs of the patient, whether it be holding the patient's hand, observing the consultation or asking questions on behalf of the patient.
5. Some reasons a patient may request the presence of a support person(s) are:
  - they feel more comfortable with the presence of a support person(s)
  - it is the first consultation in a new doctor-patient relationship
  - the patient's cultural expectations include the presence of a third person
  - the patient's age (either young or old)
  - the patient would like assistance to understand what happens in the consultation
  - the patient has some form of mental or physical disability.

### Interpreter

6. In some circumstances an interpreter may be present to assist in the communication between the doctor and patient. An interpreter may assist with interpreting a different language (i.e. a foreign language) or with the communication or understanding of someone with a disability or alternative form of communication (i.e. sign language). This is the patient's right under Right 5(1) of the Code of Health and Disability Services Consumers' Rights.
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### **Observer for the doctor**

7. This person is present at the doctor's request. A doctor may request an observer for a number of reasons:
  - it is the policy of the organisation or practice to have an observer in attendance. Some employers have a practice policy that a third person should be in attendance for certain types of examinations or consultations (e.g. internal examinations).
  - an observer may be used in continual professional development (CPD) to assess the doctor, with the intention of providing advice and guidance on how the doctor can improve their skills.
8. The role of the observer is to observe the consultation or part of a consultation on the doctor's behalf, including the communication between the doctor and patient and any examination that takes place. The level of the observer's interaction in the consultation should be agreed to before the consultation is initiated, both between the doctor and observer, and between the doctor and patient.
9. Consent for the presence of the observer should be obtained from the patient prior to the start of the consultation.

### **Students or trainees**

10. As part of their education, health professional students and trainees need to have the opportunity to access and learn from senior doctors with on-the-job training. This means attending actual patient consultations. Participation in teaching is covered by the Code of Health and Disability Services Consumers' Rights.
11. If a doctor would like to have one or more students or trainees attend a consultation the patient should be provided with an explanation prior to the consultation about the role that the student or trainee may take in the consultation and asked whether they consent to the student or trainee being present.
12. If a student or trainee is present during a consultation, they should be formally introduced to the patient.

### **Chaperones**

13. Some doctors have conditions on their registration or annual practising certificate that require a chaperone to be present at certain types of consultations. This condition is usually as a result of past disciplinary action and is intended to provide protection for patients. It requires a notice to be put up in the waiting and examination areas to inform patients.
14. The doctor who has this condition on their practice should inform any employer of the conditions.
15. The presence of a chaperone is not optional and if a patient does not feel comfortable with this requirement the patient will need to see another doctor. A doctor with a chaperone condition should disclose the reason behind the requirement if questioned why by a patient.
16. The only exception to the chaperone condition is in an emergency situation. A doctor with a chaperone condition may attend an emergency, even when a chaperone cannot be located.

### **Principles of the process**

17. Third person policies should be displayed in the practice waiting and examination areas. Arrangements for the presence of a third person should be in place prior to the start of the consultation.
  18. All parties involved in the consultation must understand the role of the third person. The patient must give informed consent for a third person to be present and the role they will take.
  19. The Council advises that the doctor speak with the patient about the presence of a third person in private, away from the nominated third person. This is to ensure that the patient does not feel obligated to accept someone due to the discomfort of saying 'no' in front of the third person.
  20. The Council recommends to doctors that if they require a third person to attend a consultation the third person should preferably be another health professional.
  21. If a third person attends all or part of a consultation or procedure you need to ensure that the third person is aware of its confidential nature and that the patient's personal information and physical privacy must be respected.
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**What if the patient or doctor refuses to have the nominated third person?**

22. Not every patient will want to have a third person in attendance, especially if there is an intimate aspect to the consultation that includes a physical examination for which the patient may have to undress. Some patients have indicated that a third person makes them feel an audience is present. A patient has the right to decline a third person being present.
  23. If there is no agreement on the attendance of a third person, or who that third person should be, either the doctor or the patient has the right to withdraw from the consultation until a mutually acceptable third person is available. Alternatively, the patient may be referred to another doctor. This should not have any adverse effect on the care that is provided.
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## Related resources

- **Good medical practice**
- **Information, choice of treatment and informed consent**
- **Cultural competence**
- **Maintenance and retention of patient records**
- **Ending a doctor-patient relationship**
- **Providing care to yourself and those close to you**
- **What to do when you have concerns about a colleague**
- **Professional boundaries in the doctor-patient relationship**
- **New Zealand Medical Association's *Code of ethics for the New Zealand medical profession.***

## November 2018

**This statement is scheduled for review by November 2023. Legislative changes may make the statement obsolete before the review date. The contents of this statement supersede any inconsistencies in earlier versions of the statement.**