CLINICAL SCIENCE

SEXUAL HARASSMENT IN THE PHYSICIAN-PATIENT INTERACTION: ANALYSIS OF CHARGES AGAINST DOCTORS IN THE STATE OF SÃO PAULO

Claudio Cohen, Rogério L'Abbate Kelian, Reinaldo Ayer Oliveira, Gisele Joana Gobbetti, Eduardo Massad

doi: 10.1590/S1807-59322009001100007

Cohen C, Kelian RL, RA Oliveira, GJ Gobbetti, E Massad. Sexual harassment in the physician-patient interaction: analysis of charges against doctors in são paulo state. Clinics. 2009;64(11):1075-83.

OBJECTIVE: This research intends to discuss sexual harassment within the doctor-patient relationship based on four parameters: doctor's characteristics, accuser's characteristics, accusation characteristics, and the evaluation by the Medicine Council of São Paulo.
METHOD: It is a descriptive, quantitative approach using a retrospective documental analysis. Studied subjects were doctors who were allegedly engaged in sexual harassment. This analysis considered all accusations made from January 2000 to December 2005 (n=150).
RESULTS: For this type of sexual abuse, there was a prevalence of male professionals (96.6%) who committed abuse against female patients (90.3%) during adulthood (77.7%). The mean age of the accused was 46.87 years, ranging from 30–76 years, concentrated between 46–75 years. The intrinsic difficulty of understanding sexual harassment by a professional constrained ethical evaluation of the cases, with 24.1% of the cases being considered proceeding charges by the professional council. When the cases were recognized as proceeding, they were either filed (88.2%) or were considered to be ethical infringement (11.8%) becoming Professional Ethical Process (PEP). In the majority of proceeding cases (87%), there was a Police Occurrence Report enclosed.
DISCUSSION AND CONCLUSION: The incidence of sexual abuse by professionals was independent of education, as the accused professionals came from a large variety of medical colleges, without significant differences related to institution. The predominance of accusations against older professionals may occur due to the frail personality structure that allows professional acting out. Objective evidence is very important in ethical evaluations compared to psychological and subjective evidence.

KEYWORDS: Sexual harassment; Sexual abuse; Physician-patient relationship; Medical errors; Physician impairment.

INTRODUCTION

The doctor-patient relationship presupposes confidentiality, privacy, and autonomy while also considering human diversity, customs and beliefs. It is necessary to recognize the limits of medical science along with the limits of human relationships and to respect the freedom of choice and decision-making of both parties in the relationship.

Throughout the years, medical science and technological advances have transformed the doctor-patient relationship into an exaggerated rationalization that underestimates psychological, social, and cultural aspects.[1] Indeed, the doctor-patient relationship has become marked by excessive worry over objective measurement and quantifying a dual perspective of body-mind.[2]

Since the time of Hippocrates, a sexual relationship between doctor and patient has been prohibited as there is dysfunctionality in this asymmetric relationship, which has been labeled as polymorphic incest.[3] It is well known that the patient's confidence is linked to the perception of the limits of medical practice, which are both important for the therapeutic relationship.

A sexual relationship between doctor and patient is forbidden in several countries by ethical code.[4-5] This kind of relationship is a historical conflict, a functional deviation in which both people allow themselves to develop

Legal Medicine, Medical Ethics, Social and Occupational Medicine, Faculdade de Medicina da Universidade de São Paulo - São Paulo/SP, Brazil.
Email: ccohen@usp.br
Tel: 55 11 3061.8420
Received for publication on June 18, 2009
Accepted for publication on August 04, 2009

different roles from those that are socially acceptable. It can also be understood as a perversion resulting from "transference love" in the doctor-patient relationship.[6] Transference provides the structure for an adequate therapeutic relationship according to psychoanalysis.[7] However, it lacks adequate clinical management by the professional for the patient's benefit.

According to an evaluation by the Medicine Regional Council of São Paulo State (CREMESP), sexual harassment represented 2.49% of the professionals in this council who were sued between 2000-2006. These data show the importance of the theme of sexual abuse within the doctor-patient relationship, which has important social consequences and of the professionals in this council who are sued, thus is a matter of public health.

There is currently great difficulty in making an accusation of sexual assault before this council due to the lack of objective proof against doctors/professionals who are sued for this offense. Nevertheless, this type of abuse can cause a loss of confidence in the doctor-patient relationship. Most accusers withdraw their accusations, providing evidence of human fragility. On the other hand, proven accusations demonstrate a reality that differs from the sacred and unquestionable doctor's image.

It is clear that psychic maturation aids in the perception of such human conflict, allowing the doctor to act ethically. This can happen by appropriation of moral limits, which impose an external authority and provide a structure through which the subject can deal with sexual desires.

It is recognized that judicial decisions concerning sexual abuse are not sufficient since the complexity of the concept of human sexuality and its limits must be embraced by the area of health. Ethical discussions about this phenomenon are scarce.

This paper aims to analyze sexual assault between of patient by doctor, emphasizing the characteristics of the accused doctor, peculiarities of the abused party, and the ways in which such factors influence the ethical and moral evaluations of the class council.

In order to analyze sexuality from a bioethical viewpoint, it is impossible to ignore the evolution of sexual context and sexual ethics throughout history. This history brings up deep scars, especially in relation to the exploitation of women. Medicine, along with philosophy and religion, have established the concepts of sexual ethics, sometimes keeping creeds and influencing paradox transformations. An example of this fact can be observed in the way in which medicine in the 19th Century in Western Europe addressed matters related to masturbation, such its connection with insanity and homosexuality, its treatment as a perversion and gender-related issues, specifically the implications regarding women's capacities for sexual desires.[8]

Before discussing the moral orders foreseen in ethic codes, it is vital to understand that sexual intercourse between doctor and patient results in a conflict concerning both parties' expected social function, not only their individual interests. Reports on attraction of patients to psychotherapists are common. In the same way, attraction of doctors to patients is not unusual.[9]

From the psychoanalytic viewpoint, several authors have described transference love in the doctor-patient relationship as a fundamental part of the therapeutic relationship.[10] However, it is necessary to adjust it through a professional clinical management in order for the patients to benefit from it.[11]

It is worth saying that transference love is not connected to the genital aspect of sexuality. The latter involves aspects introduced in the concept of sexual pulsion, which differs from the biological sexual instinct, which has the aim of species reproduction.

Subjectivity in the doctor-patient relationship is not defined by the moral rules that are characteristic of codes. Each human relation has its own characteristics that must be analyzed in each case.

The word love (*amore* in Latin) is defined as the emotion that inclines someone to wish good to another person or thing. Plato defined two different types of love, "authentic love" and "possessive love". The first sets the subject and his/her suffering free and the latter tends to devour the other object via harassment of him/her.[12]

Kant emphasized that only altruism in love, the "action-love", disregards one's exclusive interest for the other's well being and, thus, is the truly acceptable type. On the other hand, "passion-love" considers individual interests and is nearly always associated with disregard for the other person.[13]

Freud defined Love, Eros, as being intrinsically connected to sexuality. He saw it as the propelling impulse within the psychic apparatus, i.e., what drives the subject's sexual desire to a certain object. Freud introduced the concept of Oedipus Complex, which is necessary for psychic development, and emphasized the presence of sexuality from early childhood. This was the first observation of the non-sexual relationship within the family. This fact allows for man to no longer be driven by desires at random but to learn how to divert the impulses to another place, making interactions within social relations as well as the culture possible.[14]

Freud considered incest prohibition the first and fundamental law for social relationships.[15] Lévi-Straus argued that such prohibition allows exogamy and the passage from the natural being into a cultural being.[16]

Cohen restated that sexual intercourse between doctor and patient is analogically similar to intra-familial sexual relationships under the social function view. A sexual relationship between a professional and his/her client perverts the expected social function of both subjects. These characteristics led Cohen to label the phenomenon as polymorphic incest, alluding to the polymorphic perverse infantile sexuality that is due to narcissism, which is unable to drive itself to any object.[3] Other researchers also considered the emotional and interpersonal dynamic of a sexual relationship between doctor and patient as similar to incestuous sexual abuse.[17,18]

For Foucault, sexuality has an aspect that is connected to the power relations observed in familial, working, religious, gender, and other relationships. He did not consider sex to naturally tend toward excess and, thus, be in need of controlling. On the contrary, he believed that power is a constituent of sexual desires, determining them, modeling them, and developing them into sexuality.[19]

Sex, which potentially latently causes a variety of human behaviors, began to receive scientific status through interpretation and medicine abused of concept of sexuality in the 20th Century through a nearly polymorphic movement. Thus, a true discourse over sexuality began. Its abusive manifestations would no longer be a part of guilt or sin or even transgression but would, in fact, be gradually classified between the binomial normal and pathologic.[20]

The greatest human difficulty is not to learn moral limits and even to prohibit sex within professional relationship, but understanding feelings and to divert attitudes ethically. Ethical attitudes observed in the actions of individuals are related to the emotional sensibility to mediate "what the heart speaks and the head thinks". Under this perspective, three fundamental principles of ethics are considered: perception of conflicts, autonomy, and coherence. The first is connected to conscience, the second to responsibility, and the third to adhering to an ethical attitude toward the other person as well as the relationship.[21]

Perverse use of sexuality between doctor and patient has a long history and it has been prohibited since Hippocrates' Code. However, since the 70ties, scientific papers have been published on the human complexity regarding this attitude. Several international authors including authors from Brazil have significantly contributed to the conceptual construction of sexual abuse.[9,14,22-23]

The Brazilian Penal Code defines sexual assault as follows: "constraining someone aiming to obtain advantages or sexual favors, with the agent taking advantage of his/her hierarchically superior position or condition with respect to work position or function".[24] It is wise to highlight the use of the word function in such an illicit act. The term function implies subjectivity and, thus, supports the notion that this topic should be analyzed from an ethical view.

MATERIAL AND METHOD

The current work is an exploratory-descriptive, quantitative approach that applies retrospective documental analysis. For this study, all accusations of sexual harassment registered in cases against doctors in São Paulo city from January 2000 to December 2005 were collected.

The research found 150 cases against doctors alleging sexual harassment registered with the professional council.

This paper was submitted to and approved by the Local Ethical Commission by Analysis of Research Projects. Doctors', patients' and institutions' identities were preserved, thus guaranteeing the professionals' and patients' confidentiality.

Research material was obtained from defense texts composed by doctors in response to charges made by patients who suffered alleged sexual harassment as well as from ethical evaluation reports from the medical professional council.

Data collection was conducted by one examiner. For the analysis, tables were created with the aim of standardizing data collection and providing a quantitative and comparative analysis. Those tables included the following variables and groups:

- Characteristics – Doctors: sex, age, specialty, college
- Characteristics – Accuser: sex, development phase, responsible for accusation
- Characteristic – Accusation: registration year, place of the alleged act, the time within the professional relationship in which the alleged sexual harassment occurred, time gap between the abuse and the accusation, number of victims of the same professional.
- Characteristic – Ethical evaluation: number of proceeding and non-proceeding charges, evaluation of non-proceeding and proceeding charges, and medical science ethical code infringement.

Collected data were inserted into a personalized table set in Microsoft Excel-XP and compared according to frequency, percent, and relative percent.

RESULTS

In terms of gender analysis, it was observed that all charges involved male professionals (96.67%), with no charges involving female professionals and little charges without this data (3.33%). The doctors had a mean age of 46.87 years. The following age groups were particularly represented in the sample: >36-45, >46-55, and >56-65

(Table 1). This is more evident when analyzing these age ranges relative to the total registered doctors in São Paulo the involving doctors with more advanced ages (Table 2).

Table 1 - Distribution by age group of accused physicians

Age group	%	% Accumulated
26 – 35	5.41	5.41
36 – 45	27.7	33.11
46 – 55	34.46	67.57
56 – 65	18.92	86.49
66 – 75	6.76	93.25
> 76	1.35	94.6
No observed data	5.41	100

Table 2 - Accusal frequency for various age groups relative to the frequency of total registered doctors in São Paulo

Age group	% relative frequency
26 – 35	0.036
36 – 45	0.186
46 – 55	0.235
56 – 65	0.266
66 – 75	0.308
> 76	0.127
No observed data	0.114

Concerning the specialties of accused doctors, most charges were found for Gynecology and Obstetrics (24.67%), General Surgery (5.33%), Pediatrics (4.67%), Cardiology, Medical Clinic, and Psychiatry (4%), and Urology and Traumatology (3.33%).

Figures show a higher incidence of charges relative to all registered doctors for doctors who were graduated at the following institutions respectively: Campos Medical Science College (FMC), São Paulo State; Federal University of Minas Gerais (UFMG), Barbacena Medical Science College (FUNJOB) Minas Gerais State; Medical Science School in Alagoas (ECMAL), Alagoas State; Pelotas Federal University (UFPel) in Rio Grande do Sul State and Para State Medical School (UEPA) in Pará State (Figure 1).

Whether the doctors graduated from a public institution (50%) or a private institution (40%) had little effect on the number of accusations.

In terms of the characteristics of the subjects of the alleged abuse, most were adults (77.71%), followed by adolescents (13.14%) and children (2.29%) (Figure 2). A gender analysis showed that 90.29% were women, 7.43% men; in 2.29% of cases, this data was not available. The proportion of allegedly abused adolescents who were male was considerable (53%), in comparison to children (who were primarily female) and adults (3.82% male) (Figure 2).

A percent difference was observed in the proceeding of charges of sexual harassment in relation to who made the accusation. Accusations initiated by the Medicine Regional

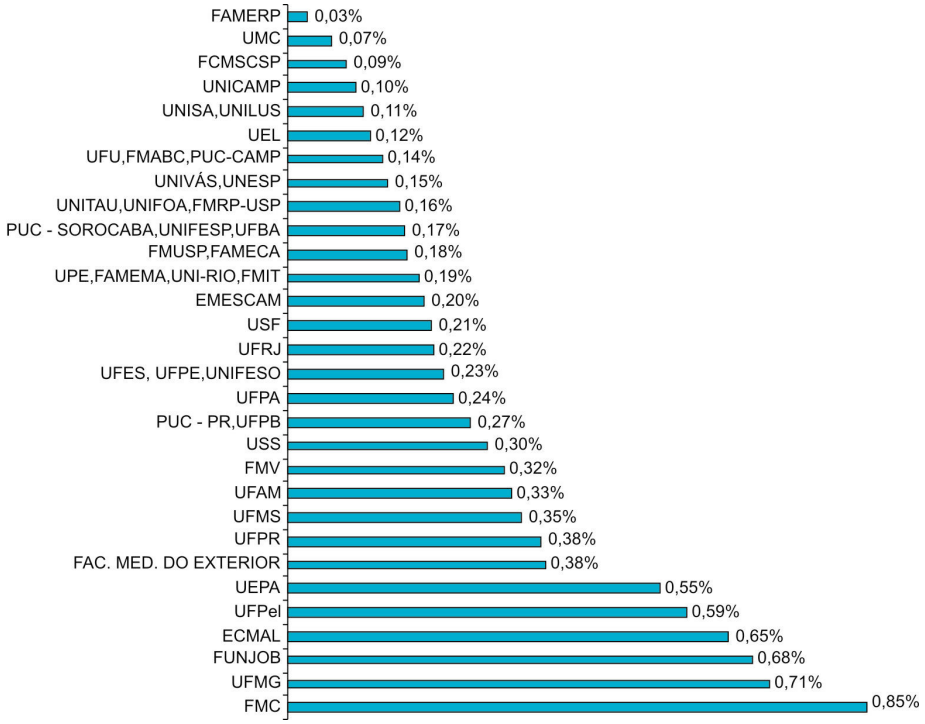

Figure 1 - Distribution by college of doctors charged with sexual offenses

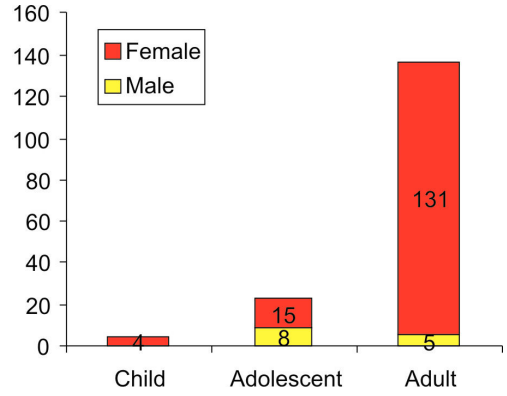

Figure 2 - Development phase and sex of the abused

Council of São Paulo State (CREMESP) itself were more frequently subject to a Professional Ethical Process (PEP) than accusations by either the District Attorneys (DA) or the victim. On the other hand, when the family made the accusation, most of the cases failed to proceed (Table 3).

Table 3 - Proceeding charges in relation to who has made the accusation

	Victim	DA*	CREMESP**	Family	Another institution
Total accusations	62	28	25	18	12
Processes in course	12	6	11	2	2
Relative Percent	19.35%	21.43%	44%	11%	17%

(*DA - District Attorney, ** Medicine Regional Council of São Paulo State)

As shown in Table 4, from 2000 to 2005, there was an average of 25 cases per year (n=150). In 2003, the highest number of charges were observed (36), and the lowest number was found in 2005 (15). From 2000 to 2003, a 56.52% growth in charges is observed; however, charges decreased in the following years by 58.73%.

In terms of the locations of the alleged occurrence, 34% were in public institutions and 38% in private ones. It is interesting to observe that 23% of cases did not show data identifying the location of the occurrence and 4% referred to other locations, that is, outside of the workplace. These results are not significantly different than those for cases sent to ethical professional evaluation, of which 47.06% were in private institutions and 44.12% were in public institutions, with data missing for 8.82% of the reported cases.

Sampling analysis showed a low percentage difference with regards to the time of occurrence of the alleged harassment. Of the total charges sent to PEP, harassment allegedly occurred within the doctor's office in 61.76% of cases, with 32.35% of the incidents occurring at the first appointment and 29.41% at subsequent appointments.

An interval between the moment in which sexual harassment was alleged until the accusation occurred in 52.38% of the cases was within 48 hours and up to 6 months. Although most accusations were made within that interval, there were some differences between accusations made after the first 48 hours and the others. Accusations that did not contain data related to this interval were excluded (Figure 3).

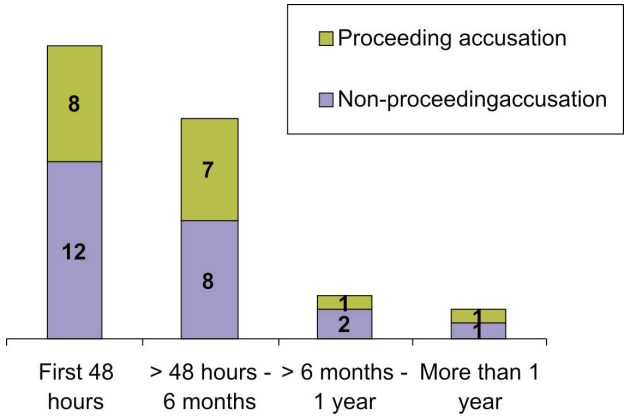

Figure 3 - Interval between the alleged abuse and the accusation

A difference was observed in the probability of ethical evaluation based on the number of victims (specifically, the higher the number of victims, the higher the possibility that the case was sent to PEP). Thus, findings showed that for cases involving one accuser, 20% of the cases were sent to PEP. When charges involved two victims, 57.14% were sent to PEP, and for cases involving more than two victims, 100% were sent to PEP.

In terms of the evaluation of cases by the ruling institution for the medical profession, results showed a high percentage of non-proceeding accusations (73.33%) in cases of alleged sexual harassment committed by doctors. The most common reason for the non-proceeding of charges was

Table 4 - All charges considered by the professional council related to the sexual harassment charges

Year	2000	2001	2002	2003	2004	2005
Sexual harassment charges	23	24	30	36	22	15
Total charges	2023	2413	2600	2404	3044	3082
Relative Percent	1.14%	0.99%	1.15%	1.50%	0.72%	0.49%

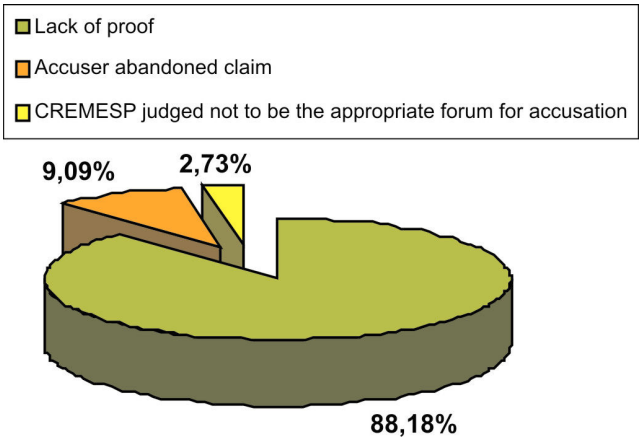

Figure 4 - Evaluation of non-proceeding accusations

lack of proof (88.18%) followed by the accuser ending the claim (9.09%), as shown in Figure 4.

Cases that included a Police Occurrence Report were sent to PEP at a much higher frequency that those that did not (83.36% vs. 13.64%, respectively), demonstrating the importance of this datum for ethical evaluation.

DISCUSSION

This work demonstrated that no charges of sexual harassment involved female professionals. The same is observed in crimes of sexual abuse, in general. However, in spite of the prohibition against incest, it is conducted by both sexes. These data are similar to other research[9] that observed a similar lack of female doctors who had sexual intercourse with patients (100% were male professionals). For total sampling in the same study, a nine to one proportion of male professionals to female professionals was found.

Some researchers who analyzed the prevalence of sexual intercourse between psychiatrist and patients observed that 81% were male professionals and 19% female professionals.[25]

Findings in this study show that 96.67% of charged doctors were men, 90.29% of charges were made by women, and only 7.43% were made by men. These data imply that in Brazil, difficulties in making charges of homosexual misconduct remain. These findings are similar to another study that observed charges of sexual harassment against doctors throughout Brazil and showed that 94.8% of the accused doctors were male doctors, and only 1.7% were female doctors.[26]

Even though sexual harassment by doctors is considered an abusive, unethical, and incestuous act due to the asymmetric nature of the doctor-patient relationship, the issue of accusing a woman who is allegedly the aggressor is complex. This is understandable if one uses an analogy to the mother in a family, who is primarily responsible for childcare from the time of breastfeeding. It is difficult to realize the exact moment at which a tender act becomes excessive and when love surpasses the healthy border and becomes abusive. If such perception is complex, making an accusation seems to be even more complex. On the other hand, recognizing when a father-child intra-familial relationship is inappropriate is not difficult. Furthermore, sexual intercourse is not the only type of sexually abusive act; there are also attitudes that are subtle and difficult to perceive that can easily violate a person's boundaries.

In terms of sampling group age, the observed average age of the accused doctors was 46.87, ranging from 30 to 76 years. Another study found doctors accused a little younger, with the most frequency of these cases between 45 to 54 years, with an average age of 45.6 and a range from 25 to 74 years.[29] The study analyzed such data as socio-cultural and psychopathological factors related to affective re-establishment, affective familial living, spouse/husband unsteadiness, and professional stress resulting from the dual demands of family and the professional social role. Other research found an even younger doctor sample ranging from 30 to 50 years old, with the most frequency of doctors accused from 41 to 50 years.[9] Another author found 42% of the physicians from 40 to 49 years old accused for patients of sexual harassment and 33% of theses cases involving professionals between 50 and 59 years old.[26] In addition, other studies found similar data for psychotherapists who become sexually involved with patients, with the highest prevalence being among psychotherapists who were 40 to 50 years old with significant clinical experience.[14,27]

When the relative frequency was analyzed considering all professionals registered at the medical board of the state of São Paulo, the data indicates older doctors from 46 to 75 years old instead of 36 to 65 according to absolute frequency. This demonstrates that the studied phenomenon has an important relation to the more advanced age group and raises the possibility that other factor is related to this phenomenon, such as the doctors' psychic structures for facing old age.

Maybe another reason might explain this concentration of doctors observed between 46-75 years that may be due a probable conviction that older doctors domains the medical-patient relationship and so they would have total control of consequences and acts practioned. Other hypothesis would be a big existential insatisfaction that makes the doctors transfer to doctor-patient relationship.

Interestingly, the age group from 26 to 35 years accounted for only 5.41% of the charges, while the age group from 36 to 75 years accounted for 87.83% of charges. On the other hand, this fact contradicts the perception that

the elderly are asexual beings, similar to the situation with children, who were long believed to be asexual before psychoanalysis contradicted this belief.[28]

Psychoanalysis has provided very few investigations concerning elderly sexuality. There is a Brazilian author named Corrêa who discussed the hypothesis of a reoccurrence of the Mirror Phase in the elderly. This process causes the subject to recognize the life span through his/her own image, transforming aging into anguish. The Mirror Phase is of great importance for recognizing symbolic body imaging and recognizing the other one inside oneself, thereby causing a child to observe his/her own body and address the sexual desire. In older age, a lack of recognition of the other one, due to changes in one's image caused over time, prevents this addressing of sexual desire. These changes may lead to an identity crisis.[29]

The highest percentage of accused doctors specialized in Gynecology and Obstetrics (24.67%). This fact can be easily understood by the obvious object of work in this specialization; thus, this data was not considered as relevant in this study. Furthermore, it is important to highlight the high number of accusations in which the doctor's specialty was not mentioned.

Based on an analysis of the colleges attended by doctors accused of sexual harassment (a great number of institutions were involved), it was found that such acts are not related to the doctor's academic training. There was little difference in sexual harassment cases with regards to college when considered relative to the total number of doctors that graduated and were within the working market. This fact has been observed by other authors who stated that sexual abuse in the physician-patient relationship occurs independent of educational formation.[21,22]

This research shows that 90.29% of abused people were women and 7.43% were men. It is also observed that homosexual abuse charges were concealed considering that the alleged abusers were all men. Furthermore, the great majority of abused men were adolescents (53%).

In terms of reporting sexual abuse, 77.71% of accusers were adults, followed by adolescents (13.14%) and children (6.68%) (Figure II). Therefore, even though the majority of the sample was adult subjects, ethical matters regarding valid consent should be addressed.

The highest number of proceeding accusations (44%) were carried out by CREMESP itself, even compared to cases in which District Attorneys (21.43%) were the accusers. The lowest number (12%) of proceeding accusations occurred when the accuser's family made the charge. Data show that ethical evaluation may be disconnected from the judicial view and may also attribute low importance to accusations when the family is in the accuser.

The prevalence of sexual abuse charges was 1% relative to the all charges made against doctors. However, when compared to the total number of doctors punished by professional council, sexual abuse has a higher importance (2.495% of the cases). In addition, CREMESP reported an increase of 120% from 2000 to 2005 in charges against doctors and an increase of 75% in sued professionals.[30] These data suggest a high increase in the number of charges against doctors. However, charges of sexual harassment did not increase in the same proportion. This might mean that sexual abuse between doctors and patients is decreasing.

The locations where the alleged harassments occurred included public and private institutions, with no significant difference between these locations. It is worrisome that harassment occurs at a similar level in private institutions and public institutions, considering there is a different degree of autonomy concerning administrative aspects in private institutions. This may show a failure of all institutions.

Data analysis showed a mean interval of 53 days between the alleged act and the charge. In 52.38% of the cases, the accusation was made within the first 48 hours, and in 14.28% of cases, it was made from 5 to 16 months after the act. When examining proceeding accusations, the importance of making the charge between the first 48 hours and 6 months is not so clear, with insignificant percentage difference between proceeding and non-proceeding charges. Thus, the timing of the accusation seems not to be relevant to the ethical evaluation of charges. On the other hand, the fact that it takes over 6 months for some accusations to be made (12%) indicates how traumatic the act is for the accuser.

For the proceeding accusations, the abuse primarily occurred in the work place (61.76%), with 32.35% of occurrences at the first appointment and 24.41% following the first appointment. However, the high number of cases for which these data are not known reveals that they may not be significant for an ethical evaluation. Nevertheless, this phenomenon should be differentiated in order to understand that the link was established within the doctor-patient relationship.

The number of accusers abandoning their charge (9.01% of cases) was significant, which may be related to the stress associated with making an accusation or the difficulty of providing objective proof. The phrasing used, "giving up on the charge," is similar to criminal language.

The high number of non-proceeding charges in this study may suggest difficulties in objectively clarifying such charges and also in the ethical evaluation of this complex issue. This difficulty seems to be alleviated somewhat by the POR, which is presented in some cases sent to PEP, even if it is not sufficient to prove the alleged act. It is known that in all sexual crimes there is difficulty in obtaining concrete

proof, but an ethical evaluation should have a different procedure than judicial proceedings, considering other aspects without prioritizing objective aspects. This would influence the high number of filed cases lacking proof (83.62% of samples).

CONCLUSION

There are multiple reasons for sexually abusive behavior has a lower threshold for what he/she considers consent, whether it involves consensual sexual involvement or not, including biological, psychological and social influences.

The professional who has difficulties repressing the pressures of sexual instincts and also cannot differentiate professional relationships from other types of affective relationships has a lower threshold for what he/she considers consent. The same can be observed in relation to the patient, who is in a vulnerable position because he/she threw oneself into the therapeutic relationship, giving his/her intimacy and confidence searching to be aided.

The Medicine Regional Council of São Paulo State is one of the forums that judges doctors' professional behavior; however, it is not only important to judge and condemn, but also to understand the psychosocial aspects underlying the sexual abuse in order to treat and prevent it.

The role of Civil Justice is to compensate damages, and that of Penal Justice is to punish law breakers. Thus, the medical professional council's role is to provide ethical professional judgment of sexual harassment. Therefore, this council should not only consider objective proof, which is present in 88.18% of proceeding cases, but also include subjective matters that are relevant for an ethical evaluation. Most cases in which a doctor is charged by more than one patient are set to PEP. However, for cases in which there is only one accuser and no objective proof, only about 20% are sent to PEP. Concerning the accused doctors' characteristics, most were men aged 46 to 75 years. This seems to argue that the common perception of reduced ethical standards among recent professional graduates is unjustified, raising the possibility that unethical acts are related to personality traits that are beyond understanding from a deontological view. Understood as an unethical act, the occurrence of sexual abuse in the doctor-patient relationship on the part of more senior physicians may result from a powerful identity crisis that occurs at this age and causes a new fixing process of sexual desire.

There were few differences in institutions, showing that sexual abuse is an individually intrinsic phenomenon, and thus, it is present in all places regardless of the moral order or the education traits. This observation causes us to suggest that it is not sufficient for doctors to learn about MEC and for the colleges to teach it; it must also be understood and interpreted (instead of simply adhering to its rules and norms).

Results show that patients who made charges of sexual abuse were primarily adults and women. However, it is interesting to observe that abused men were primarily adolescents. These data might mean a paedophilic act, but should be more deeply studied.

A decrease in charges of sexual harassment against doctors within the time period cited in this paper counteracts the general view of increasing cases against doctors. The fact that the number of accusations of sexual abuse decreased while number of cases of doctors being sued increased reinforces the idea that many cases are not reported and that the reported cases of sexual abuse represent the "tip of the iceberg".

With regards to the complexity of the theme and also the historical aspects, it is noted that sexuality investigations have throughout history expended great amounts of scientific, religious, and social effort to understand human subjectivity through its excessive sexual manifestations.

Sexual intercourse at the first appointment should be considered as an acting out of the therapeutic relationship by the professional considered a misconduct and thus, he/she should legally be considered guilty. If the intercourse occurs later, it could be considered predictable by the professional and thus a deceitful act.

The designation of "accuser giving up" for filed cases that were abandoned due to lack of proof is similar to forensic evaluation language. However, an ethical evaluations should be done in all cases independent of desistance and objective data, that is, considering the individual subjective data through evaluation of professional personality.

The complexity of sexuality should not be treated as only an objective fact, for example, biological sex. Human sexuality is subjective and should be repressed in such a way that it is not randomly acted upon such that the individual accepts the functions of social relations and can live within the culture. For this reason, it is important to conduct a psychological evaluation in each case in addition to searching for objective and concrete points.

REFERENCES

1. Caprara A, Rodrigues J. Asymmetric doctor-patient relationship: rethinking the therapeutic bond. Ciência & Saúde Coletiva. 2004;9:139-46.

2. Helman C 1984. Culture health and illness.Wright, Bristol.

3. Cohen C. Bioética e sexualidade nas relações profissionais. São Paulo: Associação Paulista de Medicina; 1999.

4. Conselho Federal de Medicina. Código de Ética Médica 1998 [online]. Disponível em: http://www.portalmedico.org.br/novoportal/index5.asp

5. American Medicine Association. AMA Code of Medical Ethics 2007 [online]. Disponível em: http://www.ama-assn.org/

6. Freud S. (1915) Observações sobre o amor transferencial. In: Freud S. Obras psicológicass completas. Rio de Janeiro: Imago, 1980, v. 12.

7. Laplanche J, Pontalis JB. Vocabulário de Psicanálise. São Paulo: Martins Fontes; 1988.

8. Farley MA. Sexual Ethics. In: Reich WT (org.). Encyclopedia of Bioethics. New York: Simon & Schuster Macmillan; 1995.

9. Pope KS, Bouhoutsos JC. Sexual intimacy between therapists and patients. New York: Praeger, 1986.

10. Bissoli, S S P. O conceito de transferência nos "Estudos sobre a histeria" (Breuer & Freud, 1895). Paidéia (Ribeirão Preto); 2006; 16(33); 19-23 disponível em: http://sites.ffclrp.usp.br/paideia/artigos/33/04.htm#_ftn1#_ftn1

11. Balint M, O médico, seu paciente e a doença. Tradução de Roberto de Oliveira Musacho. São Paulo: Livraria Atheneu, 1975.

12. Platão. O Banquete. In: PLATÃO. Diálogos. Tradução de Jaime Bruna. São Paulo: Cultrix, 1976.

13. Clèment É, Demonque C, Hansen-Love L, Khan P. Dicionário prático de filosofia. Lisboa: Terramar, 1997.

14. Freud S. O futuro de uma ilusão e o mal estar da civilização. Rio de Janeiro: Imago, 1974.

15. Cohen C. O incesto um desejo. São Paulo: Casa do Psicólogo, 1993.

16. Lévi-Strauss, C. As Estruturas Elementares de Parentesco. 3ª ed. São Paulo: Editora Vozes, 2003.

17. Limbert J, Microys G. Exploring sexual exploitation by physicians. Ontario Med Rev. 1991;58:9-14.

18. Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. JAMA. 1991;266:2741-5.

19. Foucault, M. A história da sexualidade II: o uso dos prazeres. Trad. de Maria Thereza da Costa Albuquerque. 11ª ed. Rio de Janeiro: Edições Graal, 1988.

20. Foucault, M. A história da sexualidade I: a vontade de saber. Trad. de Maria Thereza da Costa Albuquerque e J. A. Guilhon Albuquerque. 18ª ed. Rio de Janeiro: Edições Graal, 1990.

21. Cohen C, Marcolino AM. Relação médico-paciente. In: Segre M, Cohen C (org.). Bioética 3ª ed. São Paulo: Editora da Universidade de São Paulo. 2002. p. 86-90.

22. Fortune M. Sexual Violence: The Unmentionable Sin. Cleveland, Ohio: The Pilgrim Press; 1983.

23. Gomes JM. Estudo ético sobre o desvio de conduta por assédio sexual na prática da medicina em estados brasileiros: análise de processos disciplinares e protocolos no período ente 1997 e 2001 [Dissertação]. Brasília (DF): Faculdade de Medicina da UnB, 2004.

24. Código Penal Brasileiro. Dos crimes contra os costumes, Maus tratos, Tipificação de lesões. 47ª ed. São Paulo: Saraiva, 2009.

25. Gartrell N, Herman J, Olarte S, Feldstein M and Localio R. Psychiatrist-patient sexual contact: results of a national survey. In: Prevalence. Am J Psychiatry 1986,143:1126-1131. Disponível em: http://ajp.psychiatryonline.org/cgi/content/abstract/143/9/1126.

26. Kardener S, Fuller M, Mensh I. A survey of physicians' attitudes and practices regarding erotic and non-erotic contact with patients. Am J Psychiatry. 1973;130:1077-81.

27. Pope KS. Research and laws regarding therapist-patient sexual involvement: implications for therapists. Am J Psychother. 1986;40:564-71.

28. Freud S. (1905) Três ensaios sobre a teoria da sexualidade. In: Freud S. Obras psicológicas completas. Rio de Janeiro: Imago, 1980, v.7.

29. Correa, CP. Visão psicanalítica da idade numerada. Cogito, 2003, vol.5, p.31-37. Disponível na World Wide Web: http://pepsic.bvs-psi.org.br/scielo.php?script=sci_arttext&pid=S1519-94792003000100005&lng=pt&nrm=

30. Conselho Regional de Medicina do Estado de São Paulo (2007). Disponível em: http://www.Cremesp.org.br/library/modulos/centro_de_dados/arquivos/denuncias_Cremesp.pdf