Can Patients Sexually Harass Their Physicians?

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It is the fate of certain fashionable legal terms that capture the attention of the media to have their usage expanded beyond the contexts for which they were originally designed. Such is the case with the term sexual harassment. Essentially, it describes situations in which a powerful person attempts to influence an individual's economic or academic status based on his or her response to sexual comments or behaviors. Title VII and Title IX of the US Code contain federal laws that prohibit discrimination based on sex in the workplace and in the education system, respectively. Accordingly, sexual harassment that occurs within the context of the employment or academic arena is prohibited under Title VII and Title IX and has evolved to apply to hostile work or academic environments that do not per se influence an individual's economic or academic status.

Additionally, states have adopted individual restrictions prohibiting sexual harassment in both employment and educational institutions. Recently, California expanded the scope of its sexual harassment statute, effective January 1995, to prohibit sexual harassment of patients or clients by professionals and persons in positions of power and authority. This amendment significantly expands restrictions on sexual harassment beyond the employment and academic setting.1

Within medical education, sexual harassment of this nature is common. Surveys of medical students suggest that somewhere between 36% and 52% of students experience sexual harassment during the medical school years. A survey of internal medicine residents found that 22% of the men and 73% of the women had experienced sexual harassment during their training.3 In these studies, as is generally the case, women are usually the victims and men the perpetrators.

Recently, the term sexual harassment has been invoked to describe situations in which patients engage in certain behaviors toward their physician, including sexually suggestive looks and gestures, sexual comments, obvious exposure of body parts, and actual physical groping or grabbing. In a survey of 599 female family physicians in Ontario, Canada, with a return rate of 70%, Phillips and Schneider4 reported that more than 75% of the respondents recounted sexual harassment by a patient at some time during their careers. The authors recognized that the expansion of the term to the clinical situation might be questioned by some because of the power residing with the physician in the doctor-patient dyad. They also stressed, however, that female physicians nevertheless share the vulnerability of other women, regardless of their professional status. The harasser in these instances was generally male (92%) and usually one of the physician's own patients (36%). The other cases consisted of a colleague's patient, new patients, emergency department patients, or walk-in clinic patients.

Sexual harassment in the study ranged from requesting genital examinations, displaying erections during physical examinations, sending gifts to a physician, sending a tape of love songs, giving a G-string to a physician (in one case), and grabbing or fondling the physician's breasts.

The use of the term sexual harassment

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ment in this context raises complex legal and clinical issues. In this communication we will discuss some of those complexities and consider the advantages and disadvantages of applying the term in this setting.

**DEFINITION**

Requests for sexual favors, sexualized physical or verbal conduct, and/or unwelcome sexual overtures are considered sexual harassment in an employment setting only if one of the following three conditions established by the Equal Employment Opportunities Commission is met: (1) submission to the advances is understood either implicitly or explicitly as a requirement for continued employment; (2) compliance with or rejection of the conduct is used as a basis to determine the employment status of the individual; or (3) the conduct of the perpetrator must create a hostile, offensive, or intimidating work environment or interfere with the individual’s work performance.

The first two conditions imply a quid pro quo and therefore a power differential. The third condition, involving the creation of a hostile work environment, clearly does not require a difference of power between the victim and the perpetrator.

The third condition has created the most controversy (and the most consternation) in management circles. While one might assume that most sexual harassment occurs between perpetrators in authoritative positions and victims in lower positions, studies suggest otherwise. In federal employment settings, only about 40% of perpetrators are superiors, with the majority of sexual harassment coming from peers or coworkers. One major cause for concern in the hostile work environment condition is that virtually anyone can be considered a potential harasser under such a broad definition. The implications for liability are alarming to business, educational institutions, and those in health care administration.

Sexual harassment based on the hostile work environment condition has been defined more rigorously in the case of *Meriton Savings Bank v Vinson.* In that case, the ruling established that four elements are necessary to substantiate such a claim: (1) the complainant must be a member of a protected class; (2) the behavior of the harasser must be unwelcome from the employee’s point of view; (3) the employee would not have been subjected to the alleged harassment except as a result of the employee’s sex; and (4) the harassment must be pervasive or severe enough to change the conditions of employment and create an abusive work environment.

The fourth element is usually pivotal in legal proceedings. Severity and pervasiveness both can be interpreted in highly subjective ways. Several courts have ruled that a “reasonable woman” standard should be used in determining whether sexual harassment occurred because men and women may differ in their perception of the presence and/or severity of sexual harassment. The courts reason that a female is more likely to empathize with the experiences of women in such situations.

**CLINICAL VIGNETTES**

Having established the legal definition of sexual harassment, let us now consider two clinical situations:

A 30-year-old male family practice resident walked into an examining room to see a 26-year-old female patient whom he had been following up for cervical dysplasia. When he walked into the room, the patient was undraped and completely nude. Lying on her back on the examining table, she said to the physician, “I think I’m in love.” The resident inquired, “With whom?” The patient responded, “With you. Don’t you want me?” The resident, flustered and unsure what to do, walked out of the room and stood in the hallway to collect his wits.

A 31-year-old female internist was examining a 31-year-old male patient who was being seen for a complaint of chest pain. When the internist walked into the examining room the patient said, “You look lovely today.” The physician thanked him and began auscultating his chest. The patient then said, “What is that perfume you’re wearing?” The physician did not answer but continued the examination. When she finished the physical examination, the patient said to her, “You know, I’m terribly attracted to you. Would you like to go out to dinner with me?” The physician responded, “No, our relationship needs to remain a professional one.” The patient responded, “Okay, I just thought I’d ask.” The physician then went over her findings and discussed them with the patient. He listened attentively and made no other flirtatious comments.

In determining whether the term sexual harassment applies to clinical situations such as the preceding two vignettes, we must first recognize that in neither case is submission to the advances a condition of the physician’s employment or a matter that could be used as a basis to affect employment decisions. In other words, there is no quid pro quo. The ruling out of the first two criteria of sexual harassment reduces the situation to a consideration of whether a hostile environment has been created.

The first element of the hostile environment claim is the requirement that the employee is in a protected class. The hostility in the workplace must be predicated on the complainant’s gender, and a simple stipulation as to the employee’s gender establishes that the employee is a member of a protected class. This element is not usually disputed, as both men and women may bring actions for sexual harassment.

When we move to the second element required to substantiate a hostile work environment claim, the situation becomes increasingly murky. To ascertain that the patient’s behavior was unwelcome postulates a degree of certainty and an unambiguous purity that may not always be the case. In the first clinical vignette, for example, the family practice resident may have been extraordinarily attracted to the female patient on the table and flirted that she found him irresistable. In this regard, her overtures may have been welcome. On the other hand, from an ethical standpoint he knew it was necessary to maintain professional boundaries, and the threat of violating his professional ethics may have made him extremely uncomfortable. In that sense, the overtures were unwelcome. Another possibility, of course, is that the family practice resident found the patient’s proposition completely unwanted, and these feelings led the physician to flee the room in horror.

Similarly, in the second vignette, the female internist may have
be flattered by the patient’s interest in her. An alternative possibility is that she was ambivalent about his interest, making it both wanted and unwanted. Alternatively, she may have found it thoroughly offensive. By setting limits with the patient to shore up the professional boundaries, she not only acted ethically but also demonstrated how a physician may exercise her power in the physician-patient relationship.

These two brief vignettes illustrate what is universally true—one person’s appealing flirtation may be another person’s verbal assault. Studies that have sought to determine what makes a particular form of conduct offensive suggest that the severity of the conduct is the most important single factor. Differences in power between victim and perpetrator may also be influential as to whether the behavior is viewed as unwelcome.

The power differential is complicated in the second vignette. In some cases the physician role confers sufficient power to override the traditional power imbalance defined by gender. The female internist made it eminently clear who was in charge, and the patient responded accordingly. If the male patient had a menacing demeanor or was physically powerful, however, the physician may have reacted differently. If he had stood up with an erection and said, “I want you sexually,” or grabbed the physician’s breast during the examination, one could argue that the situation had gone beyond sexual harassment to sexual assault in the first instance and sexual battery in the second. Finally, one campus study determined that behaviors are seen as more offensive if initiated by older married persons rather than by those who are young and single. These factors undoubtedly operate even in the physician-patient relationship.

Turning to the third element necessary to establish a convincing case for a hostile work environment, the plaintiff must prove that “but for” his or her gender, he or she would not have been subjected to the behavior. A plaintiff satisfies this element when the nature of the harasser’s remarks create a hostile working environment, regardless of whether the victims are of the same gender, because this constitutes the type of harassment contemplated to fall within the purview of Title VII.10

The “but for” one’s gender element is confusing because it appears to state that sexually oriented abuse that is directed toward both men and women cannot constitute harassment when, in fact, courts have held that sexually oriented abuse that is directed toward men and women can still constitute sexual harassment. For example, when a man harasses a woman by making comments concerning sexual acts he desires to perform with her, he is intending to harass her because she is a woman. “But for” her gender, he would not be harassing her. Similarly, when that same man harasses a woman’s husband, he can intend to demean the husband by making comments about the husband’s sexual performance with his wife, without desiring to perform sexual acts with the husband. In this scenario, the harasser satisfies the requirement of harassing the husband because of his gender.20 In a different scenario, a homosexual harasser who makes comments concerning sexual acts he desires to perform with another man also satisfies the requirement of harassing the victim because of the victim’s gender.

The fact that sexually oriented abuse directed toward members of the same gender as the harasser can still constitute sexual harassment is consistent with clinical experience, which documents that sexual attraction in the clinical setting may not coincide with the patient’s or physician’s usual sexual orientation. Whether the therapist harasses a patient of the opposite gender would be irrelevant, as long as the harasser intended harassment because of the victim’s gender. Severity and pervasiveness are the measures to be satisfied for the fourth element of proof. To constitute legally actionable sexual harassment, the severity and pervasiveness of the conduct must alter the terms or conditions of employment and create an abusive work environment. What constitutes a sufficient level of severity varies along the same lines as the perception of offensiveness. In *Harris v Forklift Systems Inc.* the Supreme Court of the United States held that psychological injury is not necessary to establish that a work environment is severely and pervasively hostile or abusive. In both the preceding clinical vignettes, the incidents appeared to be isolated rather than pervasive (although insufficient information is provided to determine pervasiveness). Determining the employment status of a practitioner is also a complicated matter. Employees are protected under the federal law, Title VII, to the extent that they can establish that they are in fact “employee[s],” as defined in the Code, and employed by an “employer,” as defined in the Code: [§2000e (f)]

(b) The term “employer” means a person engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year, and any agent of such a person . . .

(f) The term “employee” means an individual employed by an employer . . .

With respect to employment in a foreign country, such term includes an individual who is a citizen of the United States. [§2000e (f)]

Similarly, under state law, where the requirements vary from state to state, the employee must satisfy the definitions of employee and employer set forth by the respective state. Apart from the requirements of a certain number of employees and whether one is engaged in commerce, this analysis is further complicated by the fact that some physicians are solo practitioners, others are independent contractors, and the more fortunate, for the purposes of bringing a sexual harassment action against their employers, are employees.

If the female internist in the second vignette is in solo private practice, she is self-employed and cannot sue her employer for sexual harassment based on what she may experience as a hostile work environment in the examining room. She could, of course, transfer the patient to a colleague, in effect “firing” the patient. (Charges of medical abandonment can be avoided by turning the case over to another practitioner.) The family practice resident, on the other hand, is undoubtedly working in a clinic where he could turn to an employer for redress.

While it may seem strange to
some that a resident in that situation would make a complaint to an employer, such scenarios are the stuff of liability nightmares for executives and administrators in health services organizations. The hostile work environment claims could be based on the behavior of almost anyone, including a receptionist in the clinic, a visitor to the clinic, a person making a delivery from a business, a nurse, a custodian, a physician, or a patient. Current case law suggests that regardless of a person’s status, employers must take immediate corrective action when put on notice of such harassment.\(^{26,27}\) To hold employers liable for claims based on hostile work environment, the employer must prove that the employer knew or should have known of the harassment and failed to take prompt remedial action.\(^{29}\) The failure to take such action leaves an employer open for punitive damages.

The employer, then, faces an extraordinary dilemma in knowing how to take corrective action to satisfy the complaining employee. In the preceding vignettes, should the employer send a letter to the patients suggesting that they must find treatment elsewhere? What if the sexual harassment grows out of a medical or psychiatric condition? In the study by Phillips and Schneider,\(^{6}\) female physicians were less likely to view behavior as sexual harassment if the patient had a psychiatric or neurological illness that could have accounted for the patient’s behavior. What about unconscious aspects of personality style? It is well known that certain patients, both males and females, who have histrionic personality disorder, may behave seductively toward virtually everyone.\(^{29}\) In many cases, the seductive behavior is not intended to be harassing and does not even operate at a conscious level. It is important to stress that most patients with personality disorders are not in psychiatric treatment and regularly appear in emergency departments and in the offices of physicians from any specialty.

The presence of a personality disorder does not excuse patients from legal responsibility for their behavior. Nonpsychiatric physicians, however, may choose to address the patient’s behavior clinically just as psychiatrists would. To be sure, not all personality disorders are amenable to clinical intervention. While histrionic personality disorder, for example, may respond well to treatment, antisocial personality disorder may be highly refractory to any form of treatment.\(^{29}\)

Another large group to be taken into consideration are those patients who were victims of childhood sexual abuse. Many of these patients eroticize all relationships with caretakers because they have never learned to separate caring from sexuality. There is a growing literature that suggests higher rates of revictimization in those who have childhood sexual abuse histories.\(^{30-33}\) If the physician is a psychiatrist doing psychotherapy with such a patient, the sexualization would not be regarded as harassment but as important information to be understood and processed as part of helping the patient. Consider the following vignette:

A 24-year-old female incest victim with a diagnosis of histrionic personality disorder was seeing a 38-year-old female therapist. The patient said to the therapist, “The only way you’ll ever get to know me is to sleep with me.” The psychiatrist responded, “We need to use words here in psychotherapy. Sexual contact will not be part of this relationship.” In response to this limit setting, the patient began to bring explicit sexual fantasies about her therapist and to read them out loud to her in every session. The therapist grew increasingly distressed because she did not know whether to collude with what was going on by listening to the fantasies or to stop the patient from bringing in such material.

While the female physician in this situation might feel psychologically harassed, from a legal perspective a sexual harassment claim would probably not hold up. The psychiatrist could not argue that the behavior was unwanted because the patient’s sexual behavior was central to the treatment. In fact, in a dynamic psychotherapy process, all material is welcome because only through completely and honestly sharing feelings and thoughts can the therapist gain access to the patient’s inner world. If the female physician complained to the employer, the employer would undoubtedly make it clear that she needs to work with the material, avail herself of supervision, or transfer the patient to someone else.

**CONCLUSIONS**

Let us now return to the question posed in the title of this article. Can patients sexually harass their physicians? The answer would have to be, “It depends.” On what does it depend? Because a quid pro quo is rarely involved in such situations, sexual harassment largely depends on the establishment of a hostile working environment. This dimension, in turn, depends on a number of factors. As the foregoing discussion suggests, paramount among those factors are whether the patient’s conduct is clearly unwanted, whether the patient is being seen in a psychotherapeutic or quasi-psychotherapeutic context where sexual aspects of the behavior are the focus, whether the practitioner is self-employed or in a clinic situation, whether the behavior is regarded as severe and pervasive, and whether that behavior is regarded as offensive.

When a patient is clearly intimidating and uses threats or force on a physician, few would have any question that sexual harassment, assault, or battery has taken place. In situations that are primarily verbal, we enter a gray zone where consensus is difficult. Sex-role stereotypes invariably play a role in determining what is sexual harassment. Men are more likely to be seen as predators and women as victims of male predators. The literature on sexual harassment clearly suggests that usually women are harassed by men. However, when the physician is female and the patient a male, the male patient may become flirtatious out of aixiety about the reversal of the power situation and attempt to reverse it by asserting himself as a sexual male.

Most female physicians find that they can and do handle these situations by an appropriate exercise of the authority and power in their role of physician. As women physicians mature, most find that advances or sexual innuendos decrease in number and frequency. We suspect that this has less to do with the aging process and more to do with a mat-
ter of deportment. Because of the insecurity they project in the physi-
cian-patient interaction, inexperi-
enced clinicians may inadvertently 
leave themselves more vulnerable to 
sexual overtures by a patient. By con-
trast, the seasoned physician con-
veys a sense of professionalism and 
self-confidence that may inhibit and
discourage misuses of the profes-
sional relationship for other agenda.
Indeed, in the Phillips and Schneider 
study, only a minority (22%) of the 
female family practitioners consid-
ered sexual harassment by patients a 
serious problem.

In many cases, physicians who
encounter sexual comments or be-
havior by their patients can take other 
steps short of litigation. Physicians 
who work in clinics can document 
the behavior in the medical record 
and inform their supervisor. If the
behavior persists, they may make a for-
mal complaint to their employer. For
physicians who are in solo practice 
or self-employed, they can simply tell 
the patient that they will no longer 
treat him or her and make an appro-
riate referral.

A final point of controversy re-
volves around whether physicians
have an ethical obligation to at-
tempt a clinical approach to the pa-
tient's behavior before resorting to 
legal redress. In situations in which 
the safety of the physician is seriously 
threatened, legal mechanisms may in-
deed need to be invoked. On the 
other hand, when the conduct is con-
 fined to looks or comments, there 
may be a distinct advantage for the 
physician to deal with it as a clinical 
problem rather than as a cause for 
litigation. The patient may well benefit 
from a clinical situation in which 
problematic interpersonal behavior is 
addressed and examined in a forth-
right manner. Certainly psychia-
trists would make such attempts, and 
many primary care practitioners 
would argue that psychological in-
terventions are within their pur-
view as well.

There are several strategies that 
may effectively deal with this situa-
tion as a clinical problem. First, in 
the case of a single incident, fur-
ther sexualization may be inhibited 
by the physician's scrupulous at-
tention to professional boundaries in the 
physician-patient relationship.

As illustrated in the vignette in-
volving the 31-year-old female in-
ternist, an explicit statement about 
the strictly professional nature of the 
relationship may be sufficient. Hav-
ing a nurse in the examining room 
with the physician may also serve as 
a deterrent to such incidents.

If the sexual innuendos and 
overtures are part of a repeated 
pattern, then it may be necessary to 
call attention to the behavior in a 
more systematic way. For 
example, the physician may wish 
to have the patient come into his 
or her office after the examination 
or even make another appoint-
ment for such a discussion. While 
we do not recommend that the 
practitioner should attempt to 
interpret the unconscious origins of 
the behavior to the patient, it 
may nevertheless be important to 
point out the problematic nature of 
the pattern—not only in the 
physician-patient relationship but 
in other relationships as well— 
and to suggest that psychotherapy 
may be a useful way to help the 
patient better understand the 
behavior. If the patient is willing to 
delve deeper, then referral to a 
psychiatrist can be useful. If not, 
and the pattern continues, transfer 
to another practitioner may be 
indicated.

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