Emergency physicians and sexual involvement with patients: an Ontario survey

Evidence

Études

Howard J. Ovens, MD; Joanne A. Permaul-Woods, BSc

Dr. Ovens is with the Division of Emergency Services, Mount Sinai Hospital and the Department of Family and Community Medicine, University of Toronto, Toronto, Ont. Ms. Permaul-Woods is with the Department of Family Medicine, Mount Sinai Hospital, Toronto, Ont.

This article has been peer reviewed.

Can Med Assoc J 1997;157:663-9

Abstract

Objective: To describe Ontario emergency physicians' knowledge of colleagues' sexual involvement with patients and former patients, their own personal experience of such involvement, and their attitudes toward postvisit relationships.

Design: Mailed survey.

Setting: Ontario.

Participants: Emergency physicians practising in Ontario.

Results: Of 974 eligible mailed surveys, 599 (61.5%) were returned. Of these respondents, 52 (8.7%) reported being aware of a colleague in emergency practice who had been sexually involved with a patient or former patient. When describing their own behaviour, 37 respondents (6.2%) reported sexual involvement with a former patient. However, of this group, only 9 (25.0%) had met the patient in an emergency department. Thus, of the total number of respondents, only 1.5% (9/599) reported sexual involvement arising out of an emergency department visit. Most respondents (82.4%) agreed that it is inappropriate behaviour to ask a patient for a date after an emergency assessment and before the patient's departure, and 66.4% felt that it is inappropriate to contact the patient after discharge. However, only 10.6% believed it to be unacceptable to request a social meeting after encountering a patient previously cared for in the emergency department in a nonprofessional setting. Most respondents (96.5%) did not believe that sexual involvement could ever be therapeutic for the patient. However, only 66% felt that it was always an abuse of power and 62.4% supported zero tolerance of all sexual involvement between physicians and patients.

Conclusions: Vague regulatory guidelines currently in place have failed to dispel confusion regarding what is acceptable social behaviour for physicians providing emergency care. Our results support the need for clarification, and suggest a basis for guidelines that would be acceptable to the emergency medical community: that an emergency visit should not form the basis for the initiation of personal or sexual relationships, yet neither should it preclude their development in nonmedical settings.

Résumé

Objectif : Décrire les connaissances que les urgentologues de l'Ontario ont de contacts de nature sexuelle entre des collègues et des patients et d'anciens patients, leur propre expérience de tels contacts et leurs attitudes au sujet des relations post-consultation.

Conception : Sondage postal.

Contexte : Ontario.

Participants : Urgentologues pratiquant en Ontario.

Résultats : Sur 974 sondages admissibles, 599 (61,5 %) ont été renvoyés. Parmi ces répondants, 52 (8,7 %) ont déclaré connaître un collègue urgentologue qui a eu des contacts de nature sexuelle avec un patient ou un ancien patient. Au sujet de leur propre comportement, 37 répondants (6,2 %) ont déclaré avoir eu des contacts de nature sexuelle avec un ancien patient. De ce groupe, toutefois, 9 (25,0 %) seulement avaient rencontré la personne en cause dans un service d'urgence. Ainsi, sur le nombre total de répondants, 1,5 (9/599) seulement ont signalé avoir eu des contacts de nature sexuelle à la suite d'une consultation à l'urgence. La plupart des répondants (82,4 %) ont reconnu qu'il est inconvenant

de demander un rendez-vous à un patient après un examen d'urgence et avant son départ, et 66,4 % étaient d'avis qu'il est inconvenant de communiquer avec la personne après son départ. Cependant, 10,6 % seulement étaient d'avis qu'il est inacceptable de demander une rencontre sociale après avoir rencontré, dans un contexte non professionnel, un patient traité auparavant au service d'urgence. La plupart des répondants (96,5 %) ne croyaient pas que des contacts de nature sexuelle pourraient un jour être thérapeutiques pour la personne en cause. Cependant, 66 % seulement étaient d'avis que de tels contacts constituent toujours un abus de pouvoir et 62,4 % étaient en faveur de la tolérance zéro de tout contact de nature sexuelle entre médecins et patients.

Conclusion : Les lignes directrices réglementaires vagues en vigueur n'ont pas réussi à dissiper la confusion qui règne quant à ce qui constitue un comportement social acceptable pour les urgentologues. Nos résultats appuient le besoin de clarification et laissent entrevoir une base sur laquelle fonder des lignes directrices qui seraient acceptables pour les milieux de la médecine d'urgence : une consultation à l'urgence ne devrait pas servir à amorcer des relations personnelles ou sexuelles, mais elle ne devrait pas empêcher non plus l'évolution de telles relations en contexte non médical.

Prohibition of sexual involvement with patients is an ancient medical dictum. However, in many jurisdictions, changing social circumstances have focused new attention on this old issue.[1] Sexual involvement has been reported between psychotherapists and their patients.[2–4] More recently, other specialty groups have been surveyed.[5–8]

In the guidelines outlining appropriate physician–patient relationships for different specialties, a general consensus is evident in a number of areas. These include no sexual contact between physician and patient in the following circumstances: in the examining room, between visits when there is an ongoing professional relationship, for a prolonged period of time after psychotherapy and never after psychoanalysis. There is controversy, however, over the propriety of sexual involvement with former patients after less intense physician–patient interactions. In issuing guidance, many governing bodies suggest that personal relationships after episodic care are acceptable.

Several provincial guidelines on physician–patient relationships refer to the emergency visit as an example of an encounter involving little dependency or potential for exploitation. The Corporation professionelle des médecins in Quebec[9] distinguishes between "psychotherapeutic relationships," "ongoing therapeutic relationships" and "limited therapeutic relationships." Although these guidelines recognize the potential for exploitation in limited relationships, this category is clearly defined as being a less significant one in which greater latitude is permitted with respect to subsequent physician–patient involvement. The College of Physicians and Surgeons of Manitoba stresses that exploitation is related to the degree of dependency: "This quality of dependence can be very deep as in the case of the psychotherapeutic relationship or it may be marginal as in the case of a single episode of medical care for a minor medical emergency."[10]

The College of Physicians and Surgeons of Ontario (CPSO) is even more explicit in citing emergency care as a prototype of physician–patient interactions that may result in relationships with relatively little potential for exploitation. However, at the other extreme, their most recent guidelines endorse a lifelong prohibition after psychotherapeutic relationships. The text also makes clear that "in all other cases . . . as a general rule, the physician should not have sexual contact with a former patient for a period of one year. . . . In some instances it may never be appropriate for a post-termination sexual relationship to develop. In others it may be unnecessary to wait for one year . . . for example, an emergency room physician who has treated a patient on one occasion."[11]

The message being conveyed by these guidelines is that there is a spectrum of physician-patient relationships. At the one extreme, psychotherapists and others who have intense professional relationships with their patients are given a clear message to resist sexual involvement. But what message is being conveyed to physicians at the other end of the spectrum who deliver emergency or episodic care? Are they being told that postvisit relationships are permitted? If so, is this message ethically valid, and is it supported by emergency physicians?

Several articles on the ethics of physician–patient relationships have examined the concept of boundaries.[12–15] The underlying approach in these analyses has been to distinguish between physician benefit and patient benefit and to identify the potential problems with ambiguous or blurred roles. What happens if these concepts are applied to a typical emergency department visit?

In the emergency department, most patients do not

know who their physician will be. Patients are asked to reveal personal information (marital status, home phone number, drugs taken, etc.) before meeting the physician, and the medical assessment often includes intimate questions and examinations. The patient, therefore, is asked to place a great deal of trust in the emergency medical system. If, however, patients suspect that personal information might be used for nonmedical reasons (a boundary violation), they might become suspicious of the motives of a physician pursuing clinically necessary information. If this were to occur, the risk of misunderstanding and misadventure could increase.

The professional guidelines are vague but somewhat permissive regarding the propriety of sexual involvement after episodic care, yet theoretic analysis suggests that such relationships could be problematic. The published literature says very little about the frequency of such relationships, nor does it reveal the attitudes of providers of episodic care. To address this deficiency, we conducted a survey of a group of key providers of episodic care in Ontario: emergency physicians.

The objectives of this study were to describe Ontario emergency physicians' knowledge of colleagues' sexual involvement with their patients and former patients, their own personal experience of such sexual involvement and their attitudes toward postvisit relationships. These results may be useful to regulatory bodies, practising physicians and the public to clarify what is and is not acceptable after care in an emergency department.

Methods

The survey instrument, based on one previously developed for obstetrician-gynecologists,[5] was adapted for this study population to meet specific objectives. To establish face validity, the instrument was pretested in a pilot study of 80 academic emergency physicians with faculty appointments at the University of Toronto. The results of this test were used to clarify and simplify the survey.

The final questionnaire contained 63 questions. Of these, 40 applied only to physicians with either a history of sexual involvement with a patient or former patient or knowledge of a colleague with a history of sexual involvement. (The questionnaire is available from the authors on request.) As well, all respondents were asked 3 questions regarding 3 hypothetical scenarios (described below) to assess their attitudes toward the development of a personal relationship after an emergency visit.

The primary focus of the study was to examine attitudes toward sexual involvement between a physician and a patient; however, a request for a "date" was used in the scenarios, although social requests do not always lead to sexual involvement. We chose this wording because we felt that asking for a date is a clear, concise and relatively unintrusive way in which people often signal their desire to move into a nonprofessional interaction.

In the first scenario a physician asks a patient for a date after completing an emergency assessment but before the patient's discharge. In the second scenario the physician contacts the patient sometime after discharge to request a social meeting. In the final scenario the physician has an unplanned encounter with a former patient from the emergency department in another setting (club, party or other nonprofessional situation) and requests a date. After each scenario the respondents were asked, "Is this behaviour inappropriate and/or unethical?" They were given the choice of answering "yes," "no" or "don't know" and were invited to make comments.

The study population was made up of emergency physicians in Ontario. We used a commercial mailing list that contained the names of 1039 physicians with a primary interest in emergency medicine. On the basis of a modified Dillman[16] technique, we mailed the questionnaire, along with a cover letter (a copy of the letter is available on request) explaining the objectives and ensuring anonymity. A numbered postcard was included, to be returned separately. This allowed follow-up of nonrespondents without requiring any identifying information. The initial mailing was done in May 1995; 2 weeks afterward, nonrespondents were sent a reminder letter, and 4 weeks after the initial mailing, nonrespondents received a package containing a second copy of the survey.

Physicians who were not eligible for inclusion in the study (i.e., those who were not emergency physicians or who had moved) were removed from the study population.

Data were entered and analysed with the use of SAS (version 6.1 for Windows, SAS Institute I Inc., Cary, NC, 1993). Initial analyses were descriptive; χ^2 analyses were used to determine whether demographic variables had any association with attitudes and personal experiences. These variables included the sex of the physician, age group, years in practice, location of practice (urban v. rural), type of emergency practice (part-time v. full-time) and training or country of graduation (Canadian v. foreign). Further χ^2 analyses were used to examine attitudes based on personal involvement with a patient or former patient. Because the data were subjected to multiple analyses, a p value of 0.01 was considered statistically significant.

Results

Response rate

Of the 1039 surveys mailed, 599 eligible surveys were returned. Sixty-five physicians (6.3%) were identified as ineligible (47 did no emergency work and 18

had moved, were out of the country or could not be located). There were 375 nonrespondents. Thus, the final response rate was 599 out of an eligible sample of 974 (61.5%).

Physician characteristics (Table 1)

The typical respondent was young (mean age 39), male (82.7%) and a graduate of a Canadian medical school (93.4%). Most respondents were married (82.6%), lived in an urban setting (70.7% in a cities with a population greater than 50 000) and worked in community hospitals (75.7%). The respondents were more evenly distributed regarding full-time and part-time emergency practice, qualifications and training.

Colleague's sexual involvement

Fifty-two respondents (8.7%) reported being aware of a colleague in emergency medicine who had been involved in a sexual encounter with a patient or former patient. Of this group, 46 (88.5%) believed this involvement would currently be regarded as a form of sexual impropriety, transgression or violation (these terms were defined in the survey; Appendix 1). Male and female respondents were equally likely to report a colleague's involvement.

Physicians who were aware of a colleague who was sexually involved with a patient were asked to complete a series of questions exploring their knowledge of the nature of the most recent encounter that they knew of. They were asked both about where the physician and patient met (results are given below) and where the sexual encounter occurred (Table 2). The total number of responses per question in this section was variable. For example, 53 respondents answered the question "Where did the physician meet the patient?". (One respondent answered this question but, in a previous question, had not indicated awareness of a colleague who was sexually involved with a patient.) Of these, 29 of 599 (4.8%) knew of a colleague who had been involved with a patient he or she met in the emergency department, and 24 (4.0%) knew of a colleague who had met the patient elsewhere in his or her practice. Fifty respondents identified the sex of the physician involved: 44 (88.0%) were male. All of the relationships reported were heterosexual. Forty-three respondents classified the patients: 25 (58.1%) were identified as "current" patients and 18 (41.9%) as "former patients." Forty-six respondents indicated whether the physician and patient eventually married: in 13 cases (28.3%), they did marry. Twenty-five physicians who responded (25/52, 48.1%) felt that personal difficulties in the life of the colleague played a role in the initiation of the encounter.

Personal sexual involvement

Overall, 37 (6.2%) of the 599 respondents reported sexual involvement with a former patient and 3 (0.5%) reported involvement with a current patient at the time of the encounter. Male and female physicians were not sig-

Table 1: Characteristics of emergency physicians

Characteristic	No. (and %) of respondents *n = 599*
Sex	
Male	492 (82.7)
Female	103 (17.3)
No response	4
Marital status	
Married/common-law	492 (82.6)
Single	76 (12.7)
Divorced/separated	25 (4.2)
Widowed	3 (0.5)
No response	3
Age, yr	
20–29	39 (6.6)
30–39	299 (50.2)
40–49	208 (35.0)
≥ 50	49 (8.2)
No response	4
Average hours on duty/wk	
0–10	143 (29.9)
11–20	130 (27.1)
21–30	72 (15.0)
31–40	114 (23.8)
41 or more	20 (4.2)
No response	120
Training*	
CCFP (at least)	317 (59.6)
CCFP (EM)	187 (37.9)
Residency trained	97 (54.2)
Practice eligible	82 (45.8)
FRCPC	79 (17.7)
Residency trained	44 (60.3)
Practice eligible	29 (39.7)
Other postgraduate training	115 (19.1)
Location	
Rural (community size < 50 000)	173 (29.3)
Urban (community size ≥ 50 000)	417 (70.7)
No response	9
Hospital affiliation	
Teaching hospital	121 (22.2)
Community hospital	412 (75.7)
Teaching and community hospital	11 (2.0)
No response	55
Practice type	
Full-time	217 (39.9)
Part-time	327 (60.1)
No response	55

*Multiple responses to this question were possible.

nificantly different in reporting personal sexual involvement: 32 of the male respondents (6.5%) and 5 of the female respondents (4.9%) reported sexual encounters with a former patient. All 3 respondents who reported sexual encounters with a current patient were male. As in the questions about colleagues, physicians were asked where they had met the patient concerned (results below) and where the encounter had occurred (Table 2). Only 9 of 36 (25.0%) physicians involved with a former patient (1 physician did not answer the question) met the patient in the emergency department; the others met in an "office" (13/36, 36.1%) or "other medical setting" (14/36, 38.9%). Seven of 37 (18.9%) physicians reported marrying the patient, and 9 (24.3%) other relationships were ongoing at the time of the survey. Thirty-three of 37 (89.2%) respondents reported involvement with only 1 former patient; 3 (8.1%) physicians had been involved with 2 patients; and 1 (2.7%) physician reported involvement with 3 patients. The time from discontinuation of care until the onset of the relationship ranged from 1 week to 15 years.

Most of the encounters with former patients (23/36, 63.9%) were initiated by the patient, 9/36 (25.0%) by the physician and 4/36 (11.1%) by both the physician and the patient. Eleven (29.7%) of the 37 physicians responding cited personal difficulties as playing a role in their instigation of the encounter, and 10 (27.0%) specified this difficulty to be the recent breakdown of a personal relationship. One of the physicians who cited a relationship breakdown also reported sexual problems as being a factor, and 1/36 (2.7%) physician stated that chronic health problems played a role. There was 1 male homosexual encounter reported; all of the other encounters experienced by both male and female physicians were heterosexual.

Marital status was the only demographic variable that had a statistically significant association with sexual involvement. More single physicians (single, separated, widowed or divorced) (13/104, 12.5%) reported sexual encounters with a former patient than those who were married (24/492, 4.9%; χ^2, $p = 0.003$; Fisher's exact test, $p = 0.006$).

Physician attitudes

With regard to the behaviour described in the first scenario (a date requested in the emergency department), most (82.4%) of the respondents agreed that it was inappropriate or unethical, 14.5% found it acceptable and 3.1% were uncertain. For the second scenario (a date requested after discharge), most (66.4%) of the respondents found the behaviour inappropriate or unethical, 20.6% found it acceptable and 13.0% were uncertain. In contrast, the final scenario (a physician meets a former patient in a different setting and requests a social meeting) produced responses the reverse of those to the first 2. Only 10.6% of respondents found this behaviour unacceptable, 79.1% found it appropriate and 10.3% were unsure. There were no differences in attitudes with respect to physician characteristics, including sex, marital status, age group, community size, training and hospital affiliation.

Table 2: Descriptions of sexual encounters with patients involving colleagues and self

Description	No. (and %) of physicians* reporting colleagues' contact with		No. (and %) of physicians† reporting their own contact with	
	Patient *n = 28*	Former patient *n = 24*	Patient *n = 3*	Former patient *n = 37*
Where encounter occurred				
Emergency department	12 (42.9)	0	0	2 (5.5)
Another medical setting	1 (3.6)	7 (30.4)	0	1 (2.8)
Patient's home during a house call	2 (7.1)	1 (4.3)	0	0
Setting where physician was not engaged in the practice of medicine	11 (39.3)	11 (47.8)	3 (100.0)	33 (91.7)
Do not know	2 (7.1)	4 (17.4)	0	0
Who initiated the encounter				
Physician	14 (50.0)	5 (21.7)	0	9 (25.0)
Patient	6 (21.4)	10 (43.5)	3 (100.0)	23 (63.9)
Both	0	0	0	4 (11.1)
Do not know	8 (28.6)	8 (34.8)	0	0
Marital status of physician				
Single	4 (14.3)	4 (16.7)	0	6 (16.2)
Separated	1 (3.6)	0	0	2 (5.4)
Married/common-law	22 (78.6)	16 (66.7)	3 (100.0)	24 (64.9)
Widowed	1 (3.6)	1 (4.2)	0	0
Divorced	0	3 (12.5)	0	5 (13.5)

*One respondent with a colleague involved with a former patient did not answer the questions about where the encounter occurred and who initiated the encounter.
†One respondent involved with a former patient did not answer the question about where the encounter occurred, and one did not answer the question about who initiated the encounter.

In several instances, the replies were incongruous with the accompanying comments. For example, following the first scenario, the survey asked, "Did you feel this behaviour is unethical or inappropriate?" One respondent replied No, but then wrote under Comments, "An emergency is not a singles' bar!" The respondent probably intended to convey the idea that this behaviour was not appropriate rather than not inappropriate. Some respondents may have been confused by the double negative.

Three questions further examined attitudes in general toward sexual involvement (Table 3). Most of the respondents (96.5%) did not believe that sexual involvement could ever be therapeutic for the patient. However, only 66.0% felt that it was always an abuse of power and 62.4% supported zero tolerance of all sexual involvement between physicians and patients. Once again, there were no differences in attitudes according to physician characteristics.

Discussion

This study was the first to survey emergency physicians in Ontario on the subject of sexual involvement with patients and the first to examine attitudes toward postvisit relationships by providers of emergency or episodic care.

The 3 scenarios in the survey were used to assess attitudes toward postvisit relationships in different contexts. Most respondents believed that requesting a date at the conclusion of an emergency assessment before the patient's departure was wrong and that requesting a social meeting with a patient after discharge was also inappropriate. However, most respondents believed that requesting a social meeting with a previous patient encountered in a different setting (e.g., party or club) was not inappropriate.

The distinctions made with respect to the 3 scenarios are of practical importance. One of the most frequent comments (approximately 10% of all respondents) referred to the special problems of rural physicians. Small communities are finding it harder than ever to attract and retain physicians. One problem particular to these locations is that physicians are uncertain how to behave when their patient population and social circle overlap.[12,13] One anecdote reported in this survey illustrates well the anxiety felt by some physicians in a type of situation that few would consider ethically problematic. A female physician working in an emergency department met a male patient, whom she had known in high school, presenting with a minor injury. She had not seen the man in many years and had never dated him. A month after discharge he contacted her and they went out socially. They are now married. Yet the respondent felt that in today's environment she would have been taking a risk by responding to his initiative.

This raises the question "What constitutes acceptable or unacceptable behaviour?" A number of factors may play a role in one's perception of the potential for abuse, such as the sex of the patient and physician, whether the patient or physician initiates contact and the nature of the emergency department visit. An examination of these factors may be helpful in a retrospective analysis of a particular case to determine the extent (if any) of the patient's dependency on the physician or of the physician's abuse of the relationship, or both. However, the multiple and interactive nature of these factors, and their subjective basis, make it difficult to rely on them for general behavioural guidelines. The alternative concept in current Ontario guidelines is a 1-year waiting period.[11] However, when there is potential for abuse, the waiting period may not be adequate to prevent it, and when a relationship is appropriate (such as the one in the preceding anecdote), it would be unfair to impose this interval. To us, the important distinction in this anecdote is between patients whom the physician encounters in a nonpatient capacity (before or after the emergency department visit) and patients who are known only as patients. This distinction can form a clear and logical basis for creating new guidelines.

Another important distinction is that between patients whom the physician encounters in a nonpatient capacity before or after the emergency department visit and patients who are known only as patients. Current Ontario guidelines do not address this issue.[11]

Fewer respondents in our study (8.7%) were aware of a colleague in emergency medicine who had sexual involvement with a patient than respondents to a recent survey of Canadian obstetrician-gynecologists (17%).[5] The proportion who reported personal involvement with patients (0.5%) and former patients (6.2%) is low compared with results of earlier studies of psychotherapists (7% to 13%)[2–4] but closer to the results of recent surveys of Cana-

Table 3: Attitudes toward sexual involvement with patients

Statement and response	No. (and %) of respondents
Sexual involvement with a patient can be therapeutic at times	
Yes	20 (3.5)
No	556 (96.5)
No response	23
Sexual involvement with a patient always is an abuse of power	
Yes	381 (66.0)
No	196 (34.0)
No response	22
There should be "zero tolerance" of all sexual involvement of physicians and patients	
Yes	354 (62.4)
No	213 (37.6)
No response	32

dian obstetrician-gynecologists (3%)[5] and physicians in British Columbia (3.8%).[8]

Lamont and Woodward[5] have speculated that a trend toward lower rates of self-reporting in later surveys may reflect better response rates. Another possible explanation for the trend is that changing societal expectations may be having an effect on physician behaviour.[1,8,12,18] A third possibility is that sexual involvement may be more likely to occur in intense relationships such as psychotherapy and less likely after episodic care. Although this last factor is reflected in regulatory guidelines,[9,10,11] the relative infrequence of sexual relationships after episodic care does not negate the need for clear guidelines for the benefit of both physicians and patients.

There were some limitations to this study. The target population was difficult to identify because of the diversity of the study group and the lack of a single governing body with a comprehensive membership. Although measures were taken to ensure anonymity, the personal nature of the survey questions may have dissuaded physicians from responding. In addition, the ability in general of an anonymous, self-reporting survey to accurately depict complex behaviour is uncertain. However, the similarity of this study population to that of a recent survey of Canadian emergency physicians[17] is reassuring, and the similarity to previous study methods supports comparison of results.

Another source of bias could have been the wording of the questions related to the 3 scenarios. The use of the double negative "not inappropriate" with "yes" listed as the first possible response may have prompted respondents to agree with the question. Instead, the question "Is this behaviour appropriate?" might have produced a more accurate response.

Further research could validate these results in other populations of emergency physicians or providers of episodic care. In addition, the views of patients and the public are needed.

Conclusion

The great majority of respondents in all subgroups agreed that an emergency department visit should not form the basis for the initiation of a personal or sexual relationship. However, they also agreed that it should not preclude the development of a relationship initiated in other settings. These results both support the need for clarification of the vague guidelines currently set by licensing bodies, and suggest a basis for revision that would be broadly supported by the emergency medical community.

We wish to thank all of the participating emergency physicians for their candour and for their contribution to this study. We also thank Drs. June Carroll, Warren McIsaac and Brian Goldman for their valuable comments and suggestions, and Ms. Kathleen Abe for her secretarial support.

This project was funded by the Department of Family Medicine, Mount Sinai Hospital, Toronto, and the Department of Family and Community Medicine, University of Toronto.

References

1. Campbell ML. The oath: an investigation of the injunction prohibiting physician-patient sexual relations. *Perspect Biol Med* 1989;32(2):300-8.
2. Gartrell N, Herman J, Olarte S, Feldstein M, Localio R. Psychiatrist sexual contact: results of a national survey, 1: prevalence. *Am J Psychiatry* 1986;143(9):1126-31.
3. Herman JL, Gartrell N, Olarte S, Feldstein M, Localio R. Psychiatrist–patient sexual contact: results of a national survey, 2: psychiatrists' attitudes. *Am J Psychiatry* 1987;144(2):164-9.
4. Gartrell N, Herman J, Olarte S, Localio R, Feldstein M. Psychiatric residents' contact with educators and patients: results of a national survey. *Am J Psychiatry* 1988;145(6):690-4.
5. Lamont JA, Woodward C. Patient–physician sexual involvement: a Canadian survey of obstetrician-gynecologists. *Can Med Assoc J* 1994;150:1433-9.
6. Gartrell N, Milliken N, Goodson WH III, Thiemann S, Lo B. Physician–patient sexual contact — prevalence and problems. *West J Med* 1992;157(2):139-43.
7. Cohen M, Woodward CA, Ferrier B, Williams AP. Sanctions against sexual abuse of patients by doctors: sex differences in attitudes among young family physicians. *Can Med Assoc J* 1995;153:169-76.
8. Sheps SB, Schechter MT. *Attitudes and behaviours in physician–patient relationships: results of surveys of physicians and the public in British Columbia*. Vancouver: University of British Columbia; 1993.
9. Corporation professionnelle des médecins du Québec. *Sexual misconduct in the physician–patient relationship*. Montreal: The Corporation; 1983.
10. College of Physicians and Surgeons of Manitoba. *Sexuality and the doctor/patient relationship*. Winnipeg: The College; 1991. Guideline no. 119.
11. College of Physicians and Surgeons of Ontario. *CPSO sexual abuse recommendations*. Toronto: The College; 1992.
12. Shaw D. Sexual involvement between physicians and patients: regulations are not a panacea. *Can Med Assoc J* 1994;150:1397-9.
13. Rourke JTB, Smith LFP, Brown JB. Patients, friends, and relationship boundaries. *Can Fam Physician* 1993;39:2557-65.
14. Linklater D, MacDougall S. Boundary issues. What do they mean for family physicians? *Can Fam Physician* 1993;39:2569-73.
15. Rourke J, Rourke L, Goertzen J, Brown JB, Smith L. Physician–patient relationships: patients as friends and patients who harass [letter]. *Can Med Assoc J* 1996;154:1149.
16. Dillman DA. *Mail and telephone surveys: The total design method*. New York: John Wiley & Sons; 1978.
17. Lloyd S, Streiner D, Shannon S. Burnout, life and job satisfaction among Canadian emergency physicians. *J Emerg Med* 1994;12:559-65.
18. College of Physicians and Surgeons of Ontario. *The final report on sexual abuse of patients*. Toronto: The College; 1991.

Reprint requests to: *Dr. Howard Ovens, Division of Emergency Services, Mount Sinai Hospital, 600 University Ave., Rm. 323, Toronto ON M5G 1X5; fax 416 586-4719*

Appendix 1: Definitions of terms used in the survey of emergency physicians in Ontario

Sexual impropriety
Any behaviour such as gestures or expressions that are sexually demeaning to a patient or that demonstrate a lack of respect for the patient's privacy

Sexual transgression
Any inappropriate touching of a patient that is of a sexual nature, short of sexual violation

Sexual violation
Physician–patient sex, whether or not initiated by the patient, including, but not limited to, sexual intercourse, masturbation, genital-to-genital contact, oral-to-genital contact, oral-to-anal contact and genital-to-oral contact

Source: Independent task force commissioned by the College of Physicians and Surgeons of Ontaro. The final report on sexual abuse of patients, 1991.[18]