Federation of STATE MEDICAL BOARDS

Addressing Sexual Boundaries: Guidelines for State Medical Boards

Adopted as policy by the House of Delegates of the Federation of State Medical Boards

May 2006

Section I. Introduction

Sexual misconduct by physicians and other health care practitioners is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. The purpose of this report is to provide state medical boards with a framework within which to handle sexual misconduct cases[1]. Physician sexual misconduct exploits the physician-patient relationship, is a violation of the public trust, and is often known to cause harm, both mentally and physically, to the patient.

Sexual misconduct is an issue that affects all jurisdictions and is not limited by geographic or socioeconomic boundaries. It is the primary responsibility of state medical boards to protect the safety and welfare of the public it serves. In doing so, it is medical boards' responsibility to inform licensees that sexual misconduct, in any form, will not be tolerated and, when sexual misconduct does occur, to take prompt and decisive ac-tion against any licensee found to have participated in such conduct. As state medical boards are required to respond to an increasing number of complaints, it becomes imperative that medical boards use guidelines for dealing with sexual boundary issues and take measures to educate their licensees about sexual boundary issues.

Regardless of whether sexual misconduct is viewed as emanating from an underlying form of impairment, it is unarguably a violation of the public's trust. It should be noted that although an addictive disorder, mental disorder, sexual disorder, phase of life crisis may be a contributory circumstance, boards are still charged with taking appropriate steps to see that the public is protected. While sexual addiction is a frequently used phrase, it is not recognized as a disease in the Diagnostic and Statistical Manual of Psychiatric Disorders, Version IV (DSM IV).

The following report defines physician sexual misconduct and provides recommendations to assist medical boards with the investigation process, preparation for formal hearings, crafting an appropriate disciplinary response, physician monitoring, and physician education.

Section II. Definitions

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient or patient's surrogate[2] as sexual. Hereinafter, the term "patient" includes the patient and/or patient surrogate whose sexual boundaries have been violated.

For the purposes of this report, there are primarily two types of professional sexual misconduct: sexual impropriety and sexual violation. Both types are the basis for disciplinary action by a state medical board if the board determines that the behavior exploited the physician-patient relationship.

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient, that may include, but are not limited to:

1. neglecting to employ disrobing or draping practices respecting the patient's privacy, or deliberately watching a patient dress or undress;

1. These guidelines are intended to apply to all health care professions regulated by the state medical board.

2 Surrogates are those individuals closely involved in patients' medical decision-making and care and include (1) spouses or partners (2) parents (3) guardians, and/or (4) other individuals involved in the care of and/or decision-making for the patient.

2. subjecting a patient to an intimate examination in the presence of medical students or other parties without the patient's informed consent or in the event such informed consent has been withdrawn;
3. examination or touching of genital mucosal areas without the use of gloves;
4. inappropriate comments about or to the patient, including but not limited to, making sexual comments about a patient's body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation, making comments about potential sexual performance during an examination;
5. using the physician-patient relationship to solicit a date or romantic relationship;
6. initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician;
7. performing an intimate examination or consultation without clinical justification;
8. performing an intimate examination or consultation without explaining to the patient the need for such examination or consultation even when the examination or consultation is pertinent to the issue of sexual function or dysfunction; and/or
9. requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation.

Sexual violation may include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to:

1. sexual intercourse, genital to genital contact;
2. oral to genital contact;
3. oral to anal contact, genital to anal contact;
4. kissing in a romantic or sexual manner;
5. touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent;
6. encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present; and/or
7. offering to provide practice-related services, such as drugs, in exchange for sexual favors

Section III. Guidelines for State Medical Boards:

Investigations

Board Authority

It is imperative that state medical boards have sufficient statutory authority to investigate complaints and any reported allegations of sexual misconduct. State medical boards should place a high priority on the investigation of complaints of sexual misconduct due to patient vulnerability unique to such cases. The purpose of the investigation is to determine whether the report can be substantiated in order to collect sufficient facts and information for the board to make an informed decision as to how to proceed. If the state medical board's

investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.

Each complaint should be investigated and judged on its own merits. The investigation should include a review of previous complaints to identify any such patterns of behavior, including malpractice claims and/or settlements. The investigation of all complaints involving sexual misconduct should include interviews with the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may include an interview with a current or subsequent treating practitioner of the patient and/or patient surrogate; colleagues, staff and other persons at the physician's office or worksite; and persons that the patient may have told of the misconduct. Information and physical evidence that can be valuable in resolving discontinuities are: details about each incident or extent of the relationship; identifying marks on practitioner that would be known only to someone who had been intimate with physician; objects in physician's home or environment, outside the office, where the misconduct occurred; articles of clothing with possible DNA; billing records related to visits; patient record; appointment book; phone records; written communications (e-mail, letters, cards, etc.); motel or hotel bills; credit card receipts, etc. In some cases, an undercover operation, in which the patient is wired, may be used to obtain statements and admissions from physician. It may also be necessary to discreetly involve other practice areas in an investigation, such as hospitals where the physician has privileges.

Complainant Sensitivity to Investigation

Because of the delicate nature of complaints of sexual misconduct, boards should have special procedures for interviewing and interacting with such complainants. Therefore, professionals who are appropriately trained in the area of sexual misconduct should conduct the investigation and subsequent intervention. Boards also should consider providing specialized training for investigators and consider using investigators appropriate to the gender of the complainant. In the event complainants express a desire to "tell their side of the story," the board is encouraged to afford complainants the opportunity to appear before a board subcommittee or the board itself.

Section IV. Guidelines for State Medical Boards: Hearings

Following investigation and evaluation, if deemed appropriate, the board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled. This section will discuss issues encountered by boards when preparing for an administrative hearing and will provide specific recommendations regarding those issues.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient's testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a formal hearing. Boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.

Open vs Closed Hearings

If boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what oc-

curred. Boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient's identity so that patients are not discouraged from coming forward with legitimate complaints against physicians. The boards should have statutory authority to ensure nondisclosure of the patient's identity to the public. This authority should include the ability to delete from final public orders any patient identifiable information.

Testimony

Sexual misconduct cases do involve complex issues; therefore, boards may consider the use of one or more expert witnesses to fully develop the issues in question and to define professional standards of care for the record. Additionally, the evaluating/treating physician or mental health care practitioners providing assessment and/or treatment to the respondent physician may be called as witnesses. The provider may provide details of treatment, diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a current or subsequent treating practitioner of the patient, especially a mental health provider, may be called as a witness. Such witnesses may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician's rehabilitative potential and risk for recidivism.

Other Issues

1. Rules of evidence applicable in all other administrative hearings should be applied in hearings involving sexual misconduct.
2. Boards should not consider romantic involvement, patient initiation or patient consent a legal defense, although these may be factors for the board's consideration in cases of sexual misconduct.
3. Witness credibility is often an important factor in hearings involving sexual misconduct.

Section V. Comprehensive Evaluation

State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive psychological evaluation may be valuable to the board's ability to assess future risk to patient safety.

The purpose of the evaluation is not to determine findings of fact but rather to assess and define the nature and scope of the behavior, identify any contributing illness or underlying conditions that may have predisposed the physician to engage in sexual misconduct, make treatment recommendations if rehabilitative potential is established, and identify any underlying illness or condition that might put patients at risk in the future. An evaluation may be valuable in determining whether or not a longstanding maladaptive pattern of inappropriate behavior exists.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing. The following guidelines should be considered by the board when selecting an evaluator(s) to conduct the evaluation:

1. Evaluators should be licensed health care professionals who have demonstrated knowledge, based upon education, training, and supervised experience in the realm of sexual misconduct and recognition of the characteristics of physicians who have engaged in sexual misconduct with patients or patient surrogates.
2. The evaluation should be conducted by an independent evaluator to avoid a conflict of interest.
3. There should be no prior professional or personal relationship between the evaluator and the physician being evaluated.
4. Former sexual misconduct offenders should not be approved to conduct evaluations.
5. Evaluator(s) should be approved in advance by the board.

The evaluation of a physician for sexual misconduct is complex. It may require a multidisciplinary approach and should contain the following elements:

The general goals of the evaluation

1. Identify, if present, the nature and severity of any psychiatric, psychological, medical, or cognitive impairment.
2. Help medical boards and physician health programs understand any contributory factors that may have predisposed the physician to engage in sexual misconduct. This understanding does not excuse the physician's conduct but may help parties involved understand, in part, why sexual misconduct occurred in order to inform treatment and possibly the nature of disciplinary action (e.g., history of antisocial behavior or severe personality disorder(s), bipolar illness, cognitive impairment, addiction disorder(s), professional burnout resulting in depression and poor judgment, etc).
3. Estimate the physician's risk to re-offend and formulate an opinion regarding the physician's rehabilitative potential.
4. Conclusions regarding fitness to practice and treatment if appropriate.

Elements of the evaluation process

1. Comprehensive medical evaluation with appropriate laboratory studies, medical history, toxicology screens for substances of abuse.
2. The evaluation should include a review of all collateral materials believed pertinent by the evaluation team including, but not limited to, the board's investigative file; prior applicable diagnoses and courses of treatment; information from the state's physician health program; and, if available, the results of any prior medical, social, psychiatric evaluations and psychological testing.
3. Comprehensive psychiatric evaluation and history including a mental status examination.
4. Alcohol and drug history that includes ruling out the presence or history of substance abuse.

5. Psychosocial/development history.
6. Comprehensive psychological testing and clinical interview following a forensic protocol. Within the context of this component of the evaluation, the examiner will employ valid and reliable psychological instruments and clinical means to rule out cognitive/neuropsychological deficits, latent or frank psychosis, affect/mood instability, bipolar spectrum, depression, impulse-control, anxiety, paraphilic, and thought disorders. Based on these findings, the examiner will describe the nature and severity of difficulties, if present, and determine their impact on future risk to patient safety.
7. Comprehensive sexual history that includes ruling out the presence of compulsive sexual behavior or paraphilic interests or practices.
8. Forensic polygraph examination if indicated (questions need to be clearly focused on past behavior and not intent).
9. Multidisciplinary team meeting where all members involved in the evaluation can present clinical data, review collateral information, explore personal and professional biases, challenge each other's conceptualizations, and arrive at a consensus regarding the physician's psychiatric, psychological, medical, and cognitive disposition.
10. A report summarizing all the elements of assessment.
11. Evaluation by a psychiatrist and/or doctoral level psychologist for the presence or absence of an Axis I or Axis II disorder(s).
12. Conclusions: A medical/psycho-legal determination regarding the physician's psychiatric, psychological, medical, and cognitive disposition and fitness to practice. Statement regarding the physician's risk to reoffend and rehabilitative potential.
13. Recommendations (may include PHP monitoring, boundary monitoring, extensive treatment, further evaluation, e.g., neuropsychological testing, MRI, MRA, SPECT, PET, additional laboratory studies, etc).
14. The evaluation of a physician for sexual misconduct should be contingent upon agreement by the independent evaluator to release to the board all records pertaining to the identity, diagnosis, prognosis, and treatment of the physician. Such records should include but not be limited to those records maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research. Upon completion of the evaluation, results must be released to the medical board.

Section VI. Guidelines for State Medical Boards: Discipline

State medical boards have a broad range of disciplinary responses designed to protect the public. Upon a finding of sexual misconduct, the board should take appropriate action and impose a sanction(s) reflecting the severity of the conduct and potential risk to patients.

Findings of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician's medical license. However, boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation. In the event the board makes a finding of sexual impropriety, the board may consider a less severe sanction than for a finding of sexual violation.

In determining an appropriate disciplinary response, the board should consider the following:

1. patient harm

2. existence of social support system
3. opportunity (type of practice)
4. severity of impropriety or inappropriate behavior
5. context within which impropriety occurred
6. culpability of licensee
7. psychotherapeutic relationship
8. existence of a physician-patient relationship
9. scope and depth of the physician-patient relationship
10. inappropriate termination of physician-patient relationship
11. age and competence of patient (minor)
12. vulnerability of patient
13. number of times behavior occurred
14. number of patients involved
15. period of time relationship existed
16. evaluation/assessment results
17. prior professional misconduct/disciplinary history/malpractice
18. recommendations of assessing/treating professional(s) and/or state physician health program

License Reinstatement/Removal of License Restriction(s)

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board's consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician's treating professionals, state physician health program, or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

Section VII. Guidelines for State Medical Boards: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a board establish appropriate monitoring of the physician and his continued practice. Monitoring should be individualized and based on the findings of the multidisciplinary evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of contributory mental/emotional illness, addiction, or sexual disorder has been established, the monitoring of that physician should be the same as for any other mental impairment and boards are encouraged to work closely with their state physician health program as a resource and support in monitoring. Conditions, which may also be used for other violations of the medical practice act, may be imposed upon the physician, such as:

1. Supervision of the physician in the workplace by a supervisory physician
2. Requirement that chaperones are routinely in attendance and sign the medical record attesting to

their attendance during examination or other patient interactions as appropriate. Further, physician must provide the chaperone a copy of the order, and the chaperone must certify to the board she/he read the order.

3. Periodic on-site review by board investigator or physician health program staff if indicated.
4. Practice limitations as may be recommend by evaluator(s) and/or the state physicians health program.
5. Regular interviews with the board and/or state physician health program as required to assess status of probation.
6. Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment.
7. Complete a course in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

Section VIII. Physician Education

Recognizing that physician sexual misconduct frequently has been inadequately addressed during a physician's medical training, medical boards should take a proactive stance to educate their licensees about sexual misconduct. Because of lack of education/awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team. Educational curricula about what is acceptable behavior in regard to boundary issues should be incorporated throughout the continuum of medical education.

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

Information about boundary issues, including physician sexual misconduct, should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public.

Section IX. Conclusion

Physician sexual misconduct can encompass a wide range of behaviors and can occur in multiple contexts. It is very damaging to patients and patient surrogates, as well as to the integrity of the medical profession. These guidelines cannot anticipate all possible scenarios. However, they do provide a general set of principles for boards to follow in cases of sexual misconduct.

Section X. Reading List

Able GG, Osborn CA, Warberg BW. Professional Sexual Misconduct. In Marshall, WL, Fernandez YM, Hudson SM and Ward T. (eds) Sourcebbok of Treatment Programs for Sexual Offenders, New York, Plenum, (1998).

American College of Obstetricians and Gynecologists *Code of Professional Ethics,* (2001).

American College of Obstetricians and Gynecologists Sexual misconduct in the practice of obstetrics and gynecology: ethical considerations, (2002).

American Medical Association, Council on Ethical and Judicial Affairs. Sexual misconduct in the practice of medicine. *JAMA*, (Nov 20 1991); 266(19):2741-2745

American Psychological Association, Ethical Principles of Psychologists and Code of Conduct, (2002).

Anderson SK, Kitchener KS. Nonromantic, nonsexual post-therapy relationships between psychologists and former clients: An exploratory study of critical incidents. *Professional Psychology: Research and Practice*, (1996); 27(1):59-66.

Bayer T, Coverdale J, Chiang E. A national survey of physicians' behaviors regarding sexual contact with patients. *Southern Medical Journal*, (1996); 89 (10): 977-982.

Beecher LH, Altchuler SI. Sexual Boundary Violations, The Conduct, the Code, and the Consequences. *Minnesota Medicine*. (2005); 88(6): 42-44.

Bennett BE, Bryant BK, Vandenbos GR, Greenwood A. *Professional Liability and Risk Management*. Washington, D.C.: American Psychological Association, (1990).

Bloom JD, Nadelson CC, Notman, MT. (Eds). *Physician Sexual Misconduct*. Washington, D.C.: American Psychological Association, (1999).

Borys DS, Pope KS. Dual relationships between therapists and clients: a national study of psychologists, psychiatrists and social workers. *Professional Psychology: Research and Practice*, 20(5), 283-293 (1989).

Brodskey A. Sex between patient and therapist: psychology's data and response. In Gabbard, G.O. (Ed) (1989) *Sexual Exploitation in Professional Relationships*. Washington, D.C., American Psychiatric Press (1989).

Burgess AW, Hartman CR, (Eds). Sexual Exploitation of Patients by Health Care Professionals, S*exual Medicine*, V.4, New York: Praeger, (1986).

Carr GD. Professional sexual misconduct – an overview. *J. Miss State Med Assoc*, (2003); 44:283-300.

Clinical Concerns in Boundary Issues, *Psychiatric Times*, August (1999); 14 (8).

College of Physicians and Surgeons, Nova Scotia Sexual misconduct in the physician-patient relationship, (2000).

College of Physicians and Surgeons of Ontario. *Avoid Complaints of Sexual Abuse*.

Council of Ethical and Judicial Affairs, American Medical Association Sexual misconduct in the practice of medicine. *JAMA* (1991), 266: 2741-47.

Coverdale J, Bayer T, Chiang E, Thornby J, Bangs M. National survey on physicians' attitudes toward social and sexual contact with patients, *South Med J*, (1994); 87(11):1067-1071.

Cullen RM. Arguments for zero tolerance of sexual contact between doctors and patients. *J Med Ethics*, (1999);25(6):482-6.

Dehlendorf CE, Wolfe, SM Physicians disciplined for sex-related offenses. *JAMA*, (1998); 279(23): 1883-88.

Dreiblatt, IS, "Health Care Providers and Sexual Misconduct," Annual Meeting, The Federation of State Licensing Boards, Seattle, WA, April 25, 1991.

Edelwich J, Brodsky A. *Sexual Dilemmas for the Helping Professional*. NY; Brunner/Mazel, (1991).

Enbom JA, Thomas, CD. Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners 1991 to 1995. *Am J Obstet Gynecol*, (1997); 176(6):1340-1346.

Gabbard GO, (Ed). *Sexual Exploitation in Professional Relationships.* Washington, D.C., American Psychiatric Press, (1989).

Gabbard GO, Nadelson, C. Professional boundaries in the physician-patient relationship. *JAMA* (1995); 273(18): 1445-1449.

Gabbard GO. Transference and countertransference in the psychotherapy of therapists charged with sexual misconduct. *Psychiatric Annals*, (1995); 25(2): 100-105.

Gartrell N, Herman J, Olarte S, Feldstein M, Localio R. Prevalence of psychiatrist-patient sexual contact, *Am J Psychiatry*, (1986); 143:1126-31.

Gartrell N, Herman J, Olarte S, Feldstein M, Localio R. Psychiatrist-patient sexual contact: results of a national survey. In Gabbard, G.O. (Ed) (1989) *Sexual Exploitation in Professional Relationships*. Washington, D.C., American Psychiatric Press, (1989).

Gartrell N, Herman J, Olarte S, Feldstein M, Localio R. Psychiatry residents and sexual contact with educators and patients: results of a national survey. *Am J Psychiatry*, (1988);145:690-694

Gartrell N, Miliken N, Goodson WH. Physician-patient sexual contact. Prevalence and problems. *West J Med*, (1992); 157: 139-143.

Gechtman L. Sexual contact between social workers and their clients. In Gabbard GO (Ed). *Sexual Exploitation in Professional Relationships*. Washington, D.C., American Psychiatric Press, (1989).

Goldberg PE. The physician-patient relationship, three psychodynamic concepts that can be applied to primary care. *Arch Fam Med*, (2000); 9 (10): 1164-1168.

Goodwin J, Bemmann K, Zwieg J. Physician sexual exploitation; Wisconsin in the 1980s. *J Am Med Womens Assoc*, (1994); 49(1): 19-23.

Gonsiorek JC. Suggested remediations to "Remediation." *Professional Psychology; Research and Practice*, (1997); 28(3): 300-303.

Gutheil TG. Borderline personality disorder, boundary violations and patient-therapist sex: medical legal pitfalls. *Am J Psychiatry,* (1989); 146: 597-602.

Gutheil TG. Ethical issues in sexual misconduct by clinicians. *Jpn J Psychiatry Neurol*. (1994);48 Suppl: 39-44.

Gutheil TG, Gabbard GO. Misunderstanding of boundary theory in clinical and regulatory settings. *Am J Psychiatry* (1998); 155(3): 409-414.

Hamilton JC, Spruill J. Identifying and reducing risk factors related to trainee-client sexual misconduct. *Professional Psychology: Research and Practice*, (1999); (3): 318-327.

Haspel KC, Jorgenson LM, Wincze JP, Parsons JP. (1997) Legislative intervention regarding therapist sexual misconduct. *Professional Psychology: Research and Practice*. (1997); 28(1): 63-72.

Herman JL, Gartrell N, Olarte S, Feldstein M, Localio R. Psychiatrist-patient sexual contact: results of a national survey, II: Psychiatrists' attitudes. *Am J Psychiatry*, (1987); 144(2): 164-169.

Irons R. The seductive patient. *J of Med Assoc of Ala*, (1994); 64(6):13-17.

Johnson, S.H. Judicial review of disciplinary action for sexual misconduct in the practice of medicine. *JAMA*. (1993); 270:1596-1600.

Kay J, Roman B. Prevention of sexual misconduct at the medical school, residency and practitioner levels. Bllor, J.D., Nadelson, C.C., Notman, M.T. (eds). *Physician Sexual Misconduct*. Washington, D.C.: American Psychiatric Press, (1999).

Keith-Spiegel P, Koocher GP. Ethics in Psychology: Professional Standards and Cases. NY: Random House, (1985).

Lamb DH, Catazaro SJ. Sexual and non-sexual boundary violations involving psychologists, clients, supervisees, and students: Implications for professional practice. *Professional Psychology: Research and Practice*. (1998); 29(5): 498-503.

Layman MJ, McNamara JR. Remediation for ethics violations: Focus on psychotherapists' sexual contact with clients. Professional Psychology: Research and Practice, (1997); 28(3): 281-292.Layman MJ, McNamara JR. Remediation Revisited. *Professional Psychology: Research and Practice*, (1997); 28(3): 304-305.

Massachusetts Board of Registration in Medicine. General Guidelines Related to the Maintenance of Boundaries in the Practice of Psychotherapy by Physicians (Adult Patients). Boston, Mass; (1994).

Medical Council of New Zealand. Sexual Abuse in the Doctor/Patient Relationship State for the Profession. Wellington, New Zealand; (1994).

Morrison J, Wickersham P. Physicians disciplined by a state medical board. *JAMA*, (1998); 279(23): 1889-1893.

Pope K. Rehabilitation Plans and Expert Testimony for Therapists Who Have Been Sexually Involved with a Patient. Independent Practitioner, (1991); 2(3): 31-39.

Pope KS, Bouhoutsos JC. *Sexual Intimacy Between Therapists and Patients*. NY: Greenwood Press, (1986).

Pope K, Vasquez JT. *Ethics in psychotherapy and counseling: a practical guide*, second edition. San Francisco: Jossey-Bass, (1998).

Professional Boundaries in Health-Care Relationships, *College of Psychologists of Ontario*, (1995);25 (1).

Professional Sexual Misconduct – An Overview. *Journal of the MSMA*, (2003); 44 (9):283-300.

Public Citizen Health Research Group, Physicians disciplined for sex-related offenses, (1997).

Rutter P. *Sex in the Forbidden Zone*. NY: Fawcett Crest, (1989).

Schoener GR. Assessment and rehabilitation of psychotherapists who violate boundaries with clients. Walk-in Counseling Center, (1998).

Schulte HM, Kay J. Medical students' perceptions of patient-initiated sexual behavior. *Acad Med*. (1994);69:842-846.

Sederer LI, Libby M. False allegations of sexual misconduct: clinical and institutional considerations. *Psychiatic Service* (1995);46:160-163.

Swiggart W, Starr K, Finlayson R, Spickard A. Sexual boundaries and physicians: Overview and educational approach to the problem. Center for Professional Health, Vanderbilt University Medical School.

http://www.mc.vanderbilt.edu/root/vumc.php?site=cph&doc=742.

The Therapeutic Covenant, Paradigm. Fall 2002.

Winn JR. Medical boards and sexual misconduct: an overview of Federation data. *Fed Bull: J Med Licens Discipl*. (1993);80:90-97.

Ad Hoc Committee on Physician Impairment

Barbara S. Schneidman, M.D., M.P.H., Chair
1991–1992 FSMB President
Associate Vice President
American Board of Medical Specialties

Roy J. Ellison Jr., M.D.
Past Board Member
South Carolina Board of Medical Examiners

Alexander F. Fleming, J.D.
Executive Director
Massachusetts Board of Registration in Medicine

Ruth Horowitz, Ph.D.
Board Member
Delaware Board of Medical Practice

Philip M. Margolis, M.D.
Past Board Member
Michigan Board of Medicine
Member, FSMB Board of Directors

Maurice J. Martin, M.D.
President
Minnesota Board of Medical Practice

Karen W. Perrine, J.D.
Deputy Executive Director, Discipline
Virginia Board of Medicine

Julie F. Pottorff, J.D.
Iowa Department of Justice

Hormoz Rassekh, M.D.
1993–1994 FSMB President
Past Board Member
Iowa State Board of Medical Examiners

Nicholas E. Stratas, M.D.
Past Board Member
North Carolina Medical Board

Gerald L. Summer, M.D.
Medical Director
Physicians' Recovery Network
Medical Association of the State of Alabama

John J. Ulwelling
Executive Vice President
The Foundation for Medical Excellence
Lake Oswego, Oregon

George J. Van Komen, M.D.
Chair, Utah Physicians' Licensing Board
Member, FSMB Board of Directors

Andrew Watry
Executive Director
Georgia Composite State Board of Medical Examiners

Consultant:

Rendel L. Levonian, M.D.
Past Board Member
Medical Board of California
Past Member, FSMB Board of Directors

Ex Officio:

Robert E. Porter, M.D.
1995–1996 FSMB President

Gerald J. Béchamps, M.D.
1994–1995 FSMB President

Federation Staff:

James R. Winn, M.D., Executive Vice President
Wendy Athon, Executive Administrative Assistant

Sexual Boundaries Workgroup

Steven I. Altchuler, M.D., Ph.D.
Board President
Minnesota Board of Medical Practice

Philip T. Merideth, M.D.
Board Member
Mississippi State Board of Medical Licensure

Ruth Horowitz, Ph.D.
Department of Socialogy
New York University

Irwin S. Dreiblatt, Ph.D.
Seattle, Wash.

Susan R. Johnson, M.D.
Board Secretary
Iowa Board of Medical Examiners

Karen Perrine, J.D.
Deputy Executive Director, Discipline
Virgina Board of Medicine

Gary Carr, M.D.
Mississippi Physician Health Program
Purvis, Miss.

Scott Stacy, Psy.D.
Professional Renewel Center
Lawrence, Kansas

Janelle A. Rhyne, M.D.
Board Member
North Carolina Medical Board

William J. Sieber, Ph.D.
Division of Family Medicine
University of California, San Diego

Priscilla Ray, M.D.
St. Lukes Medical Center
Houston, Texas

Lance A. Talmage, M.D.
Board Secretary
State Medical Board of Ohio

FSMB Staff:

Lisa Robin, Vice President
Government Relations, Policy and Education
Dallas, Texas

Inge Williams, Administrative Associate
Government Relations, Policy and Education
Dallas, Texas