



Of Doctor-Patient Sex and Assisted Suicide

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Abstract

The ethical chapter of the Israel Medical Association has recently issued guidelines with regard to sexual relationships between doctors and patients or past patients. This paper juxtaposes the paternalistic and severe attitude to doctor-patient sex with the relaxation and individualization of decisions regarding doctors' involvement in assisted suicide, passive and active euthanasia. The discussion bears on our concepts of palliative care and our expectations from it.

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The ethical chapter of the Israel Medical Association has recently published a statement regarding sexual relationships between doctor and patient [1]. The statement proscribes categorically any form of intimate relationship during therapy and within one year from the termination of the therapeutic interaction. Prof. Reches, chairman of the ethical chapter, explains: "The fundamental presumption is that a [sexual] doctor-patient interaction cannot be truthfully and fully consensual, since the power relationship is not equal. There is a unilateral dependence of the patient on the doctor."

In general, the law clearly prohibits any form of sexual activity without the full consent of the participants. The statement takes one step further, as it claims that in the case of a sexual relationship between doctor and patient, even explicit consent and cooperation are not considered genuine. The patient may feel, say and act as if he or she wants to have sex with his or her doctor; but the truth is that he or she does not. Dependency on one's doctor blinds one's judgment.

Moreover, sexual intimacies with doctors are ruinous to the patients. As a matter of fact, this kind of sexual relationship is so potentially exploitative and dangerous that it justifies a paternalistic and potentially harmful policy. After all, this ban might put a stop to innocent pleasures and might also prevent the formation of many potentially honest and long-lasting relationships. Patients' trust in their physicians entails a sense that they will not be exploited. But if some patients want sex and if this is good for them, no exploitation is involved. It is no secret that one of Israel's former prime ministers met his wife when she worked as a flight attendant, and he was a frequent flyer. Had she been his doctor, their relationship might have been considered unethical. In the contemporary corporate culture of massive healthcare systems,

the balance of social power between many doctors and many patients is not far from that between a passenger and his flight attendant. Maybe sex between a professor and his young resident or nurse is more of an ethical concern and an imbalance of power than sex between the resident and a former patient in her ward.

This new Israeli policy fits into the spirit of "zero tolerance" toward sex between doctors and patients [2]. Regarding relationships between doctors and their past patients, the Israeli position is actually less severe than that advocated abroad, but this is still considered a "gray area" [3,4]. Similar guidelines were published by the American Medical Association [5].

Since many psychiatric patients are lacking in insight, judgment and mental energy, and since the psychotherapeutic interaction often includes the discussion or even the invocation of erotic motifs, sex between psychiatrists and their patients is of particular concern, and the ethical guidelines are usually even stricter [6]. The extensive personal exposure involved in psychotherapy aggravates the asymmetry in a doctor-patient relationship.

Over and above the considerations particular to the clinical encounter, a sexual or romantic relationship between doctor and patient crosses "moral boundaries" [7] between "spheres of justice." It is widely held that sex is not a commercial product because eroticism does not belong in the marketplace (but see Primoraz [8]). Similarly, sex does not belong in the medical sphere either. The mixing of activities from different spheres of life enables imbalances in power to ooze from sphere to sphere, as for example when money rightfully earned in the marketplace influences rulings of the court of justice. On the other hand, complete and unconditional separation of social spheres is usually not practical and possibly not desirable [9]. Climbing the social ladder by means of sex that leads to marriage, or sex within it, is common worldwide.

It is also crucial that we distinguish between overlapping activities, such as a sexual liaison during an ongoing therapeutic relationship, and a doctor-patient relationship that metamorphoses into a romantic one; between sexual intercourse in the clinic and attempts at keeping the sexual apart from the therapeutic. Many patients, particularly severely disabled young men*, ended up

* I am not aware of statistical data. This is a commonplace in Israel where, for example, wounded soldiers married their nurses. Some of my own elderly patients married their live-in caregivers.

marrying their nurses. Is this unethical too? Is a severely handicapped patient less dependent on his nurse than on his doctor? Is the sexual ethics of nurses different from that of doctors? As the very word "care" implies, the ethics of care typically involves the *overlapping* of a relationship of dependency and a relationship of intimacy, although not necessarily of the romantic kind.

A "zero tolerance" policy is biased by the alienated interpersonal relationships of modern, capitalistic and industrialized urbanism, as it brings about discrimination against bachelor practitioners in small and intimate communities. Young unmarried doctors will have to find a spouse from far away or stay celibate. It has long been a Jewish practice not to appoint Rabbis who are unmarried.

The statement mentioned earlier ignores the significance of a context for sexuality. Carnal indulgences differ from the gradual cultivation of a tender relationship and mutual responsibility. Philosophers debate whether loveless sex, lust, is ethically inferior to sex that is coupled with love [10]. The statement also ignores the very common situation in which a romantic and even matrimonial bond precedes the therapeutic interaction.

The roots of the statement reach as far as the Hippocratic oath [11]: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free from all intentional injustice, of all mischief, and in particular of sexual relations with both female and male persons, be they free or slaves." The oath refers both to sexual misconduct the way we perceive it today and probably also to the habit of paying doctors with sexual access to slaves. This point might be relevant to the public debate over the selling of organs for transplantation. I am afraid that current trends are not far from legalizing the selling of sexual favors in specially supervised bordellos for the sake of procuring expensive medical services, such as the very organs offered for sale. This may be the only way that many poor people might be able to afford the care they need. Possibly some patients consent to sex with high ranking doctors because they could not otherwise get their attention.

Regrettably, Prof. Reches does not refer to the oath. Israeli doctors take the "Oath for the Hebrew physician" which was composed in the twentieth century. This and some similar oaths and prayers for Jewish physicians throughout history do not mention doctor-patient sex [12], possibly because this was a common libel against Jewish doctors in the Middle Ages [13].

Patients' dependence in and trust in their doctors may combine with their vulnerability and despair so as to make them consent to abuses other than the sexual. Doctors whose fame and funding is dependent on research are entrusted with the informed consent of patients who are subjected to uncomfortable and risky studies and experiments. Yet, the bioethical world seems content with the current situation in which special committees supervise the outlines of research, but not the individual confrontation between the researcher and his or her "subjects"/patients. In 1991 the American pioneer of assisted suicide, Kevorkian, harvested the kidneys of one of his "patients" and announced his intention to turn such patients, upon informed consent, into irreversibly comatose subjects of medical experimentation. These ideas are seriously entertained by ethicists and other professionals [14].

It seems that the severe attitude towards doctor-patient sex is

not on par with prevalent movements towards the commercializing of the bodies of the needy in the service of medicine and in the name of saving life.

The limits of terminal care and the limits of relationships of care

My intent here is not to offer comprehensive evaluation of the statement just released by the Israel Medical Association, but to put it next to another topic similarly treated by the Hippocratic oath: "I will never give a deadly drug to anybody if asked for it." Although it is possible that this statement addresses doctors who are bribed by a third party to poison a patient, the accepted reading of this clause refers to euthanasia [15]. The doctor swears not to kill his patient even if the patient pleads with him to do so. Similar to sexual intimacies, it has been widely held that death in the hand of the doctor can never be good for the patient and that anguish, pain and dependence on care cloud the patient's clarity of mind so as to render his request for euthanasia inauthentic.

Medical ethics has known numerous transformations since antiquity. Today, respect for personal autonomy is often considered a prime value. Medicine has a duty to be vigilant for possible abuse and bias, but it is also held that these concerns may be dealt with in ways that protect the basic right to choose death over life as a rational and ethical preference. Respect for autonomy also stresses one's absolute control over one's body. Opinions vary regarding the duties of caregivers in respect to that right. The point, however, is that in some countries recent legislation and lobbying by eminent philosophers successfully promotes the notion that patients have a right to make up their own minds regarding end-of-life care and even euthanasia. The Steinberg report, recently released in Israel [16], fully acknowledges the right of every terminal patient to be considered a "patient who does not want to go on living," and to be treated accordingly (however, the Steinberg report allows for only some forms of passive euthanasia).

Weithman [17] argues that euthanasia and assisted suicide must be prohibited on the same grounds that sex between doctor and patient is taboo. Doctors are not only tempted by sex, but also by a drive to rid themselves of "difficult" and undesired patients* [16]. The latter urge is not as overwhelming as sexual passion, but economic and social pressure to cut down on medical expenses is often relentless, maybe even brutal. Weithman claims that since sex and death are prone to self-deceit and abuse, these issues are too sensitive to be deliberated on a case by case basis. A wall to wall prohibition against the mere discussion between doctor and patient on the subject of sex or killing is mandatory in order to secure trust in medicine and in doctors.

Dworkin [20] retorts that life-and-death decisions must be made on behalf of patients, so the patients themselves are the ones to make them. Nobody can beg the question of putting patients on life support, so we should not shun the question of assisted suicide either. A sexual relationship between doctor and patient has

* In addition to the research cited by Weithman, consider the notorious commonplace GOMER (Get Out of My Emergency Room) [18,19].

nothing to do with the clinical encounter. Discussing end-of-life issues is an essential part of terminal care, while discussion, let alone the practice, of a sexual relationship between doctor and patient infringes on and besmirches the very notion of care. Dworkin's retort fails to account for the medicalization of death as seen in the wider context of commercializing the body in the name of personal autonomy. After all, the selling of organs and the renting of uteri are not part of clinical medicine. Obviously, deliberate lethal use of medicinal apparatuses and drugs is not part of medicine either; it is the very issue at stake in the euthanasia debate. We need not take sides in this debate in order to acknowledge the fact that we still tend to treat sexual matters in medical ethics in a paternalist way that has fallen from favor in other dimensions of the doctor-patient interaction.

What may all this teach us about our society, about the practice of medicine, about our own moral selves? Why are we willing to categorically ban all forms of sex between doctor and patient, while disconnecting life support and assisted suicide are deliberated on individually? Why are we willing to accept the notion that death by the hand of doctors is *good* for some patients, whereas having sex with them never is? Is it possible that we have grown more wary of sex than of death; that we are ready to crack down on sex and liberate killing at the very same moment in the history of medicine? Is it possible that we mistrust the only kind of consent given intimately, namely consent to erotic love, and at the same time embrace more and more forms of "supervised" consents to commercialize, industrialize, exploit in the name of science and even kill patients? Is power domineering only at the intimate level?

Evidently, severe measures against doctors who had sex with their patients did not spring from purely theoretical considerations. Patients came out complaining against doctors whom they had previously consented to have sexual relationships with. Many such patients sustained serious psychological injuries from which some never recovered. Patients who chose to die cannot have afterthoughts and sue their doctors. Is this a good reason not to protect them from being killed by their doctors as vigorously as we wish to protect them from sex? Do we respect the value of autonomy consistently?

Do these ethical developments reflect a growing ethos of death in medical ethics? Does Thanatos have the upper hand over Eros? Are we willing to take significant risks for the sake of procuring death, but not for worldly gratifications such as sex, drugs and even less controversial life-affirming activities such as singing, dancing or even prayer? If doctors can kill their patients or merely let them die, why can't they dance and pray with them? There were times and places where caregivers kissed the sores of the sick, not out of morbid eroticism but as a sincere token of utmost care and compassion. If all this sounds bizarre or mad when helping patients to die becomes a serious medical concern, it seems then that the spirit of Thanatos and the whip of the policing gaze have been quite successful in infiltrating our consciousness and conscience.

An outsider critic recently referred to the fledgling discipline of bioethics as "the culture of death" [14], protesting against the unprecedented energies directed at promoting notions such as "a

duty to die" and patients' right to death. The criticism might be too severe, but we had better heed the impact that trendy bioethical discourse has on the public.

"Whose Life Is It Anyway" is a 1981 movie about a sculptor who became tetraplegic and dependent on dialysis. The patient fights courageously for his right to die and not to remain locked in a cocoon of hospital care for the rest of his life. Although his life was miserable indeed, he had known moments of joy. In one scene he was smuggled outside the ward for a session of live rock 'n' roll and smoking marijuana. In another scene the patient cannot help insinuating his desire to be sexually relieved by his female nurses. Was the hero's adamant request to die a result of his medical condition or from the imprisonment this condition imposed on him within a routine of rigid hospital discipline and surveillance? Is it possible that had he been provided with raving music, recreational drugs and voluntary or commercial sex, he would have opted to go on living?

Do doctors and nurses have to entertain their patients or provide them with the particular ambiance that might encourage them to "carry on"? I do not know. All I want to say is that if doctors and nurses may assist patients to die, they may also try to expand patients' quality of life in every way possible.

Free and promiscuous sex has its disadvantages; many patients need protection from being sexually exploited by their doctors. A free society has a special duty to protect the weak from relentless utilization of their bodies and persons by powerful figures that they trust and depend upon. An absolute prohibition on making free choices within relationships of power might paralyze social life. Whatever the right measure in these matters should be, I hope contemporary practice is not influenced by Thanatos' victory over Eros, which is reflected by liberating death and policing sex.

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