PROFESSIONALISM
Standards of Professionalism

Professional Relationships

Adopted April 18, 2005

AAOS Standards of Professionalism (SOPs) establish the minimum standards of acceptable conduct for orthopaedic surgeons. Violations of any SOP may result in professional compliance actions against an AAOS Fellow or Member found in violation. Not prepared using a systematic review, SOPs are developed through a consensus process and are ultimately adopted as official AAOS statements by the two-thirds vote of the AAOS Fellowship casting ballots.

As healers and professionals with specialized knowledge, orthopaedic surgeons hold a unique position of trust with patients, fellow physicians and health care providers. The professional relationships established between orthopaedic surgeons, fellow physicians and health care professionals are powerful tools that aid in caring for patients. To this end, the American Academy of Orthopaedic Surgeons and the American Association of Orthopaedic Surgeons (“AAOS”) have adopted these Standards of Professionalism.

The medical profession requires physicians to subordinate their own interests in favor of the patient’s best interests and hold themselves to high ethical and moral standards. Patients who entrust their medical care to orthopaedic surgeons have an expectation that they will be treated with compassion, empathy, honesty and integrity. It is incumbent on orthopaedic surgeons to develop professional relationships with colleagues and other health care professionals that satisfy the patient’s expectations.

The Standards of Professionalism draw from the aspirational Code of Medical Ethics and Professionalism that appears in bold italics. The statements that follow the aspirational Code establish the minimum standard of acceptable conduct for orthopaedic surgeons in their professional relationships. Violations of these minimum standards may serve as grounds for a formal complaint to and action by the AAOS as outlined in the AAOS Bylaws Article VIII.

These Standards of Professionalism apply to all AAOS Fellows and Members in their interactions as healers and as professionals valued for their knowledge and expertise. Only an AAOS Fellow or Member may file complaints of an alleged violation of these Standards of Professionalism regarding another AAOS Fellow or Member.
Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, I. A.:

*The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns.*

**Mandatory Standard:**

1. An orthopaedic surgeon shall, while caring for and treating a patient, regard his or her responsibility to the patient as paramount.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, V. A.:

*Good relationships among physicians, nurses, and other health care professionals are essential for good patient care. The orthopaedic surgeon should promote the development and utilization of an expert health care team that will work together harmoniously to provide optimal patient care.*

**Mandatory Standards:**

2. An orthopaedic surgeon shall maintain fairness, respect, and appropriate confidentiality in relationships with colleagues and other health care professionals. An orthopaedic surgeon shall communicate in a manner that enhances the profession.

3. An orthopaedic surgeon shall conduct himself or herself in a professional manner in interactions with colleagues or other health care professionals.

4. An orthopaedic surgeon shall work collaboratively with colleagues and other health care providers to reduce medical errors, increase patient safety, and optimize the outcomes of patient care.

5. An orthopaedic surgeon who transfers care of a patient to another physician or other health care provider shall facilitate the transfer of care for the welfare of the patient and cooperate with those receiving the patient.

Adopted April 18, 2005
Standards of Professionalism

Providing Musculoskeletal Services to Patients

Adopted April 18, 2005. Amended April 24, 2008

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The orthopaedic profession exists for the primary purpose of caring for the patient. As a member of this profession, an orthopaedic surgeon should be dedicated to providing competent musculoskeletal service with compassion and respect.

The Standards of Professionalism draw from the aspirational Code of Medical Ethics and Professionalism that appears in bold italics. The statements that follow the aspirational Code establish the minimum standard of acceptable conduct for orthopaedic surgeons when providing musculoskeletal services to patients. Violations of these mandatory standards may serve as grounds for a formal complaint to and action by the AAOS as outlined in the AAOS Bylaws Article VIII.

These Standards of Professionalism apply to all AAOS Fellows and Members in their interactions as healers and as professionals valued for their knowledge and expertise. Only an AAOS Fellow or Member may file complaints of an alleged violation of these Standards of Professionalism regarding another AAOS Fellow or Member.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, I. A.: The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns.

Mandatory Standard:

1. An orthopaedic surgeon shall, while caring for and treating a patient, regard his or her responsibility to the patient as paramount.
Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, I. C.:  
The orthopaedic surgeon shall not decline to accept patients solely on the basis of race, color, gender, sexual orientation, religion, or national origin or any basis that would constitute illegal discrimination.

Mandatory Standard:

2. An orthopaedic surgeon shall treat patients equally and shall not decline to accept patients solely on the basis of race, color, ethnicity, gender, sexual orientation, religion or national origin.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, I. D.:  
The orthopaedic surgeon may choose whom he or she will serve. An orthopaedic surgeon should render services to the best of his or her ability. Having undertaken the care of a patient, the orthopaedic surgeon may not neglect that person. Unless discharged by the patient, the orthopaedic surgeon may discontinue service only after giving adequate notice to the patient so that the patient can secure alternative care. Both orthopaedic surgeons and patients may have contracts with managed care organizations, and these agreements may contain provisions which alter the method by which patients are discharged. If the enrollment of a physician or patient is discontinued in a managed care plan, the physician will have an ethical responsibility to assist the patient in obtaining follow-up care.

Mandatory Standard:

3. An orthopaedic surgeon, or his or her qualified designee, shall be available to provide needed and appropriate care of a patient.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, I. F.:  
When obtaining informed consent for treatment, the orthopaedic surgeon is obligated to present to the patient or to the person responsible for the patient, in understandable terms, pertinent medical facts and recommendations consistent with good medical practice. Such information should include alternative modes of treatment, the objectives, risk and possible complications of such treatment, and the complications and consequences of no treatment.

Mandatory Standard:

4. An orthopaedic surgeon, or his or her qualified designee, shall present pertinent medical facts and recommendations to and obtain informed consent from the patient or the person responsible for the patient.
Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, II. B.:  
The orthopaedic surgeon should conduct himself or herself morally and ethically, so as to merit the confidence of patients entrusted to the orthopaedic surgeon’s care, rendering to each a full measure of service and devotion.

Mandatory Standards:

5. An orthopaedic surgeon shall serve as the patient’s advocate for treatment needs and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.

6. An orthopaedic surgeon shall safeguard patient confidentiality and privacy within the constraints of the law.

7. An orthopaedic surgeon shall maintain appropriate relations with patients.

8. An orthopaedic surgeon shall respect a patient’s request for additional opinions.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, IV. A.:  
The orthopaedic surgeon continually should strive to maintain and improve medical knowledge and skill, and should make available to patients and colleagues the benefits of his or her professional attainments. Each orthopaedic surgeon should participate in relevant continuing medical educational activities.

Mandatory Standards:

9. An orthopaedic surgeon shall commit to life-long medical and scientific learning.

10. An orthopaedic surgeon shall provide only those services and use only those techniques for which he or she is qualified by personal education, training, or experience.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, II. D.:  
Because of the orthopaedic surgeon’s responsibility for the patient’s life and future welfare, substance abuse is a special threat that must be recognized and stopped. The orthopaedic surgeon must avoid substance abuse and, when necessary, seek rehabilitation. It is ethical for an orthopaedic surgeon to take actions to encourage colleagues who are chemically dependent to seek rehabilitation.
Mandatory Standards:

11. An orthopaedic surgeon with a temporary or permanent impairment due to substance abuse (alcohol and/or drugs) shall seek professional evaluation and treatment in order not to jeopardize patient care and safety. He or she shall limit or cease his or her practice as recommended by his or her physician(s) or health care professional(s).

12. An orthopaedic surgeon with a temporary or permanent physical or mental disability shall seek professional evaluation and treatment in order not to jeopardize patient care and safety. He or she shall limit or cease his or her practice as recommended by his or her physician(s) or health care professional(s).

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, III. A.:
The practice of medicine inherently presents potential conflicts of interest. When a conflict of interest arises, it must be resolved in the best interest of the patient. The orthopaedic surgeon should exercise all reasonable alternatives to ensure that the most appropriate care is provided to the patient. If the conflict of interest cannot be resolved, the orthopaedic surgeon should notify the patient of his or her intention to withdraw from the relationship.

Mandatory Standard:

13. An orthopaedic surgeon shall disclose to the patient any conflict of interest, financial or otherwise, that may influence his or her ability to provide appropriate care.

Aspirational: AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons, III. B.:
If the orthopaedic surgeon has a financial or ownership interest in a durable medical goods provider, imaging center, surgery center or other health care facility where the orthopaedic surgeon’s financial interest is not immediately obvious, the orthopaedic surgeon must disclose this interest to the patient.

Mandatory Standards:

14. An orthopaedic surgeon shall not enter into any contractual relationship whereby the orthopaedic surgeon pays for the right to care for patients with musculoskeletal conditions.

15. An orthopaedic surgeon shall make a reasonable effort to ensure that his or her academic institution, hospital or employer shall not enter into any contractual relationship whereby such institution pays for the right to care for patients with musculoskeletal conditions.

16. An orthopaedic surgeon or his or her professional corporation shall not couple a marketing agreement or the provision of medical services, supplies, equipment or personnel with required referrals to that orthopaedic surgeon or his or her professional corporation.
Opinions on Ethics and Professionalism

Care and Treatment of the Medically Underserved

An AAOS Opinion on Ethics and Professionalism is an official AAOS statement dealing with an ethical issue, which offers aspirational advice on how an orthopaedic surgeon can best deal with a particular situation or circumstance. Developed through a consensus process by the AAOS Ethics Committee, an Opinion on Ethics and Professionalism is not a product of a systematic review. An AAOS Opinion on Ethics and Professionalism is adopted by a two-thirds vote of the AAOS Board of Directors present and voting.

Issue raised

What are the orthopaedic surgeon’s obligations to care and/or treat the medically underserved, i.e., patients who do not have insurance and who are unable to pay for such services?

Applicable provision of the Principles of Medical Ethics and Professionalism in Orthopaedic Surgery

“X. Societal Responsibility. The orthopaedic surgeon has a responsibility not only to the individual patient, to colleagues and orthopaedic surgeons-in-training, but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support and participation of the orthopaedic surgeon.”

Applicable provisions of the Code of Medical Ethics and Professionalism for Orthopaedic Surgeons

“I. B. The physician-patient relationship has a contractual basis and is based on confidentiality, trust and honesty. Both the patient and the orthopaedic surgeon are free to enter or discontinue the relationship within any existing constraints of a contract with a third party. An orthopaedist has an obligation to render care only for those conditions that he or she is competent to treat.

“I. D. The orthopaedic surgeon may choose whom he or she will serve. An orthopaedic surgeon should render services to the best of his or her ability. Having undertaken the care of a patient, the orthopaedic surgeon may not neglect that person. Unless discharged by the patient, the orthopaedic surgeon may discontinue services only after giving adequate notice to the patient so that the patient can secure alternative care. Both orthopaedic surgeons and patients may have contracts with managed care organizations, and these agreements may contain provisions which alter the method by which patients are discharged. If the enrollment of a physician or patient is discontinued in a managed care plan, the physician will have an ethical responsibility to assist the patient in obtaining follow-up care. In this instance, the orthopaedic surgeon will be responsible to provide medically necessary care for the patient until appropriate referrals can be arranged.”
“VI. C. Physicians should be encouraged to devote some time and work to provide care for individuals who have no means of paying.”

“IX. A. The honored ideals of the medical profession imply that the responsibility of the orthopaedic surgeon extends not only to the individual but also to society as a whole. Activities that have the purpose of improving the health and well-being of the patient and/or the community in a cost-effective way deserve the interest, support, and participation of the orthopaedic surgeon.”

**Other references**


American Medical Association, *Current Opinions* of the Council on Ethical and Judicial Affairs,

Section 2.095 (“The Provision of Adequate Health Care”)  
Section 9.065 (“Caring for the Poor”)

American Medical Association Council on Ethical and Judicial Affairs, “Caring for the Poor,”  

**Background**

A significant portion of the citizens in the United States have inadequate access to medical care. According to a 1992 study, 17 percent of Americans had inadequate access to physicians, reflected in such factors as premature death and disability caused by controllable illnesses and high rates of infant and child mortality. A 1996 study by researchers in the Harvard School of Public Health found that 37 million Americans (31 percent) were without health insurance or had difficulty getting or paying for medical care at some time during 1995.

Since 1988, the number of uninsured persons in the United States has increased steadily each year. The non-elderly uninsured population grew from 33.5 million in 1988 to nearly 40 million in 1994, the year of the most recent national estimate. The number of American under age 65 with private insurance who are underinsured is estimated to be between 25 to 48 million, or ten to twenty percent of the population. These figures are 50% larger than analogous figures for 1987 and may be growing, since employers are offering less generous health insurance policies than in the past. In addition, the percentage of Americans with employer-sponsored health insurance is decreasing; nearly 6% fewer American under age 65 had such insurance in 1995 than in 1988.

While a lack of insurance or underinsurance do not necessarily result in reduced access to medical care, it clearly has an impact. People who are uninsured report up to 47% fewer visits to physicians and fewer hospitalizations than those who have insurance, even though they are in worse health.

The lack of access to health care in the United States is disproportionately distributed throughout the population. Well over half of U.S. population living under the poverty level are women and children. One in seven children in the United States is without health insurance. This is nearly one-fourth of the total uninsured population. When compared to the insured, they are four times more likely to report needing, but not receiving health care. In addition, strong differences in access to and utilization of health care persist for various racial and ethnic
groups. The lack of access to health care, particularly primary and preventative health care, has pronounced consequences both for the health care system and for society in general.

In addition, as the health care environment changes, there has been tendency by many Managed Care Organization (MCOs) not to cover those without insurance or those who are underinsured.

**Ethical Considerations**

I. **Obligation of Individual Physicians To Treat the Medically Underserved**

Organized medicine has long recognized that the individual physician has an ethical obligation to treat the medically underserved. For example, the first Code of Ethics of the American Medical Association (AMA) in 1847 provided that “to individuals in indigent circumstances, professional services should be cheerfully and freely accorded.” More recently, in 1993, the AMA Council on Ethical and Judicial Affairs stated that medical professionals should reaffirm their responsibility for making health care available to the needy.

Each physician has a moral and ethical obligation to care for the medically underserved. The objective of the medical professional is to care for the sick, to treat the ill without regard for who they may be, what their diseases are or whether they can pay. While reimbursement may follow, the pursuit of material gain is not the primary end of the medical profession.

The obligation of individual physicians to help care for the medically underserved is based in the concept of professionalism, including its pursuit of moral ideals such as justice and beneficence. By drawing on the physician’s mercy, compassion and empathy, charity care strengthens the bond between physician and patient that have often been weakened by increased commercialization of medicine. Providing care to patients without expectation of payment reaffirms the primacy of medicine as a helping profession.

Although physicians provide considerable charity care, improvements can and should occur. For example, in 1996, the AMA House of Delegates recognized a growing need for voluntary physician efforts to care for the uninsured in an era of increased fiscal constraint in both public and private sector programs. While most physicians provide free or reduced fee care within their practices, in 1993 as many as one-quarter to one-third failed to provide services to the medically underserved.

*What Care Individual Physicians and Orthopaedic Surgeons Are Providing*

In 1994, the AMA reported that 68% of all practicing physicians provided some free or reduced fee care, and devoted an average of 12% of their work time, 7.2 hours per week, to caring for the medically underserved, up from 6.5 hours per week in 1990.

According to *Orthopaedic Practice in the United States: 1996/7*, approximately ten percent of the care provided by orthopaedic surgeons is uncompensated or is paid by the Medicaid program. Four percent of the care is entirely uncompensated. In the most recent Orthopaedic Census Survey that specifically dealt with the issue of orthopaedic surgeon’s providing uncompensated care, the Academy found:
• Eighty-one percent of orthopaedic surgeons regularly provide care for
  patient from whom they neither expect nor receive compensation
  (including charity care clinics);

• Orthopaedic surgeons provide, on average, 37 professional hours per
  month on uncompensated care or where compensation is Medicaid or
  other reduced payment. This includes 9.1 hours where compensation is
  neither expected nor received; 13.3 hours where compensation is
  expected but not received; and 14.8 hours where compensation is
  Medicaid or similar reduced payment; and

• Sixty percent of orthopaedic surgeons indicate they are providing more
  uncompensated or reduced compensated care than they were five years
  ago. The average increase in hours per month indicated was 31
  percent.12

Recommendation of the AMA Council on Ethical and Judicial Affairs

In 1993, the Council on Ethical and Judicial Affairs of the AMA adopted a
 guideline regarding the individual physician’s obligation to treat the medically
 underserved. The Academy generally endorses this guideline and has revised it
 as appears below:

Caring for the medically underserved should be a normal part of
 each physician’s overall service to patients. Although the measure
 of what constitutes an appropriate contribution may vary with
 circumstances such as community characteristics and geographical
 location, orthopaedic surgeons should work to ensure that the
 needs of the medically underserved in their communities are met.
 Since a large number of the medically underserved are children, the
 orthopaedic surgeon has a special obligation to treat them without
 discrimination based on the ability to pay.

Orthopaedic surgeons should devote their energy, knowledge, and
 prestige to designing and lobbying at all levels to better programs
 to provide care for the medically underserved.

II. Obligation of Society and the Medical Profession To Treat the Medically
 Underserved

The duty to care for the medically underserved rests not only with individual physicians,
 but also with society and the medical profession as a whole. The policies of the
 Academy make improved access to medical care a clear priority. Since 1992, the
 Academy has publicly supported universal, affordable health care available to all. In its
 response to health care reform, the Academy stated that this country “must provide an
 essential and universally accepted health package for all Americans, regardless of
 ability to pay. This health care package must include a basic level of high quality health
 services, including musculoskeletal services.” In 1992, the Academy also stated that
 the medically underserved should be covered through “an expansion of the federal-state
 health care financing system.”
What Services the AMA and Medical Societies Are Providing?

A survey conducted by the AMA in 1997 found that 29 state or metropolitan medical societies conducted programs to arrange for the provision of free care by participating physicians in the state or area. In addition, 36 state or metropolitan medical societies sponsored or participated in free clinics to serve the medically underserved.10

Recommendation of the AMA Council on Ethical and Judicial Affairs

In 1993, the Council of Ethical and Judicial Affairs of the AMA adopted a guideline regarding the obligation of society and the medical profession to treat the medically underserved. The Academy generally endorses the guideline and has revised it as appears below:

The American Academy of Orthopaedic Surgeons and state and local medical societies should help society meet its obligations to provide health care services to the medically underserved. By working together in providing care for little or no compensation, by volunteering at local free clinics and/or by participating in active professional organizations and their affiliated alliances, orthopaedic surgeons and other physicians can be directly involved in and can encourage the provision of coordinated quality care for the medically underserved.

References:

5. Short PF and Banthin JS, New estimates of the underinsured younger than 65 years, JAMA, 174: 1302-1306 (1995)
9. Lundberg GD, National Health Care Reform; Answers of Inevitability is Upon Us, JAMA, 265: 2565-2567 (1991)


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Opinions on Ethics and Professionalism

Sexual Harassment and Exploitation

An AAOS Opinion on Ethics and Professionalism is an official AAOS statement dealing with an ethical issue, which offers aspirational advice on how an orthopaedic surgeon can best deal with a particular situation or circumstance. Developed through a consensus process by the AAOS Ethics Committee, an Opinion on Ethics and Professionalism is not a product of a systematic review. An AAOS Opinion on Ethics and Professionalism is adopted by a two-thirds vote of the AAOS Board of Directors present and voting.

Issue raised

What is sexual harassment? What should an orthopaedic surgeon do to help eliminate sexual harassment and exploitation?

Applicable provisions of the Principles of Medical Ethics and Professionalism in Orthopaedic Surgery

"II. Integrity. The orthopaedic surgeon should maintain a reputation for truth and honesty with patients and colleagues, and should strive to expose through the appropriate review process those physicians who are deficient in character or competence or who engage in fraud or deception."

"III. Legalities and Honor. The orthopaedic surgeon must obey the law, uphold the dignity and honor of the profession, and accept the profession’s self-imposed discipline. The orthopaedic Surgeon also has a responsibility to seek changes in legal requirements that are contrary to the best interest of the patient.

"V. Confidentiality. The orthopaedic surgeon should respect the rights of patients, of colleagues, and of other health professionals and must safeguard patient confidences within the constraints of the law."

"VII. Cooperation. Good relationships among physicians, nurses, and health care professionals are essential for good patient care. The orthopaedic surgeon should promote the development of an expert health care team that will work together harmoniously to provide optimal patient care."

"X. Societal Responsibility. The orthopaedic surgeon has a responsibility not only to the individual patient, to colleagues and orthopaedic surgeons-in-training, but also to society as a whole. Activities that have the purpose of improving both the health and well-being of the individual and/or the community in a cost-effective way deserve the interest, support, and participation of the orthopaedic surgeon."
Applicable provisions of the Code of Medical Ethics and Professionalism for Orthopaedic Surgeons

"II. A. The orthopaedic surgeon should maintain a reputation for truth and honesty. In all professional conduct, the orthopaedic surgeon is expected to provide competent and compassionate patient care, exercise appropriate respect for other health care professionals, and maintain the patient’s best interests as paramount."

"II. C. The orthopaedic surgeon should obey all laws, uphold the dignity and honor of the profession, and accept the profession’s self-imposed discipline. Within legal and other constraints, if the orthopaedic surgeon has a reasonable basis for believing that another orthopaedic surgeon or other health care provider has been involved in any unethical or illegal activity, he or she should attempt to prevent the continuation of this activity by communicating with that person and/or identifying that person to a duly-constituted peer review authority or the appropriate regulatory agency. In addition, the orthopaedic surgeon should cooperate with peer review and other authorities in their professional and legal efforts to prevent the continuation of unethical or illegal conduct."

"V. A. Good relationships among physicians, nurses and other health care professionals are essential for good patient care. The orthopaedic surgeon should promote the development and utilization of an expert health care team that will work together harmoniously to provide optimal patient care."

Other references


American Medical Association, Reports of the Council on Ethical and Judicial Affairs:

   o "Sexual Harassment and Exploitation Between Medical Supervisors and Trainees," 1989; and


Background

Unwelcome sexual advances, requests for sexual favors, and other verbal or physician conduct of a sexual nature constitute sexual harassment when submission to or rejection of this conduct explicitly or implicitly affects an individual’s employment, unreasonably interferes with an individual’s work performance or creates an intimidating, hostile or offensive work environment.

Sexual harassment can occur in a variety of circumstances, including but not limited to the following:
• The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
• The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.
• The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
• Unlawful sexual harassment may occur without economic injury to or discharge of the victim.
• The harasser’s conduct must be unwelcome.

Despite years of media coverage of this topic, surveys of women in medical school, post graduate programs, and in academic medicine show the incidence of perceived gender discrimination and harassment to be unchanged. Recent articles indicate that nearly half the women experience some form of gender-based harassment, especially early in their medical careers. ¹ & ²

Legal considerations

In recent years, the number of complaints of sexual harassment in the workplace has increased substantially as has the number of lawsuits alleging violations of state or federal law based on incidents of sexual harassment.

Legal claims of sexual harassment fall into two categories: “quid pro quo harassment,” whereby submission to or rejection of the sexual conduct is used as the basis for employment decisions; and “hostile environment harassment,” in which conduct is so pervasive that it unreasonably interferes with an individual’s job performance or creates an intimidating, hostile or offensive working environment.

Perceptions of what constitutes offensive behavior sometimes differ between men and women. Men generally are less inclined than women to view sexual teasing as harassment. Recently, some courts have begun to adopt the “reasonable woman” test for sexual harassment, ruling that behavior was sexual harassment if a “reasonable woman” would view it as such.

In a case of alleged hostile environment sexual harassment, a plaintiff must prove that “the employer did not respond promptly and effectively when it was apprised of (or should have discovered) the harassment.” An internal investigation followed by appropriate disciplinary action, when warranted, has been held to constitute a proper response in a number of cases.

Employees, such as nurses and support staff, who are sexually harassed may also seek redress from the federal Equal Employment Opportunity Commission (EEOC) and its state counterparts. In the educational context, medical schools and medical trainees are often perceived as sharing an educational rather than an employment relationship. However, the EEOC has determined that interns and residents are sometimes considered to be employees of the medical schools that provide them with clinical training. As such, interns and residents may have the same legal standing as employees to file charges of sexual harassment and discrimination under Title VII of the Civil Rights Act of 1964. In addition, the Civil Rights Act of 1991 gives victims of sexual harassment, whether employees or physicians-in-training, the right to receive punitive damages of up to $300,000. Sexual harassment is also widely prohibited under state law.
Ethical considerations

By definition, conduct that would constitute sexual harassment is unethical. Patient care may be jeopardized in this circumstance by the creation of a sexually hostile or offensive work environment.

Orthopaedic surgeons should ensure that their actions cannot be considered sexual harassment even by the most critical observer. They should strive to stop sexually harassing behavior by others in the work environment whether they are witness to or the recipient of such activity. The orthopaedic surgeon should promptly inform the harasser that his or her behavior is inappropriate and report continuation of said behavior to the appropriate authority. The orthopaedic surgeon must ensure that the nurturing and caring health care environment does not become sexually hostile or offensive by inappropriate communications, touching or sexual favoritism.

Consensual sexual relationships between medical supervisors and trainees are generally considered unethical because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees. Whenever a sexual relationship exists between a medical trainee and a supervisor who has professional responsibility for the trainee, the supervisory role must be eliminated if they wish to pursue their relationship.

Policies dealing with sexual harassment and exploitation

The American Academy of Orthopaedic Surgeons urges orthopaedic surgeons to comply with institutional sexual harassment policies and to develop and enforce such policies (or the concepts underlying these policies) in their own offices. These policies should acknowledge that both men and women are subject to sexual harassment or exploitation from members of the same or opposite gender and that mechanisms for resolving inappropriate sexual conduct must be equally stringent in all cases. Sexual harassment policies should also assure the rights of both the accuser and the accused and, to the extent possible, should protect the confidentiality of all involved. Generally, an effective sexual harassment policy will include:

- A description of the types of conduct that constitute sexual harassment;
- A strong statement that sexual harassment is unethical and unlawful and that the institution/orthopaedic surgeon will not tolerate such behavior;
- A statement of an employee’s right to complain about harassment without fear of retaliation;
- A requirement that supervisors and employees promptly report any sexually harassing conduct;
- A procedure for prompt, full and objective investigation of sexual harassment charges; and
- A statement that offenders will face disciplinary action and possible discharge.

Recommendations

The American Academy of Orthopaedic Surgeons urges orthopaedic surgeons to be aware of and sensitive to issues of sexual harassment and exploitation. Orthopaedic surgeons should conduct their activities professionally and should not jeopardize patient care through inappropriate sexual actions or comments. Policies should be implemented and followed to
ensure that all members of the health care team may perform their professional duties without fear of sexual harassment or exploitation.


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Opinions on Ethics and Professionalism

Sexual Misconduct in the Physician-Patient Relationship

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Issue Raised

What obligations does an orthopaedic surgeon have regarding sexual misconduct in the physician-patient relationship?

Applicable provisions of the AAOS Standards of Professionalism on Providing Musculoskeletal Services to Patients

Mandatory Standard 1: “An orthopaedic surgeon shall, while caring for and treating a patient, regard his or her responsibility to the patient as paramount.”

Mandatory Standard 3: “An orthopaedic surgeon shall serve as the patient’s advocate for treatment needs and exercise all reasonable means to ensure that the most appropriate care is provided to the patient.”

Mandatory Standard 5: “An orthopaedic surgeon shall maintain appropriate relations with patients.”

Applicable Provisions of the Principles of Medical Ethics and Professionalism in Orthopaedic Surgery

“I. Physician-Patient Relationship. The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns. The orthopaedic surgeon should be dedicated to providing competent medical service with compassion and respect.”

“II. Integrity. The orthopaedic surgeon should maintain a reputation for truth and honesty with patients and colleagues, and should strive to expose through the appropriate review process those physicians who are deficient in character or competence or who engage in fraud or deception.”

“III. Legalities and Honor. The orthopaedic surgeon must obey the law, uphold the dignity and honor of the profession, and accept the profession’s self-imposed discipline.”

“V. Confidentiality. The orthopaedic surgeon should respect the rights of patients, of colleagues, and of other health professionals and must safeguard patient confidences within the constraints of the law.”
Applicable Provisions of the Code of Medical Ethics and Professionalism for Orthopaedic Surgeons

"I. A. The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns."

"I. B. The physician-patient relationship has a contractual basis and is based on confidentiality, trust, and honesty. Both the patient and the orthopaedic surgeon are free to enter or discontinue the relationship within any existing constraints of a contract with a third party. An orthopaedist has an obligation to render care only for those conditions that he or she is competent to treat."

"II. A. The orthopaedic surgeon should maintain a reputation for truth and honesty. In all professional conduct, the orthopaedic surgeon is expected to provide competent and compassionate patient care, exercise appropriate respect for other health care professionals, and maintain the patient’s best interests as paramount."

"II. B. The orthopaedic surgeon should conduct himself or herself morally and ethically, so as to merit the confidence of patients entrusted to the orthopaedic surgeon’s care, rendering to each a full measure of service and devotion."

"II. C. The orthopaedic surgeon should obey all laws, uphold the dignity and honor of the profession, and accept the profession’s self-imposed discipline. Within legal and other constraints, if the orthopaedic surgeon has a reasonable basis for believing that a physician or other health care provider has been involved in any unethical or illegal activity, he or she should attempt to prevent the continuation of this activity by communicating with that person and/or identifying that person to a duly constituted peer review authority or the appropriate regulatory agency. In addition, the orthopaedic surgeon should cooperate with peer review and other authorities in their professional and legal efforts to prevent the continuation of unethical or illegal conduct."

Other references

American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs:

Section 8.45 (“Sexual or Romantic Relationships between Physicians and Key Third Parties”) [Issued December 1998.]

American Medical Association, Reports of the Council on Ethical and Judicial Affairs:

Report 29 “Sexual Misconduct in the Practice of Medicine” [Adopted December 1990.]


Background

The prohibition of sexual contact between a patient and his or her physician extends back to Hippocratic Oath: “In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasure of love with women or men, be they free or slaves.” Such prohibitions were intended to improve the poor image of the physicians of the time. In recent years, it has become clear that physician sexual misconduct is always harmful to the patient and detrimental to providing care.

The American Medical Association (AMA), the American Academy of Orthopaedic Surgeons (AAOS), and state licensing and disciplinary authorities uniformly condemn sexual contact between physicians and their patients. Highly publicized cases of physician assault of incompetent, unconscious or otherwise compromised patients have led states to elaborate and strengthen their rules of sexual misconduct. There has been an increasing awareness and public reaction to the existence of this problem and its harmful effects.

In 2006, the Federation of State Medical Boards (FSMB) issued guidelines for state medical licensure or disciplinary boards to use in dealing with physician sexual misconduct. The state boards are primarily charged with protecting public welfare in such matters. Their regulations are evolving to a policy that reflects a strict intolerance of sexual misconduct on the part of physicians which would allow the Board to take prompt and decisive action against any physician who commits sexual misconduct. Sexual misconduct exploits the physician patient relationship in a sexual way. The burden of recognizing this and avoiding this exploitation is always on the physician.

It is hard to know the true incidence of the problem, but it would appear that 5-10% of all physicians have had sexual contact with patients. Physicians from all specialties and backgrounds are involved. Nearly all violators are males and nearly all victims are females in our current awareness of the problem. It is also felt that the true extent of the problem may be much greater than our current awareness. Presently reporting systems by states do not categorize complaints or actions by type or specialty and little data is available.

Definitions

From a legal and ethical perspective, sexual misconduct may include a spectrum of behavior. Sexual misconduct is the exploitation of the physician-patient relationship in a sexual way. It is the use of the physician’s power and dominance to satisfy his or her sexual desires at the expense of the patient. Verbal or physical behavior of a sexual nature including conversation, gestures, and inappropriate touching may constitute sexual misconduct.

According to the FSMB guidelines, sexual misconduct may be categorized in two ways:

- **Sexual impropriety** – behavior, gestures or expressions that are sexually suggestive, seductive or disrespectful of a patient’s privacy or sexually demeaning to a patient.

- **Sexual violation** – physical sexual contact between a physician and a patient, whether or not it was consensual and/or initiated by the patient. This would include any kind of sexual intercourse or genital contact or masturbation, and touching of any sexualized body parts for purposes other than appropriate medical related examination or treatment. Exchange of prescriptions or other professional services for sexual favors would be another example of such a violation.
Many states have generated detailed lists of various behaviors in order to leave little doubt about what may be considered a sexual misconduct violation. Others have very brief definitions of physician sexual misconduct.

**Legal and Disciplinary Considerations**

Physicians who commit sexual misconduct face a variety of legal and licensing sanctions. If found responsible, they may be faced with medical professional liability claims and possibly criminal charges, depending on the circumstances. There is an increasing awareness and intolerance on the part of the public and professional organizations in dealing with this problem.

State licensing or disciplinary boards have a range of sanctions that may be applied to physician sexual misconduct. In cases of forced sexual contact, it is likely that the physician will lose his or her medical license. Current national tracking systems of licensing actions usually lead to similar action by other states where a physician may have a license or prevent a license from being acquired elsewhere. In other situations, a physician found guilty of sexual misconduct may be allowed to retain his or her medical license on probation and be monitored by the board. Many boards require a special evaluation of the physician and attendance at specific courses on ethics and boundary violations.

There is little information about the incidence of state licensing actions regarding physician sexual misconduct. There is also little known about recidivism for physicians who have committed sexual misconduct and continue to practice. It is felt by some experts to be very low.

In 2005, the AAOS Fellowship adopted Standards of Professionalism (SOPs) on Providing Musculoskeletal Services to Patients. Mandatory Standard 7 explicitly provides that “an orthopaedic surgeon shall maintain appropriate relations with patients.” Thus, if evidence is found of physician misconduct with patients which has not otherwise been acted upon by the state licensure or disciplinary body, the AAOS (through its Professional Compliance Program) may recommend appropriate action regarding their AAOS membership, such as censure, suspension or expulsion from the AAOS.

**Reporting of Sexual Misconduct**

Anyone, including physician colleagues, may report instances of suspected physician sexual misconduct to the state licensure or disciplinary boards. State boards are obligated to investigate such complaints. Often patients do not report sexual misconduct to the authorities because of feelings of shame, humiliation degradation and self-blame.

Physicians have an ethical and in most jurisdictions a legal obligation to report sexual misconduct by physician colleagues. Reporting of sexual misconduct is a required ethical standard by the AMA, AAOS and by many state licensing or disciplinary boards. Failure to report may be considered professional misconduct and subject to disciplinary action as well. However, studies reflect a significant discrepancy between awareness of misconduct and reporting.

**Ethical Consideration: Patient Consent and the Physician-Patient Relationship**

Substantial ethical concerns exist relating to physician sexual misconduct, even if the patient consents to the relationship or terminates the physician-patient relationship in order to then enter into a sexual relationship with his or her physician.
A patient cannot give meaningful consent to sexual contact with his or her physician due to the position of trust and the disparity of power in the patient-physician relationship. Sexual or romantic attraction between physicians and patients is common, and most physicians will acknowledge having such feelings. This may be a problem especially when the attraction may have come before or after the physician-patient relationship. While such attractions may seem natural and normal, they do not override the concerns of unequal power, vulnerability and potential for exploitation that come with a sexual relationship between the physician and the patient.

The patient must be able to trust that the physician will work only for the patient’s welfare. The needs or interests of the physician must not become a consideration in decisions about the patient’s medical care. Sexual involvement with a patient affects or obscures the physician’s medical judgment and is inevitably harmful to the patient. Accordingly, sexual relationships between patients and physicians are uniformly considered unethical and a form of professional misconduct. A consenting sexual relationship does not relieve the physician of the ethical and legal prohibition against such relationships.

Termination of a physician-patient relationship so that a sexual relationship may then be entered into may not always resolve this problem. If a physician finds there is a sexual or romantic attraction to a patient, there is an obligation to discontinue the patient relationship if the attraction cannot be appropriately controlled. However, great care must be taken when ending a physician-patient professional relationship and continuing with a romantic or sexual one. These latter cases may be unduly influenced by the previous trust, knowledge, influence, or emotions derived from the professional relationship. One is open then to the same considerations of sexual misconduct.

Some professional groups and state licensing or disciplinary boards provide designated time limits following the termination of the physician-patient relationship before the treating physician may ethically enter into a sexual relationship with a former patient. There is not agreement on such standards. Some feel such relationships with former patients are always unethical. The relevant consideration is the potential for the misuse of physician power and exploitation of patient emotions derived from the former relationship. The ethical propriety of a sexual relationship between a physician and a former patient depends substantially on the nature and context of the former relationship.

**Recommendations**

The American Academy of Orthopaedic Surgeons condemns sexual misconduct by orthopaedic surgeons and other physicians. AAOS believes orthopaedic surgeons should educate themselves about the issues of sexual misconduct in patient care and that orthopaedic surgeons who become aware of alleged sexual misconduct by colleague physicians should report it timely and appropriately. By doing so, orthopaedic surgeons will foster professional interactions with patients that are free of inappropriate sexual actions and comments.


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